

**THIS FINDING IS SUBJECT TO PROHIBITIONS AND RESTRICTIONS ON
PUBLICATION UNDER S 74 OF THE CORONERS ACT 2006**

**IN THE CORONERS COURT
AT AUCKLAND**

**I TE KŌTI KAITIROTIRO MATEWHAWHATI
KI TĀMAKI MAKĀURAU**

**CSU-2024-AUK-000211
[2026] NZCorC 847**

UNDER
WĀHANGA

THE CORONERS ACT 2006

AND

IN THE MATTER OF
MŌ TE TAKE

An inquiry into the death of

EFESO COLLINS

**(ALSO KNOWN AS FA'ANĀNĀ EFESO
COLLINS)**

Date of Findings: 5 June 2026
Whakataunga

**FINDINGS OF CORONER J ANDERSON
TE WHAKATAUNGA Ā KAITIROTIRO MATEWHAWHATI**

Introduction

[1] Fa'anānā Efeso Collins¹ died at Te Komititanga Square, Central Auckland, on 21 February 2024. He was 49 years old.

¹ Efeso Collins is referred to as Fa'anānā in these findings, in recognition of his matai name and status.

[2] Fa'anānā was the dearly loved husband of Fia (Cynthia Collins) and the father of two young daughters. He was also a highly respected Samoan matai and a Member of the New Zealand Parliament. Fa'anānā worked tirelessly representing his community and advocating for causes that he was passionate about.

[3] The week before he died, Fa'anānā gave his maiden speech to Parliament. He highlighted a number of issues that he wanted to address as a parliamentarian. These included poverty related challenges, the importance of social cohesion, and climate change. During his speech Fa'anānā stated "*I've come to this House to help. Helping is a deliberate act*".

[4] Characteristically, on the day that he died, Fa'anānā was helping others. He was participating in the WaterRun, a charity fundraising event to raise money and promote safe drinking water for children in the Pacific region.

[5] Following his death, a pathologist identified that Fa'anānā died of cardiac disease, arising from complications of diabetes, obesity and hypertension (high blood pressure).

[6] Deaths due to natural causes are not normally the subject of a coronial inquiry. However, Fa'anānā's wife raised a number of questions and concerns about the circumstances of his death, and made submissions about these matters via her lawyer, Mr Harris.

[7] Accordingly, on 29 July 2024 I opened an inquiry into Fa'anānā's death under the Coroners Act 2006 ("the Act").

Purpose of this inquiry

[6] Section 57 of the Act requires a coroner to conduct an inquiry to establish when and where a person died, the cause of their death and the circumstances of the death.

[7] A coroner can also make recommendations and comments in relation to a death which may, if drawn to public attention, reduce the chance of further deaths occurring in similar circumstances.²

[8] Coronial inquiries are not conducted for the purpose of determining civil, criminal or disciplinary liability.³

Is an inquest hearing required?

[9] I have reviewed the evidence obtained during the inquiry into Fa'anānā's death. This includes witness statements and other information provided by the police, as well as clinical records and reports from health providers and emergency services.

[10] I sought advice from the Chief Clinical Adviser to the Coroners Court, a General Practice Clinical Adviser and a very experienced independent cardiology and resuscitation expert. I have taken into account written and oral submissions made by Mr Harris and Mrs Collins at various stages of the inquiry process and during a Case Management Conference held at the Specialist Courts and Tribunal Centre on 26 March 2025. I have also reviewed audio-visual material provided by TVNZ and CCTV footage from Te Komititanga Square that is relevant to Fa'anānā's death. Written submissions have been made by New Zealand Doctors Speaking Out With Science (NZDSOS), a Covid vaccine advocacy group, and I have taken these into account.

[11] I have formed the view that I can determine the matters that I am required to decide based on the evidence already available to me and that an inquest hearing is not required. Accordingly, I have decided to conclude this inquiry by issuing written findings under s 77 of the Act. I have released a separate decision today setting out my reasons.

[12] However, I wish to make it clear that the decision to complete the inquiry in this manner is not a reflection on the importance of the issues involved, the mana of

² Coroners Act 2006, ss 57(3) and 57A.

³ Section 57(1).

Fa'anānā, or the great esteem in which he was held by many people. It reflects the steps that are required to fulfil my statutory responsibilities to determine the cause and circumstances of his death, and to make recommendations that I consider may help reduce the chance of similar deaths occurring in future.

Summary of findings and recommendations

[13] Fa'anānā died of cardiac disease, resulting from complications of diabetes, obesity and hypertension. His death occurred suddenly and unexpectedly. Efforts were made to resuscitate him after he collapsed, but he was not able to be revived.

[14] The use of automated external defibrillators (AEDs) and other resuscitative measures can increase the chance of survival after a cardiac arrest. However, there is never any guarantee that these actions will be successful. My independent cardiology expert has advised me that the best survival rates in cases like this are in the region of 50 per cent. The timeframe for commencing Cardio Pulmonary Resuscitation (CPR) and delivering the first defibrillator shock are important factors. These points are discussed in more detail later in these findings.

[15] Questions have been raised by Fa'anānā's family about the planning undertaken for the WaterRun event, the medical coverage in place, and the response after he collapsed. In my view, the steps taken by the WaterRun organisers were adequate, given the nature of the event. There was an experienced surf lifesaver on hand and there were a number of AEDs in the vicinity. The health and safety plan for the event identified the location of two AED devices. There were also a number of other AEDs nearby. The AED that was obtained and used for Fa'anānā was not one that was included in the event plan, but it was still retrieved, and used, promptly. The initial clinical readings obtained by the ambulance crew when they arrived on the scene indicate that the CPR carried out after Fa'anānā collapsed was of good quality.⁴

[16] However, there are some lessons that can be learnt from Fa'anānā's tragic death that may assist those planning community events in future. There are also important public health messages that need to be highlighted.

⁴ End tidal CO₂ reading – discussed later in these findings.

[17] Cardiovascular disease (CVD) is the leading cause of death in Aotearoa. Prompt access to AED devices and early commencement of resuscitation efforts can increase the chance of surviving a sudden cardiac arrest in the community, although it by no means guarantees survival. Ways of reducing CVD deaths include awareness about the importance of cardiovascular health; how to reduce CVD risk factors; and how to recognise cardiac symptoms.

[18] In order to reduce the chance of further deaths in similar circumstances in the future, I have made a number of recommendations and comments regarding these matters under s 57A, as set out at paragraphs [133]-[138] of these findings.

Background

Medical Background

[19] Fa'anānā had a longstanding history of type II diabetes, high cholesterol, gout, and hypertension. In 2015 he had bariatric surgery (weight-loss surgery). At the time of the operation, he had a body mass index of 41. This is classified as class III obesity. Fa'anānā's records indicate a significant family history of cardiac disease, with his father and brother both dying at a young age (from a stroke and heart attack respectively), and a sister undergoing major cardiac surgery in her thirties. Following the bariatric surgery, Fa'anānā lost a significant amount of weight.

