

Recommendations recap

A summary of coronial recommendations and comments
made between 1 January 2016 and 30 June 2016

Issue 11



OFFICE OF
THE CHIEF CORONER

OF NEW ZEALAND



Coroners have a duty to identify any lessons learned from the deaths referred to them that might help prevent such deaths occurring in the future. In order to publicise these lessons, the findings and recommendations of most cases are open to the public.

Recommendations recap identifies and summarises all coronial recommendations made over the relevant period. Where received, summaries of responses to recommendations from agencies and organisations are also included.

This issue features 46 recent coronial cases where recommendations have been made. Final findings were released by a coroner between 1 January 2016 and 30 June 2016.

This issue also features a case study report on deaths related to recreational deaths, specifically hiking and tramping. The report contains the key statistics relating to these deaths, an outline of the issues involved and the legal framework surrounding hiking deaths. It also has a summary of recommendations made by coroners following these deaths.

Disclaimer: The précis of coronial findings detailed within this publication have been produced by Research Counsel of the Office of the Chief Coroner, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case. Despite this, it should be noted that they are not exact replications of coronial findings. The original finding should always be accessed if it is intended to refer to it formally.

Please also note that summaries of circumstances and recommendations following self-inflicted deaths may be edited so as to comply with restrictions on publication of particulars of those deaths, as per section 71 of the Coroners Act 2006. Similarly, the contents of summaries and recommendations may be edited to comply with any orders made under section 74 of the Act.

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Recommendations

Adverse Effects or Reactions to Medical/Surgical Care	
Case Number CSU-2014-AUK-000522 2016 NZCorC 9	Catch Phrases
	Anaesthetic, Pneumonia, Elderly, Systemic Fat Emboli, Coma
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/9.html
Case Number CSU-2014-PNO-000068 2016 NZCorC 38	Catch Phrases
	Medical Complications, Head Aches, Sinusitis, Adequacy of general practitioners, Nelson Hospital,
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/38.html
Case Number CSU-2014-AUK-001292 2016 NZCorC 48	Catch Phrases
	Medical Complications, Post Surgery,
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/48.html
	Response from Waitemata District Health Board
	See above link
Aviation Accident	
Case Number CSU-2011-WHG-000236 CSU-2011-WHG-000237	Catch Phrases
	Drowning, Helicopter Crash, Karikari Beach,
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/49.html http://www.nzlii.org/nz/cases/NZCorC/2016/50.html
2016 NZCorC 49 2016 NZCorC 50	Response
	N/A

Child Deaths

Case Number CSU-2014-CCH-000079 2016 NZCorC 1	Catch Phrases Infant Death, Six Months Old, Sleeping Position Causing Asphyxia, Cot Mattress, Unsafe Sleeping Environment, Comments On Safe Sleep Messages Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/1.html Response N/A
Case Number CSU-2014-ROT-000351 2016 NZCorC 8	Catch Phrases Infant Death, Ten Days Old, Mother Fell Asleep While Breastfeeding, Alcohol Consumption, Comments On Safe Sleep Messages Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/8.html Response N/A
Case Number CSU-2011-CCH-000402 2016 NZCorC 11	Catch Phrases Driveway Run-Over Death, 11 Month Old, Supervision, Endorsement of Safety Messages Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/11.html Response N/A
Case Number CSU-2014-PNO-000688 2016 NZCorC 29	Catch Phrases Infant Death, 10 Months old, Accidental Asphyxiation, Put to sleep on parents bed, Comments on Safe Sleep Messages Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/29.html Response N/A
Case Number CSU-2015-AUK-000150 2016 NZCorC 47	Catch Phrases Child death, 11 years old, ketoacidosis caused by undiagnosed diabetes (probably type 1). Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/47.html Response from Royal NZ College of General Practitioners See above link

Diving, Scuba Diving, Snorkelling

Case Number CSU-2015-PNO-000287 2016 NZCorC 25	Catch Phrases
	Scuba Diving, Experience Diver, No Diving Partner, Poor Performing Equipment, Underlying Medical Condition, Likely Medical Event While Underwater, Comment Endorsing Dive Safety Recommendations
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/25.html
	Response
	N/A

Drugs/ Alcohol/ Substance Related

Case Number CSU-2015-WGN-000206 2016 NZCorC 7	Catch Phrases
	Accidental Overdose, Olanzapine, Methamphetamine, Methadone, Comment On Risk Of Purchasing Unknown Drugs
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/7.html
	Response
	N/A

Fall

Case Number CSU-2014-AUK-593 NZ CorC 27	Catch Phrases
	Domestic Internal Lift Shaft, Non-certified Domestic Lifts, Auckland Council
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/27.html
	Response
	No response received

Health Care Issues

Case Number CSU-2012-AUK-000195 2016 NZCorC 2	Catch Phrases
	Provision Of Surgery, Gastric Volvulus, Waitemata District Health Board, Eligibility For Publicly Funded Health Care, Deceased Unlawfully In New Zealand, Internal DHB Policy, Application Of Policy, Gathering Of Clinical Information, Recommendation For Future Application of Policy
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/2.html
	Response from Waitemata District Health Board
	Response pending

Case Number CSU-2012-CCH-000544 2016 NZCorC 3	Catch Phrases Rest Home Care, Influenza, Decision To Place On End Of Life Care, Cessation Of Prescribed Medication, Health and Disability Commissioner Investigation, Improper Consultation Surrounding End Of Life Care, Comments Endorsing HDC Recommendations Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/3.html Response from the Retirement Villages Association See above link
Case Number CSU-2015-HAM-000061 2016 NZCorC 20	Catch Phrases Warfarin, International Normalised Ratio (INR) Monitoring, Which Medical Professional Responsible For Monitoring, Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/20.html Response N/A
Case Number CSU-2014-WHG-000157 2014 NZCorC 18	Catch Phrases Pneumonia, Post-operative ileus, Paraplegic, Surgery Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/18.html Response N/A
Case Number CSU-2014-CCH-000598 NZ CorC 17	Catch Phrases Subdural haemorrhage, Fall, Elderly Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/17.html Response N/A

Police Pursuits

Case Number	Catch Words
CSU-2013-AUK-000523	Unlicensed Driver, Teenage Driver, Police Pursuit Called Off, Excessive Speed, Alcohol, Independent Police Conduct Authority Investigation, Multiple Fatalities
CSU-2013-AUK-000529	
CSU-2013-AUK-000530	
CSU-2013-AUK-000534	
2016 NZCorC 13	Link to Summary and Recommendations
2016 NZCorC 14	
2016 NZCorC 15	
2016 NZCorC 16	
	http://www.nzlii.org/nz/cases/NZCorC/2016/13.html http://www.nzlii.org/nz/cases/NZCorC/2016/14.html http://www.nzlii.org/nz/cases/NZCorC/2016/15.html http://www.nzlii.org/nz/cases/NZCorC/2016/16.html
	Response
	N/A

Recreational/Leisure Activities

Case Number	Catch Words
CSU-2015-CCH-000088	Aoraki Mount Cook National Park, Upper Linda Glacier, Bodies Not Found, Presumed Dead In Avalanche, Overseas Mountaineers, Extent Of Local Knowledge, Unsafe Weather Conditions, Heightened Risk Of Ice Fall
CSU-2015-CCH-000089	
CSU-2015-CCH-000090	
2016 NZCorC 4	Link to Summary and Recommendations
2016 NZCorC 5	
2016 NZCorC 6	
	http://www.nzlii.org/nz/cases/NZCorC/2016/4.html http://www.nzlii.org/nz/cases/NZCorC/2016/5.html http://www.nzlii.org/nz/cases/NZCorC/2016/6.html
	Response
	N/A
Case Number	Catch Words
CSU-2015-DUN-000245	Fiordland National Park, Kepler Track, Avalanche, Risk Awareness, Department of Conservation, Adequacy of Signage, Assumption of Risk
CSU-2015-DUN-000246	
2016 NZCorC 21	Link to Summary and Recommendations
2016 NZCorC 22	
	http://www.nzlii.org/nz/cases/NZCorC/2016/21.html http://www.nzlii.org/nz/cases/NZCorC/2016/22.html