[20] Fa'anānā was enrolled with a primary care medical centre and attended the clinic regularly. His diabetes was well controlled on medication, although he had microalbuminuria. This is a chronic leakage of protein albumin that can signal early kidney damage. A cardiovascular risk assessment was completed in November 2022. This assessed him as having a nine per cent chance of a cardiac event in the next five years, placing him in the intermediate risk category. At the time he died, Fa'anānā was taking appropriate medications to manage his health risks.

[21] During a consultation on 20 March 2023 Fa'anānā advised his doctor that he was exercising regularly and was going to the gym three to four times a week. He denied having any chest pains, shortness of breath or other cardiac symptoms.

[22] Fa'anānā's last primary healthcare consultation was on 28 November 2023. He was issued with repeat prescriptions for his regular medications and sought treatment for an ear infection. No cardiovascular symptoms were identified during the appointment.

WaterRun Event

[23] On the day he died, Fa'anānā was participating in a fundraising event for ChildFund. ChildFund is a global, non-profit, child development organisation that has been operating since 1938. The organisation works alongside communities to deliver community development programmes. ChildFund's stated aims include prioritising the perspectives of children and young people to create "environments where children and youth can grow, develop and flourish, free from violence".

[24] ChildFund worked with Campbell+Co to organise the WaterRun. Campbell+Co is an Auckland based marketing agency that specialises in experiential marketing. This includes the design and planning of events, fundraising, and related communications. Unless otherwise specified in these findings, I will refer collectively to ChildFund and Campbell+Co as the "Event Organisers".

[25] The WaterRun involved six high profile participants completing a 1km course carrying a 5-litre bucket of water in each hand. The goal was for each person to complete 15 laps around a short, flat track set up at Te Komititanga Square. Points were awarded for both the time taken to complete the course, and the amount of water in the buckets at the end of the event. The points awarded for the amount of water at the end were worth twice the value of the points awarded for the length of time taken to complete the event. The aim was to finish the course as quickly as possible but to keep water spillage to a minimum. This was in line with the key message for the event, which was that "every drop counts".

[26] Participants were given an event handbook prior to the event. This contained information about the race including what to expect, key messages for the media, and background notes about ChildFund projects. Participants were encouraged to share content about the event on social media to increase awareness and support donations.

Race kits were sent to participants. These included t-shirts, headbands, whistles, plastic buckets to practice with, and a training schedule. The schedule included details of seven challenges that participants could complete prior to the event, including hill/stair runs, speed walks, and walking lunges with filled buckets.

[27] There was a zoom call with the participants on 7 February 2024 to discuss preparation and logistics and to answer any questions about the event.

[28] A health and safety plan was prepared by the WaterRun organisers and submitted to Auckland City Council with the application for an event permit. This had a section headed “Medical Team and First Aid Procedure”. It included instructions to contact emergency services on 111 in the event of an emergency. It also identified the location of the nearest AEDs. These were noted to be near the escalators on the ground floor of the Commercial Bay shopping centre (which adjoins Te Komititanga Square) and the AIG building at 21 Queen Street (also bordering Te Komititanga Square). The nearest hospital was recorded as Auckland City Hospital, which was located approximately 3km away.

[29] A trained first aider was identified in the plan. This person, who I refer to as the Nominated First Aider in these findings, was individually named in the document. At the time of these events, the Nominated First Aider was employed as an Account Manager at Campbell+Co. She has a background as a competitive surf life saver with over ten years of experience and training in responding to emergency medical situations. The plan also recorded that two security guards, both trained first aiders, would be on site.

[30] An Event Risk Register submitted with the plan identified the possibility of a medical emergency occurring. The risks associated with this were noted to be “poor access for emergency vehicles” and “potential injuries to public and staff”. The mitigating actions were recorded as “designated emergency access, trained first aider on site, first aid kit on site”.

[31] An event permit was granted by Auckland City Council on 8 February 2024.

Events of 21 February 2024

[32] The WaterRun took place in Te Komititanga Square at the bottom of Queen Street, in Central Auckland. Te Komititanga is a large public plaza with high levels of foot traffic. It is bordered by commercial buildings, the downtown ferry terminal and the central train station. In 2024 the train station was known as Britomart, but in 2025 it was renamed Waitematā Station. The station is referred to as Britomart in these findings.

[33] The WaterRun was scheduled to start at 8:00 am on the morning of 21 February 2024, but the start was delayed and the event commenced slightly later.

[34] There was an induction for the immediate Campbell+Co event team and contractors at 7:45 am to discuss the health and safety plan and to assign responsibilities. There was a briefing with participants and the wider ChildFund team just prior to 8:00 am.

[35] Six people completed the WaterRun, including Fa'anānā. There was significant media interest in the event, including a TVNZ film crew broadcasting live from the scene as part of a breakfast television show. A well-known radio host was acting as MC and providing commentary. A small stage was set up near the racetrack.

[36] All the participants completed the WaterRun in approximately 10 minutes. Video and CCTV footage from the day shows Fa'anānā chatting and joking with the other competitors. He appears to be relaxed and happy before, during, and after completing the event. There are no indications that he is experiencing any physical symptoms or health concerns.

[37] Shortly after the event, during the prize giving ceremony, Fa'anānā was standing to the side of the stage by himself. He was smiling and interacting with the event MC during this period.

[38] Just before 9:00 am Fa'anānā suddenly collapsed without any warning, falling heavily to the ground on his right side.

[39] A number of people rushed immediately to his aid and a 111 call was placed. Fa'anānā then stopped breathing, and CPR was started by the Nominated First Aider. A portable AED device was obtained. Shocks were administered and CPR was continued until emergency services arrived at the scene. The timing of these events is discussed in more detail later in these findings.

[40] Further shocks were then administered by paramedics, along with intravenous (IV) medications to try and restore Fa'anānā's heartbeat. Despite these efforts, he was not able to be revived. Fa'anānā was pronounced deceased just after 9:30 am.

Cause of Death

[41] A post-mortem examination consisting of a CT scan, external examination and toxicology/biochemistry testing was performed by a forensic pathologist. This identified that Fa'anānā had a blunt force head injury consistent with a terminal collapse (a collapse at the time of death). There was no evidence of injury to his skull or brain. Based on height and weight measurements, it was noted that he met the clinical criteria for type two obesity. The pathologist noted that obesity causes pathology within multiple organ systems and is directly linked to diabetes, atherosclerosis (a build-up of plaque in the arteries), hypertension, sleep apnoea and certain cancers.

[42] Heavy calcification was identified in Fa'anānā's aortic valve in his heart and his coronary arteries (the blood vessels to the heart). There was also borderline enlargement of his heart, rib fractures consistent with resuscitation injuries, and calcification in a pattern suggestive of diabetes. Nothing of significance was identified through the toxicology testing. Elevated glucose levels were detected, consistent with Fa'anānā's known history of diabetes.

[43] The pathologist informs me that atherosclerotic disease is caused when abnormal fatty deposits occur within a blood vessel, commonly in the coronary arteries. When atherosclerosis has been present for a long time, it can calcify or harden. This causes a narrowing of the arteries, resulting in decreased blood flow to areas of the heart. The decreased blood flow can cause a chronic lack of oxygen (ischaemia)

which can cause the heart to form scar tissue (fibrosis). This affects the way that the heart pumps blood. It also affects how the electrical signals tell the heart to beat correctly, which makes the heart susceptible to stress.

[44] Diabetes is a chronic medical condition that results from how the body processes glucose in the blood. Over time, it can also cause damage to multiple organs, including the blood vessels (particularly the arteries of the heart), the kidneys, eyes, and nerves.

[45] The pathologist advises that hypertension is caused when the force on the blood moving through the body is too high. Over time this causes changes in the wall of the blood vessels, and changes in the heart, to overcome the increased pressure. Hypertension can also cause pathological changes in the kidneys that affect the small arteries and filtration ability of these organs.

[46] Based on the post-mortem findings, the pathologist advised me that the cause of Fa'anānā's death was cardiac disease due to complications of diabetes, obesity, and hypertension.

Family Concerns

[47] At various points during this inquiry, Mrs Collins has identified concerns regarding Fa'anānā's death. Some of these relate to matters outside the jurisdiction of the Coroners Court. By way of example, concerns were expressed about the timing and nature of media coverage after Fa'anānā's death; communications between Fa'anānā's family and state agencies after Fa'anānā passed away; issues relating to cultural practices undertaken at the scene where Fa'anānā died; and other matters that occurred after Fa'anānā's passing.

[48] Other concerns related to the adequacy of the health and safety planning for the WaterRun event, the nature of emergency medical coverage that was available, and the steps taken after Fa'anānā collapsed.

[49] During the inquiry, Mr Harris provided a written statement from one of the event security guards. The witness expressed concern that there was no EMT (Event Medical Team) assigned to work with the contracted security team covering the WaterRun. The security guard states that she has first aid training but did not think that this was sufficient to fully respond to the seriousness of the situation on 21 February 2024. She also expressed concern that she was the person who assisted to roll Fa'anānā into a recovery position and monitor his pulse during the resuscitation efforts. She said that shortly after being turned into the recovery position, she noticed that Fa'anānā stopped breathing, and she said she gave advice to start CPR. The security guard stated that there was confusion about where to obtain an AED and who was going to get it. She thought Fa'anānā would have received better urgent care if an EMT team had been on site. She said she did not think the event organisers knew what they were doing.

[50] Mr Harris also provided a statement from one of the event participants, Marina Fagaiava. He described some confusion regarding the obtaining of a defibrillator. He expressed surprise that there was no ambulance present at the event and described an “overwhelming sense of panic and concern” at the time of Fa'anānā's collapse. His view was that it was unclear who was taking charge.⁵

[51] Mr Fagaiava said he did not recall any health and safety conversations before the event. He said he was not asked to disclose any pre-existing health conditions or emergency contacts. However, he did remember being told on the morning of the event during the briefing that there was a first aider on the scene.

[52] As a result of the concerns raised by Fa'anānā's family, I obtained further information from the Event Organisers and other relevant parties. Pertinent details have been included in the description of events recorded in these findings.

[53] During the inquiry, I also requested that the police obtain CCTV security footage from Auckland Transport to assist in determining the sequence of events. The police made inquiries regarding this matter and informed me that footage was only

⁵ In contrast, a statement provided by another event participant, Hilary Barry, described the efforts to assist Fa'anānā as “swift, professional, deeply sensitive and entirely appropriate”.

held for five days, and the footage from 21 February 2024 was no longer available at the time of the request. However, Fa'anānā's family later managed to obtain copies of the Auckland Transport CCTV camera footage of the incident. This was provided by Mr Harris and the material has been of significant assistance in clarifying the sequence of events.

[54] During the inquiry I issued a production order under s 120 of the Coroners Act to TVNZ, requesting any footage held by that agency. TVNZ provided raw footage taken by crew members who were present at Te Komititanga Square filming the WaterRun event.

[55] As the inquiry progressed, I obtained expert medical advice from three experienced independent doctors - an emergency department doctor, a general practitioner and a specialist cardiologist who is also a resuscitation expert. Their advice is discussed below.

Coroners Court Clinical Advisers

Dr Clearwater

[56] Dr Clearwater is the Chief Clinical Adviser to the Coroners Court. Dr Clearwater is a very experienced emergency medicine specialist. In July 2024 I asked him to provide advice to me on certain matters relevant to Fa'anānā's death. These included the chances of successful resuscitation after a cardiac arrest, factors that can affect the likelihood of success, and whether there were any matters of concern that he could identify in relation to the resuscitation efforts on 21 February 2024.

[57] Based on the documentary records available to Dr Clearwater, he identified certain key events as follows. I note that at the time Dr Clearwater provided his advice, the CCTV and TVNZ footage referred to above was not available. Dr Clearwater's timeline is based on the Hato Hone St John emergency call automated data record system. The stated times therefore differ from the timings used later by Dr Scott, who has based his timings on the electronic clock embedded in the Auckland Transport CCTV footage.

- At 8:59 am an emergency 111 call from the Nominated First Aider was logged by Hato Hone St John. An intensive care paramedic was dispatched.
- At 9:04 am it was recorded that one AED (defibrillator) shock had been delivered and CPR was in progress.
- At 9:06 am the intensive care paramedic arrived at the scene. An ambulance arrived at 9:08am.
- At 9:10 am it was recorded that three defibrillator shocks had already been given.
- At 9:13 am it was noted that an airway tube had been inserted to keep Fa'anānā's airway open and IV access was obtained in his arm. A first dose of adrenaline was given.
- By 9:15 am Fa'anānā had been intubated and at 9:18 am a dose of amiodarone (an antiarrhythmic medication) had been given, along with further adrenaline.
- Defibrillation was continued and further adrenaline was administered at 9:24 am. Defibrillation continued but spontaneous circulation did not return. Fa'anānā was declared deceased at 9:38 am.

[58] Dr Clearwater noted that effective bystander CPR was started almost immediately, and an ambulance crew arrived 6-7 minutes after Fa'anānā collapsed. Three shocks had already been given by the time the ambulance paramedic crew administered their first shock at 9:12 am. This was consistent with the Standard Advanced Cardiac Life Support Protocols (ACLS) for Ventricular Fibrillation (VF). VF is a life-threatening heart rhythm disorder. The ACLS protocols usually advise that defibrillation shocks be given every three minutes. Dr Clearwater noted that in this case three shocks were administered between 9:04 am and 9:10 am.

[59] Fa'anānā was in persistent VF for several more minutes but did not respond to ongoing CPR, airway management, a total of 11 defibrillation shocks and the IV administration of adrenaline and amiodarone.

[60] Dr Clearwater advised me that sudden out of hospital cardiac arrests (OHCAs) are relatively common in New Zealand. The most recent report from the 2023-2024 period recorded that there were a total of 2,458 OHCAs. There was bystander CPR in 76 per cent of those cases, 23 per cent of adult cases were transported to hospital with ROSC (return of spontaneous circulation) but the overall 30-day survival was 11 per cent of all OHCAs. Dr Clearwater advises that this data is consistent with reports from paramedic systems in other developed countries.