Response from the Department of Conservation	
See above link	
Case Number CSU-2015-ROT-000098 2016 NZCorC 23	Catch Words Kayaking, Drowning, Kaituna River, "Gnarly Gorge", Grade 5 Rapids, Log And Branch Hazards In Water, Adequacy of Signage, Clearance of Logs, Voluntary Assumption of Risk
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/23.html
	Response No response received
Case Number CSU-2015-HAM-000013 NZ CorC 26	Catch Phrases Stand Up Paddle Board (SUP), Whangamata Harbour, Strong Current, Ankle Leash caught under the keel of Boat, Drowning, Adequacy of Signage
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/26.html
	Response from Waikato Regional Council See above link
Self-Inflicted	
Case Number CSU-2014-HAS-000196 2016 NZCorC 31	Catch Phrases Suicide, Mental Health Service
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/31.html
	Response No response received
Case Number CSU-2013-HAS-139 CSU-2013-HAS-221 CSU-2013-HAS-224 CSU-2013-HAS-167 NZCorC 39 NZCorC 40	Catch Phrases Flaxmere, High School, Joint Findings, Youth suicide
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/39.html http://www.nzlii.org/nz/cases/NZCorC/2016/40.html http://www.nzlii.org/nz/cases/NZCorC/2016/41.html http://www.nzlii.org/nz/cases/NZCorC/2016/42.html
	Response No response received
NZCorC 41 NZCorC 42	

Sudden Unexpected Death in Infancy (SUDI)

Case Number CSU-2015-AUK-001426 2015 NZCorC 19	Catch Phrases
	Sleeping Environment, SUDI, Undetermined
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/19.html
	Response
	N/A

Transport Related

Case Number CSU-2013-CCH-000662 2016 NZCorC 10	Catch Words
	Motorcycle vs Campervan, State Highway 6, Motorcycle Towing Trailer, Road Conditions, Insufficient Braking, Motorcycle Crossed Centre Line, Adequacy of Signage
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/10.html
	Response
	N/A
Case Number CSU-2013-AUK-001204 2016 NZCorC 12	Catch Words
	Pedestrian Fatality, Pedestrian Using Cellphone, Distraction, Stepped Into Traffic
	Link to Summary and Recommendations
	www.nzlii.org/nz/cases/NZCorC/2016/12.html
	Response
	N/A
Case Number CSU-2015-AUK-000294 2016 NZCorC 24	Catch Words
	Single Vehicle Motor Vehicle Crash, Driver Taken To Hospital, Later Deterioration, Cause Of Crash Driver Blackout, Medical Condition, Genetic Testing of Driver's Family Members
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/24.html
	Response
	N/A
Case Number CSU-2012-AUK-000208 2016 NZCorC 28	Catch Phrases
	Traffic Controller hit by Reversing Vehicle, Road Works Site, Lack of Training
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2016/28.html

	Response from Downer New Zealand Limited and New Zealand Transport Agency See above link
Case Number CSU-2013-CCH-000711 2016 NZCorC 34 2016 NZCorC 35	Catch Phrases Drowning, Lost control of vehicle on corner, Rolled into a creek, Multiple fatality, No drivers license Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/34.html http://www.nzlii.org/nz/cases/NZCorC/2016/35.html Response from Grey District Council Response pending
Case Number CSU-2014-ROT-000445 2016 NZCorC 45	Catch Phrases Mobility Scooter, Truck and Trailer unit, Pedestrian refuge, Loss of control of scooter Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/45.html Response from Ministry of Transport See above link
Water-Related (General)	
Case Number CSU-2015-WGN-000358 2016 NZCorC 30	Catch Phrases White-baiting on sandbar, Swept out to sea, Drowning, Surf lifesaver reel, Inadequate rescue equipment http://www.nzlii.org/nz/cases/NZCorC/2016/30.html Response N/A
Case Number CSU-2015-WHG-000008 2016 NZCorC 36	Catch Phrases Drowning, Swimming in River Mouth, Swept out to sea, Not a competent swimmer, Surf lifesaving Rescue, Water Safe New Zealand Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/36.html Response from Water Safe New Zealand See above link