[61] Dr Clearwater advised me that prompt administration of a defibrillation shock is the most favourable factor in survival for patients who have a “shockable” rhythm (a cardiac rhythm amenable to defibrillation). In the best-case scenario, if a patient has the onset of a cardiac arrest while in the presence of trained paramedics and while on a cardiac monitor, the 30-day survival rate after immediate defibrillation is 64 per cent. Statistical chances of survival decrease by approximately 5-10 per cent for every minute of delay from collapse to defibrillation.

[62] Dr Clearwater noted that Fa'anānā had some favourable factors. He had a witnessed collapse, prompt and competent bystander CPR, and he had a shockable rhythm. He advised that 23 per cent of adults with a witnessed OHCA who had attempted resuscitation and a shockable rhythm on a heart monitor survived to 30 days after the event.

[63] Dr Clearwater informed me that he had no significant concerns regarding the resuscitation efforts. There were some relatively minor issues that he thought may reflect the difficulty of keeping accurate records during a resuscitation attempt for cardiac arrest. In addition to prompt CPR and defibrillation, Dr Clearwater noted that there are other measures recommended via protocols, particularly the administration of adrenaline and amiodarone. However, he advised that their efficacy is nowhere near as clear. The Australian and New Zealand Committee on Resuscitation (ANZCOR) is the national authority on resuscitation issues. ANZCOR notes that “no

medication has been shown to improve long-term survival in humans after cardiac arrest”.⁶

[64] Dr Clearwater informed me that protocols for defibrillation use a sequence of interventions that cycle every two minutes after a shock, before the next shock is applied. The standard drug administered every four minutes is adrenaline, which stimulates the heart and constricts some blood vessels to give some boost to the circulation.

[65] In this particular case there was a five-minute delay (to 9:13 am) in establishing IV access in order to administer the first doses of adrenaline and amiodarone.

[66] An intra-osseous approach (inserting a needle through bone, directly into bone marrow) would have been faster and as effective and is supported by the ANZCOR. However, Dr Clearwater emphasised that there is no compelling evidence that faster administration of these drugs would have made a difference to survival.

[67] Dr Clearwater also noted in his advice to me that there were no clear details of the critical events between 9:04 am and 9:12 am. There was also mention of a public access AED device being used but there were no details available to him about whether this was deployed.

[68] Dr Clearwater stated that the statistical chances of surviving an OHCA are not great. Approximately three quarters of cases who had a shockable rhythm – the most “favourable” cardiac rhythm in OHCA - do not survive to 30 days. He noted that the ready availability of AEDs, deployed before paramedics attend, shortens the delay to defibrillation and increases the chances of successful defibrillation for shockable rhythms. It does not guarantee survival.

[69] A 2017 review reported that early defibrillation with AEDs applied by lay first responders is associated with an approximate doubling of survival (53 per cent) compared with survival when professional paramedics were dispatched to the scene to

⁶<https://www.anzcor.org/home/adult-advanced-life-support/guideline-11-5-medications-in-adult-cardiac-arrest/>.

apply defibrillation (survival of 29 per cent).⁷ He noted that it takes several minutes for an emergency service to receive details of a collapse, to alert a paramedic crew and travel to the scene. This causes an inevitable delay.

[70] Dr Clearwater thought it was quite possible that Fa'anānā was unaware that he had significant heart disease when he agreed to participate in the event. He noted that approximately 30 per cent of heart attacks are “silent” without classic features of crushing central chest pain. He thought that patients who are identified through risk assessment as having significant risk factors might be more attuned to the possibility of atypical symptoms and might potentially modify their physical activities. Dr Clearwater did not know whether Fa'anānā had been assessed for cardiovascular risks through routine screening and thought it would be useful to know whether, and how, this risk was quantified and whether all risk factors were optimally treated. However, he noted that these risks assessments are statistical profiles that provide support for modifying risk, they do not identify specific individuals with significant coronary artery disease.

Dr de Candole

[71] Following Dr Clearwater's advice, I asked an experienced general practitioner who is a member of Dr Clearwater's coronial clinical advisory team, to review the adequacy of the primary health care provided to Fa'anānā. Dr de Candole considered Dr Clearwater's advice, and she reviewed Fa'anānā's medical records and the post-mortem report.

[72] Dr de Candole informed me that Fa'anānā's general practitioners completed cardiovascular risk assessments using the PREDICT model. This is a web based clinical decision-making support tool that helps predict a patient's five-year risk of having a cardiac event. His most recent assessment was completed on 20 November 2022, and this identified that he had a nine per cent risk of having a major cardiac event within the next five years. This is classified as an intermediate risk.

⁷ Bækgaard JS, Viereck S, et al. The Effects of Public Access Defibrillation on Survival After Out-of-Hospital Cardiac Arrest: A Systematic Review of Observational Studies. *Circulation*. 2017;136(10):954. Epub 2017 Jul 7.

[73] Dr de Candole advised me that Fa'anānā's risk factors appear to have been managed in line with recommended best practice. He was taking blood pressure medication, with his most recent recordings indicating that his blood pressure was well controlled. He had never smoked, and he was taking a statin to lower his cholesterol. Dr de Candole noted that prior to the bariatric surgery, Fa'anānā's CVD risk was calculated at 15 per cent, due to obesity. This placed him in the high-risk category. His risk had lowered due to weight loss following the surgery, placing him in the intermediate risk category.

[74] Dr de Candole also noted that general practitioners are advised to discuss lifestyle interventions with patients to lower CVD risks. It was evident from the clinical records that these discussions had occurred repeatedly during consultations over the years, including diet, diabetic checks and exercise. During a telephone consultation on 20 March 2023 Fa'anānā was questioned about possible symptoms. He advised his doctor that he had no chest pain or shortness of breath. He said he was feeling tired after a long day, but he attributed this to poor sleep. He was eating a good diet and exercising at the gym three to four times per week. His weight was recorded as 129 kg.

[75] Repeat CVD screening is recommended in five years for a patient with Fa'anānā's risk profile, with his next assessment being due by 2027. Fa'anānā's family history of CVD events was taken into account by his doctors, as recommended by the guidelines.

[76] Dr de Candole informed me that the challenge in this case is that current guidelines for cardiovascular risk assessment recommend that cardiovascular risk factors are managed in general practice. Fa'anānā did not have any *symptoms* of cardiovascular disease such as chest pains, shortness of breath or pre-syncopal episodes (fainting/light-headedness). If he had, this might have prompted further investigation using the chest pain pathway used by clinical providers in the Auckland region.

[77] De de Candole advises that ultimately there is no way to accurately determine the state of anyone's arteries without specialist tests such as exercise tolerance tests or

coronary artery scans. Even though Fa'anānā's family history could increase his risk due to complex genetic and environmental factors, she thought his risk factors were very well managed within the context of the relevant guidelines and there was not much more that could have been done to identify the "silent" coronary artery disease that was found during the post-mortem. He had reduced his CVD risk with weight loss and was asymptomatic of cardiovascular disease. While Fa'anānā had not undergone further cardiac investigations prior to his tragic death, Dr de Candole's view was that this was not unreasonable.

Expert Cardiologist Advice

Engagement of expert

[78] The reports from Dr Clearwater and Dr de Candole were provided to Mrs Collins. Via her lawyer, she indicated that she still had outstanding concerns about the adequacy of the emergency response and the WaterRun preparations.

[79] Following a Case Management Conference held on 26 March 2025 I decided to engage an independent clinical expert to provide further advice to me about the likelihood of survival and issues regarding the adequacy and timing of the resuscitation efforts. Mrs Collins was provided with an opportunity to identify any specific questions she wanted the expert to address.

Expert adviser

[80] The expert I engaged was Dr Tony Scott. Dr Scott has over 25 years of experience as a specialist cardiologist, and he has been the Clinical Director of Cardiology for the Health New Zealand Waitemāta District since 2003. He also works part time as a private cardiologist. Since 2005 Dr Scott has represented the Royal Australasian College of Physicians and the Cardiac Society of Australia and New Zealand on the New Zealand Resuscitation Council. This is the New Zealand standard setting body for first aid and resuscitation training guidelines. Dr Scott has been the Chair of the Council since 2021. In that capacity he is also the current chair of the Australian and New Zealand Committee on Resuscitation and he represents Australia

and New Zealand as a delegate to the International Liaison Committee on Resuscitation.

[81] Dr Scott advised me that he concurred with the conclusions reached by Dr Clearwater and De de Candole. He noted that he had the benefit of further information that had not been available to them at the time they prepared their reports. This included the CCTV footage as well as downloads from the AED device that appears to have been used.

AED data

[82] While preparing his advice, Dr Scott informed me that it is sometimes possible to obtain data from AED devices. He indicated that this information, if it was available, would be very useful for the purposes of his report.

[83] I made inquiries with the AED supplier, Pharmco. I was advised that defibrillator machines do not retain data from all resuscitation events, but they do keep a log of the last episode when the device was used. If the device has not been used again in the interim, the data from a prior incident can still be available in some circumstances.

[84] With the assistance of Pharmco and Auckland Transport it was identified that three AED devices were present in the Britomart Train Station Building. One AED was found to have been replaced in March 2025 after failing a quality inspection. The two remaining devices were uplifted by a specialist engineer and the data was downloaded. This disclosed that one of the AEDs was last used on 3 January 2019. The second AED device contained data indicating that it was last used at 12:19 pm on 20 February 2024. Upon checking, the time display on the device was found to have a discrepancy of 20 hours, 39 minutes and 58 seconds between the displayed date/time and the actual date/time. Adding 20 hours, 39 minutes and 58 seconds to the recorded AED data time of 20 February 2024 would give an actual date/time of use of 8:59:30 on 21 February 2024. This corresponds with the resuscitation efforts commenced after Fa'anānā collapsed.

How do AED devices work?

[85] Dr Scott advised me that when a VF cardiac arrest occurs, the heart’s rhythm is interrupted by chaotic spontaneous electrical activity throughout the heart muscle. This means the heart can no longer contract. AEDs provide a shock across the heart, with the aim of momentarily stopping electrical activity (defibrillation) so that the heart’s natural pacemaker can take over again and the normal coordinated pumping action of the heart can resume.

[86] AED devices are designed so they can be used by someone with minimal skill and training. There are diagrams on the pads showing where they should be placed, and the device provides verbal queues and instructions to the operator about what to do. This includes when to stop, and restart, chest compressions. Once a ventricular fibrillation cardiac arrest has occurred, a normal heart rhythm cannot return until the fibrillation has stopped.

[87] This will only occur if a defibrillation shock is delivered. The likelihood of survival declines rapidly after the cardiac arrest occurs (approximately 10 per cent per minute prior to defibrillation). The best rates of survival (around 40 per cent) occur with observed arrests with a shockable rhythm when the first shock is delivered within six minutes – but ideally as soon as possible. Dr Scott informs me that survival may be as high as 60 per cent if the shockable arrest is “EMS (ambulance) witnessed”.⁸

Dr Scott’s advice

[88] Dr Scott advised me that the manner of Fa’anānā’s collapse, as recorded on the video, coupled with the ECG trace available from the initial AED, and the subsequent post-mortem finding, suggests that he experienced an acute cardiac event. This was most likely a myocardial infarction (“heart attack”) resulting in a cardiac arrest (ventricular fibrillation). Dr Scott thought it likely that the preceding exercise was the immediate trigger. He noted that the majority of cardiac arrests caused by acute coronary syndromes (“heart attacks”) are not related to exercise and of those that are,

⁸ St John/Wellington Free/AUT - Out of Hospital Cardiac Arrest Registry 2020/21.

the majority are associated with mild levels of exercise. While there is good evidence that habitual exercise significantly reduces the risk, Dr Scott noted that there appears to be a paradoxical transient increase in risk during and shortly after physical exercise.⁹

[89] He informed me that at a population level, there is some evidence that the effect of exercise is to bring the event forward. That is, that the cardiac event would be likely to have occurred over the subsequent weeks to months.

[90] The best survival rates are around 50 per cent in situations like this with a witnessed arrest and a shockable rhythm. The most important factor is time to first shock and early CPR (including chest compressions and rescue breaths).¹⁰ In this situation, where CPR started at around 90 seconds and the first shock was delivered at 4-5 minutes coupled with Fa'anānā's underlying good level of health, Dr Scott thought his chance of survival would be expected to be in the 40-45 per cent range.¹¹

[91] Based on the Auckland Transport CCTV timings, the footage showed that Fa'anānā collapsed at 8:59:37 am.

[92] Chest compressions were started at 9:01:25 am, approximately 90-100 seconds later. Noting the observations of the security guard and Nominated First Aider about his breathing and fading pulse, Dr Scott suspected that Fa'anānā was already in cardiac arrest at this point.

[93] The AED arrived at 9:03:05 am and the pads were applied at 9:04:00 am, 4 minutes 20 seconds after the collapse. At this time chest compressions were in progress and Fa'anānā's heart was in ventricular fibrillation (cardiac arrest).

[94] The first shock was delivered 24 seconds later and failed to defibrillate, meaning it did not shock Fa'anānā's heart back into a normal rhythm. Chest compressions were immediately restarted, and they continued until the AED indicated that the next shock should be delivered.

⁹ BMC Cardiovascular Disorders (2020) 20:318. Can Fam Physician. 2013 Jan;59(1):46-49

¹⁰ JAMA Cardiol. 2025;10(9):922-931.

¹¹ Br J Sports Med 2022 Feb19;56(18):1026–1031. European Heart Journal 2013, 34 (47), 3616 3623).

[95] The second shock was delivered at 9:06:54 am. This was 7 minutes and 17 seconds after Fa'anānā collapsed. This shock successfully terminated ventricular fibrillation and Dr Scott noted that an organised ventricular rhythm could then be seen. He noted that chest compressions were continued, as recommended. However, after about 20 seconds Fa'anānā's heart returned to ventricular fibrillation.

[96] The paramedics arrived just before the second shock and the initial AED pads were disconnected at 9:08 am. A third shock was delivered at 9:08:25 am according to the CCTV footage, with Dr Scott presuming this was from a second AED device attached to the same electrodes, because the electrodes do not seem to have been changed.