Case Number CSU-2015-WGN-000065 2016 NZCor C 43	Catch Phrases Drowning, Boat accident, Yacht Racing, Overboard, Lifejacket fault/malfunction
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/43.html
	Response N/A
Case Number CSU-2013-ROT-422 2016 NZCorC 44	Catch Phrases Unascertained cause of death, Circumstances consistent with drowning, inhalation of hydrogen sulphide relevant
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2016/44.html
	Response from Rotorua Lakes Council See above link

Case study: Recreational deaths – hiking

New Zealand is renowned for its natural beauty and is a destination for keen trekkers and hikers from all over the world. This case study looks at deaths resulting from participation in hiking, tramping or trekking.

Recreational hiking deaths at a glance

For the purposes of this case study, the following statistics show the number of deaths involving hiking or tramping in New Zealand each year.

The New Zealand Mountain Safety Council (MSC) defines tramping in its recent Insights publication *There and Back* as ‘any walk where the intention is to be more than an hour away from the nearest road. This includes day walks, overnight tramping and Great Walks’. For the purposes of this study, this is also the definition of hiking.

Exclusions

Please note these statistics exclude hunting-related tramps/walks, skiing, snowboarding and heli-skiing. The statistics include both commercial and private hiking trips over the past 8 years.

Number of deaths involving hiking

On average, 10 deaths involving hiking occur each year in New Zealand.

Case status	2008	2009	2010	2011	2012	2013	2014	2015	Total
Active							3	7	10
Closed	22	12	5	8	6	10	6	6	75
Total	22	12	5	8	6	10	9	13	85

Gender

The number of deaths involving males is consistently higher than females.

Gender	2008	2009	2010	2011	2012	2013	2014	2015	Total
Female	9	1	1	3	1	1	2	5	23
Male	13	11	4	5	5	9	7	8	62
Total	22	12	5	8	6	10	9	13	85

Age

The groups of concern are those between the ages of 20-39 and 50-59.

Age range	2008	2009	2010	2011	2012	2013	2014	2015	Total
15-19	7	1					1		9
20-24		4	1	2			2	4	13
25-29	2	2		1		1	2	2	10
30-34		2	2	1		3		1	9
35-39	4	1		1	1	1		2	10
40-44	2		1			1		2	6
45-49	3		1	1					5
50-54	1	1			4	1	1	1	9
55-59	3				1	1	1		6

60-64		1		2		1			4
65-69							1	1	2
70-74							1		1
75-79						1			1
Total	22	12	5	8	6	10	9	13	85

Deaths by region

Queenstown Lakes District had the highest number of fatalities over the past 8 years, followed by Mackenzie Country, Southland and the Tasman regions.

MSC region	2008	2009	2010	2011	2012	2013	2014	2015	Total
Buller	1								1
Central North Island	7		1						8
Chatham Islands	1								1
Dunedin	1								1
Gisborne	1								1
Hawke's Bay		1							1
Horewhenua		2							2
Kaikoura						1			1
Mackenzie	2	2				2	4	4	14
Opotiki						1			1
Queenstown Lakes	4	2	1	2	2	1	2	4	18
Selwyn	1	1							2
Southland	1	1	1	2	1		1	4	11
Taranaki	1					2			3
Tasman	1	1		2	2	2	2	1	11
Waitomo						1			1
Wellington	1								1
Westland		2	2	2	1				7
Total	22	12	5	8	6	10	9	13	85

There and back: an exploration of outdoor recreation incidents in New Zealand¹

MSC recently produced an extensive study which explores participation, injuries, search and rescues and fatalities while performing 5 outdoor activities: tramping, mountaineering, hunting, mountain biking and trail running. It's important to note their statistics don't include commercial or guided activities, nor do they include fatalities caused by natural triggers such as heart attacks. The date range of their data varies depending on the type of incident, with fatalities dating back to 2007.