[97] Dr Scott noted that the ambulance AED then appears to be connected, with the ambulance officers obtaining IV access and a controlled airway.

[98] Dr Scott advised that once the paramedics obtained an airway, the initial end-tidal CO₂ reading recorded at 9:16 am was 55 mmHg. This suggested to him that the preceding resuscitation attempts had been of very good quality and a good cardiac output was being achieved. Dr Scott informed me that this, in itself, suggested a good prognosis, all other things being equal.¹²

[99] When the paramedics arrived, the combination of chest compressions and defibrillation shocks continued along with the administration of adrenaline and amiodarone in accordance with the standard protocol. They noted that Fa'anānā's heart rhythm was variable between ventricular fibrillation and asystole (total absence of electrical and mechanical activity in the heart). In addition, his end-tidal CO₂ reading gradually declined. This suggested to Dr Scott that there was an underlying issue preventing a return of spontaneous circulation despite good-quality CPR delivered according to accepted protocols. In view of the limited post-mortem findings suggesting two-vessel coronary disease at least, he thought this may well have been an occluded heart artery secondary to infarction (heart attack). If this was the case

¹² Intensive Care Med 2015 Oct;30(7):426-35).

then without immediate intervention in a hospital cardiac cathlab¹³, Dr Scott informed me that survival would have been very unlikely.

[100] Dr Scott stated that the time to first shock and the initial rhythm are the most important factors in addition to the timing and quality of CPR. If an ambulance had been on site, he thought it was possible that the first shock may have occurred 1-2 minutes earlier. Similarly, the adrenaline and amiodarone may also have been given a few minutes earlier. However, Dr Scott noted that Fa'anānā did appear to receive good quality CPR early from trained first aiders as well as an off-duty emergency doctor who stopped to provide assistance. Based on the CCTV footage, the off-duty doctor appears to have arrived at 9:03:30 am and took over the CPR.

[101] In addition, the timing of the first shock was also relatively early. Dr Scott advised me that the quality of this initial care is supported by the ambulance officer's initial finding of an end-tidal CO₂ reading of 55 mmHg. In general, however, Dr Scott said that it is accepted that an ambulance witnessed arrest with a shockable rhythm would be expected to have a better outcome overall (than one without an ambulance). However, in a situation with early high quality bystander CPR and defibrillation that difference may only be by about 5-10 per cent.

[102] I asked Dr Scott, whether he thought that the WaterRun was an appropriate and/or safe activity for someone with Fa'anana's medical history to be participating in. Dr Scott informed me that from reading the medical reports and accounts it appears that Fa'anānā was asymptomatic from a cardiac standpoint and his risk factors were being appropriately managed. His GP records indicated that he was attending a gym three to or four times a week suggesting that he likely had a good level of fitness. Assuming this was the case, Dr Scott said he would have been comfortable with him doing the event without further investigation.

[103] Dr Scott also noted, after reviewing the TVNZ footage, that the exercise did not appear overly strenuous, and Fa'anānā did not appear stressed or overly fatigued during or after the event. Dr Scott assumed the level of activity involved would be less than during Fa'anānā's gym attendances.

¹³ A specialist hospital room with equipment for advanced cardiac imaging and procedures.

[104] I asked Dr Scott whether he thought a medical check or assessment should have been carried out before the event, and/or should be carried out prior to other similar events in the future. Dr Scott stated that a general health statement regarding medical conditions and medications used is generally a requirement prior to sporting events. However, he thought that the anticipated level of activity for this event, which appeared to have been more of a publicity exercise than a physical competition, was somewhat lower. But given its public nature, he thought a declaration of health and statement of any medical conditions or medications could have been considered.

[105] Having said that, Dr Scott informed me that as Fa'anānā appeared to have been asymptomatic, with good control of his medical conditions, this is very unlikely to have altered the outcome. He noted that formal physical evaluation is not required prior to other events that he is aware of, including those with much more vigorous activity such as Ironman events and the Coast-to-Coast race.

[106] I asked Dr Scott whether, in his opinion, an ambulance or greater degree of medical support should have been present at the event. Dr Scott advised me that it is always difficult to balance the risks against the cost (financial and otherwise) of mitigation. In his view, Dr Scott thought that this appeared to be a very low risk event involving a small number of apparently healthy individuals. A case could have been made for having an ambulance crew present, but he thought that this needed to be balanced against the demands of an ambulance service that is already stretched and under resourced. This could mean the ambulance service were unable to provide care elsewhere, regardless of the financial cost to the Event Organisers.

[107] Dr Scott noted that cardiovascular disease is the leading cause of death in New Zealand, with around 11,000 recorded in 2021. CVD accounts for roughly one-third of all deaths and many CVD-related deaths are premature and considered avoidable with better prevention and care. National data show a declining age-standardised coronary and stroke mortality over the last decade, but recent analyses raise concerns that these may be changing.

[108] The 2024 out-of-hospital cardiac arrest report reveals that 2,547 people were treated for cardiac arrest, with a 3.6 per cent increase from the previous year. Of these, 72 per cent of cardiac arrests occurred at home. The report showed that 24 per cent of those suffering a cardiac arrest survived to hospital arrival, while only 11 per cent survived 30 days following their discharge from hospital.

[109] Dr Scott informed me that the burden of cardiovascular disease is significantly greater in Pacific peoples, with higher rates of CVD risk factors, hospitalisation, and mortality than New Zealand Europeans. This is primarily driven by diabetes, hypertension, rheumatic heart and valve disease, as well as structural inequities. Coronary disease hospitalisation rates are higher as are valve disease rates, with differences even larger at ages 45 to 64. For Pacific communities, CVD is the leading cause of preventable death and health burden. Many of these deaths occur at younger ages, impacting families and working-age adults. First coronary event hospitalisation rates have increased by around 9 per cent for Pacific peoples in recent years while declining in Asian, European, and other populations. The incidence of OHCA is about 1.3 times higher in Māori and Pacific peoples with higher mortality rates overall.¹⁴

[110] To address these issues, Dr Scott informed me that it is important to work on basic primary prevention in high-risk communities. This includes aggressive management of blood pressure, lipids, and diabetes, as well as smoke-free policies, healthier foods and environments, particularly in deprived areas. In his view, implementing and monitoring ethnicity-specific CVD risk assessment and treatment targets, starting earlier for Pacific peoples, is crucial. He also identified the importance of auditing medical therapies used for the treatment of CVD including statins, ACE inhibitors, ARBs, SGLT2, and heart failure therapies.

[111] In addition, Dr Scott identified the following important steps to help reduce CVD deaths

¹⁴https://www.tewhatauora.govt.nz/assets/Publications/2022_Cardiovascular_other_Cardiovascular_related_diseases_hospitalisations_NZ.pdf. <https://bmjopen.bmj.com/content/12/6/e060145>

- (a) Working with Pacific communities, including church and family-centred programmes, Pacific language, and Pacific clinical leadership, to improve trust, access, and long-term improvement.
- (b) Expanding community CPR and AED programmes, prioritising Pacific, Māori, and high deprivation regions, ensuring dense, mapped public access defibrillator networks.
- (c) Optimising post out-of-hospital care, post-OHCA, and secondary prevention pathways with access to rapid angiography, Implantable Cardioverter Defibrillator (ICD), and heart failure clinics, and
- (d) Measuring equity metrics by ethnicity and geography, so that survival gains do not bypass Pacific people.

[112] I asked Dr Scott whether there were any recommendations that could be made to help reduce the chance of similar deaths occurring in future.

[113] He said it is difficult to make recommendations regarding events such as this because the overall risk is very low. Apart from checking the health and fitness of participants and ensuring that basic medical facilities and staff are available (which he noted appeared to have been done in this case), Dr Scott thought it unlikely that the risk could have been reduced further.

[114] In events involving larger numbers of competitors and spectators, Dr Scott's view was that on site emergency services would be appropriate with suitably scaled up emergency plans and resources – as is generally done. However, he noted that the more important issue is the maintenance of general cardiovascular health and training to recognise cardiovascular symptoms. He stated that the issue of training all individuals to recognise and manage cardiac arrest is also fundamental to improving outcomes following cardiac arrest in the community.

[115] Dr Scott also identified programs to increase CPR and resuscitation training, as well as the availability of AEDs, in particular in areas where the rates of cardiac

arrest are highest. For example, in communities with Pacific people, Māori communities and areas of socio-economic challenge and isolation. He suggested that widespread adoption of CPR and resuscitation training should also be supported, including routine education in schools.

NZDSOS submissions and Dr Scott's advice

[116] Following the Case Management Conference held on 26 March 2025, written submissions were filed by New Zealand Doctors Speaking Out With Science (NZDSOS). Drs Alison Goodwin, Matt Shelton and Cindy de Villiers signed a letter on behalf of NZDSOS. They expressed the view that Fa'anānā was likely to have been vaccinated against Covid and raised concerns that his sudden death might be related to the vaccine. NZDSOS stated:

“It will be important to consider the fundamental principle of pharmacovigilance which assumes an introduced medication to be the cause of an adverse event or outcome until such time as an alternative cause has been proven”.

[117] NZDSOS referred to a number of research articles that they considered relevant to the issues under consideration.

[118] I asked Dr Scott whether it was likely that the Pfizer Covid vaccine contributed to Fa'anānā's death. He informed me that the likelihood that the Pfizer Comirnaty vaccine contributed to the death was “vanishingly small”. He advised me that there is a clearly documented but very small increase in the risk of myocarditis (inflammation of the heart muscle) following Comirnaty and related vaccinations. Very rarely this can be associated with cardiac arrest. However, large population-based studies have not demonstrated any increase in out-of-hospital cardiac arrest overall, or sudden cardiac death rates, in vaccinated populations.

[119] The group in whom this increase in myocarditis appears to be greatest is young males. Case reports describe out-of-hospital cardiac arrest resulting in sudden collapse a few days following the vaccination, with autopsy findings consistent with acute myocarditis. However, systematic reviews have confirmed this is a very rare side effect following mRNA vaccinations. Other epidemiologic studies and case series

have suggested an increase in the myocarditis/carditis admission rates in the first month following the vaccination particularly after two doses and in males under 30 years of age. Dr Scott advises that large registries do demonstrate a marked increase in out-of-hospital cardiac arrest burden tracking with Covid infection waves and healthcare system drain, rather than after vaccination rollouts. This implies that the infection itself was the dominant driver of excess out-of-hospital cardiac arrest during the Covid pandemic.

[120] Dr Scott advises that overall, vaccination appears to be protective despite a small increase in myocarditis. Observational data in affected cohorts indicate that prior vaccination is associated with lower risks of major cardiovascular complications such as myocardial infarction or stroke following Covid infection. Data shows that vaccination substantially reduces Covid hospitalisation and death, hence directly lowering cardiovascular events. Dr Scott advises that there is now a large body of data to support this summary.¹⁵

[121] Dr Scott noted that Fa'anānā received the last of his three Covid vaccine doses on 5 March 2022, nearly two years prior to his collapse. This was well outside the timeframe of post vaccination myocarditis or other cardiac effects. He was also outside the age group affected in the very rare cases where it has been observed.

Findings

[122] I find that Fa'anānā Efeso Collins died on 21 February 2024 at Te Komititanga Square, Central Auckland. He died of natural causes, being cardiac disease arising from complications of diabetes, obesity and hypertension.

Discussion

[123] Fa'anānā's family history and his known medical conditions placed him at increased risk of cardiac death. He was monitored and treated in accordance with accepted guidelines. He did everything he could to manage the risks associated with

¹⁵ BMJMED 2023;2:e000373.JAMA Cardiology 2022;7;(6):600-612.JAMA Netw Open. 2023;6(10):e2336992

his medical conditions. This included having bariatric surgery, losing a significant amount of weight, exercising regularly and eating a healthy diet. In the period prior to his death there were no apparent indications that Fa'anānā was experiencing any specific symptoms that required further investigation or treatment.

[124] Despite these steps, Fa'anānā suffered a fatal cardiac event on 21 February 2024. This was shocking and unexpected, both for his loved ones and those who were present with him at Te Komititanga Square. There were valiant efforts to resuscitate Fa'anānā, but he was not able to be revived.

[125] Resuscitation efforts and the use of defibrillators do not guarantee survival after a cardiac arrest. While they increase the chance of a heart rhythm being established, and the person surviving the initial arrest, they do not mean that survival is assured. There is also evidence suggesting that Fa'anānā may have had an underlying issue that prevented a return of spontaneous circulation, such as an occluded heart artery. If so, this would have further reduced his chance of survival.

[126] The charity event that Fa'anānā participated in shortly before he died involved physical activity. He completed circuits on a flat surface while holding a bucket of water in each hand. The footage of the event does not suggest that he was in any distress or suffering any ill health. His collapse, several minutes after completing the event, was wholly unexpected and there appears to have been no prior warning that he was unwell or required medical attention.

[127] I have considered the concerns of Fa'anānā's family about the adequacy of the planning for the WaterRun, and the emergency medical coverage in place.

[128] It is difficult to see how a pre-event medical questionnaire would have made a difference in this case. Like many members of our community, Fa'anānā lived with some very common health conditions that placed him at a greater risk of a cardiac event. However, there was nothing to suggest that he was at imminent risk of death, and nothing to indicate that it would be unsafe for him to undertake exercise. There was no obvious impediment to Fa'anānā participating in the WaterRun. He

experienced “silent” coronary artery disease and the cardiac arrest that caused his death could have occurred at any time.

[129] While it may have been desirable for an ambulance or emergency medical team to be available at the WaterRun, I am not critical of the fact that one was not present. The event involved a small number of people, over a short time period and the physical activity was not of a particularly dangerous or risky nature. It involved six volunteers walking or jogging around a flat 1 km course holding buckets of water to raise money for charity. I agree with Dr Scott’s characterisation that this event was more in the nature of a publicity exercise than a sporting event. In my view there were adequate arrangements in place to deal with a medical emergency in this context. The presence of an experienced surf life saver and the availability of several AED devices in the immediate vicinity, were reasonable precautions in the circumstances.

[130] Several witnesses suggest that there may have been some panic and/or confusion when Fa’anānā fell and became unresponsive. However, a number of people immediately went to assist Fa’anānā, including the Nominated First Aider who promptly commenced effective CPR. Other people helped with various aspects of the resuscitation effort, including a person passing by who identified herself as an off-duty doctor. An AED was obtained, with shocks administered within minutes of Fa’anānā collapsing.

[131] If there was an ambulance on site at the event, at most, this would have provided a small increase in the theoretical chance of survival. But Fa’anānā did not live, and it is not possible for me to conclude that he would have if defibrillation had occurred a minute or two earlier and /or IV medications had been administered slightly sooner. Any such exercise would be wholly speculative and disregards the fact that even with immediate defibrillation and paramedic care, it may never have been possible to revive Fa’anānā once his heart stopped beating.

[132] However, the information obtained during this inquiry does highlight that cardiac arrests can occur anywhere, anytime, to anyone. This reinforces the importance of access to AED devices, knowledge of CPR, and community health messaging around CVD risks and symptoms. These are the important lessons that can

be learnt from Fa'anānā's tragic death, and there are steps that can be taken to address these matters.

Recommendations / comments

[133] Fa'anānā's death highlights the importance of quick access to AED devices and early commencement of resuscitation efforts when a cardiac arrest occurs in the community. Being aware of the exact location of nearby AEDs and identifying a specific person to obtain one in the event of an emergency, may increase the ability to respond quickly to an unexpected cardiac event. This is relevant for those planning public events, but also for people in their homes and going about their everyday lives. As noted by Dr Scott, most out of hospital cardiac arrests (72 per cent) occur in the home.

[134] In New Zealand, the responsibility for placement and maintenance of AEDs rests with the individual owner of the device. Hato Hone St John operates a national AED registry. This allows 111 call takers to direct bystanders to the nearest registered device when an emergency occurs. There is also a website that identifies the nearest AED based on the viewer's location (www.aedlocations.co.nz) and a related mobile phone app that can be downloaded. These are important tools for the community to be aware of. I note that the site currently indicates there are 10 AEDs within a 100 metre radius of where Fa'anānā collapsed. This includes the two identified in the health and safety plan, the three at Britomart (now Waitematā) train station, one located at the Te Komititanga McDonalds restaurant, and one at the adjacent ferry building.

[135] In order to help reduce the chance of further deaths in similar circumstances in the future, I make the following recommendations under s 57A of the Act.

[136] I recommend:

- a) *That those responsible for developing health and safety plans for public events:*

- i. consider identifying a specific person whose role it is to obtain an AED device in the event of a cardiac emergency; and*
 - ii. ensure that the nominated person familiarise themselves with the exact location of the nearest device, or devices, prior to the event in order to minimise the likelihood of any delay occurring if an emergency situation arises; and*
 - iii. consider whether a medical questionnaire or health statement is indicated and/or could assist participants to think carefully about whether the proposed activity is appropriate for them.*
- b) That members of the community, particularly those who live with heart disease and CVD risks factors, encourage family, friends and colleagues to identify the location of AED devices near their homes, schools and workplaces so they can access one quickly in the event of an emergency.*

[137] I also note the advice of my expert cardiology adviser regarding the importance of AEDs being widely available in the areas of highest need, and the benefits of education and awareness campaigns about cardiac risks, heart events and CPR.

[138] Given that cardiovascular disease is the leading cause of death in New Zealand, with 11,000 deaths occurring in 2021, I strongly endorse the comments of Dr Scott about the benefits of:

- a) general training, education and public awareness campaigns about the importance of cardiovascular health to assist individuals to lead healthy lifestyles, recognise cardiac symptoms, and respond if a cardiac arrest occurs; and*
- b) programmes to increase resuscitation training and CPR, as well as the availability of AEDs. This is particularly important in areas where rates of*

cardiac arrest are highest, such as communities with high proportions of Pacific people, Māori, and areas of socio-economic challenge and isolation.

[139] A copy of these findings will be sent to the National Heart Foundation, Hato Hone St John, and the Ministry of Health.

Publication restrictions

[140] Under s 74 of the Act, I prohibit making public any of the photographs of Fa'anānā entered into evidence by police upon the grounds of personal privacy and decency. These images are graphic and sensitive in nature, and I am satisfied that such interests outweigh any public interest in the publication of those images.

[141] I also make an order prohibiting the publication of the video footage of the WaterRun event provided to me by TVNZ pursuant to an order issued under s 120 of the Act. This material was provided under compulsion for the purposes of the inquiry. Accordingly, s 127 of the Act is relevant. This only permits the “information, document or other thing” that has been produced to be used for the purposes of the inquiry, and it must be returned to the producer at the conclusion of the inquiry process.

[142] In addition, I note that the content relates to TVNZ operational activities unrelated to the death as well as images and scenes of distressed staff and members of the public in the immediate aftermath of Fa'anānā's collapse. TVNZ has applied for a non-publication order. Mr Harris has indicated that Fa'anānā's family support the making of a non-publication order, on the basis of privacy.

[143] I have formed the view that it is in the interests of justice, decency and privacy to prohibit publication of this material. As required, I have also considered whether these interests are outweighed by the important principles of open justice and the right to freedom of expression. In making this assessment, I acknowledge that there is a significant public interest in matters pertaining to the death of a sitting member of Parliament. However, on balance I have concluded that a non-publication order

constitutes a demonstrably justified limit on open justice and the right to impart information in this case.

[144] The Auckland Transport CCTV footage was not obtained pursuant to a s 120 order. It was provided by Mr Harris for the purposes of this inquiry. The footage is taken from further away than the TVNZ cameras. It does not contain close up views or audio. The views of Fa'anānā's family, Auckland Transport, and other interested parties in respect of publication of this material are not known. Accordingly, I will provide an opportunity for submissions to be made on this point before making a decision about whether a non-publication order is appropriate.

[145] Accordingly, I make the following orders under s 74 of the Act:

- (a) An order prohibiting the publication of any photos taken of Fa'anānā by police and entered into evidence during this inquiry.
- (b) An order prohibiting the publication of all video footage provided by TVNZ pursuant to a s 120 order issued to the agency on 31 March 2025.
- (c) An interim order prohibiting publication of the Auckland Transport CCTV footage of Te Komititanga Square provided by Mr Harris.

[146] Any person or agency wishing to be heard in relation to the making of a permanent non-publication order in respect of the material described at paragraph [145] (c) above shall provide their response, including any submissions and supporting evidence, to my Case Manager *before 5pm on 17 June 2026*.

Concluding remarks

[147] The death of Fa'anānā was felt throughout Aotearoa. He achieved so much during his life, and it is beyond doubt that he would have continued to work tirelessly to bring about meaningful and positive changes for all New Zealanders. It is natural to feel robbed when someone so special is taken too soon and there are many people in this country who share the sense of grief and shock that followed his passing.

[148] I extend my sincere condolences to Fa'anānā's aiga and other loved ones for their devastating loss.

A handwritten signature in blue ink, consisting of a stylized initial 'A' followed by a horizontal line and a period.

J Anderson
Coroner