Key insights include:

- 53% of fatalities were caused by the person falling
- 31% of all fatalities occurred in December while April had not recorded a tramping fatality
- 24% of all tramping fatalities occurred on a Saturday, with the next highest day being a Monday at 18%

¹*There and back: an exploration of outdoor recreation incidents in New Zealand*, New Zealand Mountain Safety Council, July 2016, <https://issuu.com/nzmountainsafetycouncil/docs/msc.issuu.there.and.back.1.1.2016>,

- Queenstown-Lakes and Tasman both recorded more than 12 times the average number of fatalities compared to the national district average
- Of all participants 23% were aged 50-64, however of all fatalities this same age group represented 31% of fatalities

The study found an average of 6 fatalities occur a year while tramping. Of this number, 53% are due to falling, 18% occur at river crossings and 9% are due to hypothermia. The study reflects the results above, noting a higher fatality rate among males and in regions such as the Queenstown Lakes. Interestingly, the study found that in tramping deaths 67% of the deaths were New Zealanders, 11% were Australian, 7% were German, 6.7% were Asian, 4.4% were European and 2.2% other. This highlights the wide demographic of people that hike in New Zealand and the large presence of foreign tourists taking part in the activity. If you'd like to read the study in full, visit

<https://issuu.com/nzmountainsafetycouncil/docs/msc.issuu.there.and.back.1.1.2016>

Background

The coronial cases presented in this case study involve instances where hikers have been exposed to the dangers and hazards inherent in walking in mountainous terrain. Deaths in the mountains are most commonly due to trauma, high altitude illness, cold injury, avalanche burial and cardiac death.²

The study includes all deaths involving hiking, both commercial and private. It doesn't include other land leisure activities such as skiing or biking nor does it involve water-related leisure activities. The study is further limited to the object of the *Recommendations recap* – namely, cases where coroners have made specified recommendations or comments pursuant to s57 of the Coroners Act 2006 (the Act). Following are 21 coronial findings involving hiking where coroners have made such recommendations or comments.

Coroner's role in investigating and preventing recreational deaths

Coroners Act 2006 – decision whether to open and conduct an inquiry

When a coroner decides whether or not to open and conduct an inquiry, they must determine whether or not the death appears to have been natural; whether it was a result of the actions or inactions of any other person; the existence of any allegations, rumours, suspicions, or public concern; and the extent to which publicising the circumstances of the death would be likely to reduce the chances of the occurrence of other deaths in similar circumstances.³

A coroner may make specific public recommendations or comments about a death in order to reduce the chances of other deaths occurring in similar circumstances. The fact-finding role of the coroner can determine what happened and the recommendatory role can effect systemic changes to prevent future deaths.

Hiking deaths are frequently subject to a coronial inquiry as often the precise cause of death isn't known or is considered unnatural. Often there's an increased national and international public interest in the deaths as they frequently involve foreign tourists or an extreme weather phenomenon.

² G Firth, M P Grocott, H E Montgomery, G W Rodway and J S Windsor 'Mountain Morality: a review of deaths that occur during recreational activities in the mountains' (2009) 85 *Postgrad Med J* 316–321.

³ Other considerations are the desire of any members of the immediate family of the person, who is or appears to be the person concerned, that an inquiry should be conducted; and any other matters the coroner thinks fit.

In some instances, a coroner will open but not complete inquiries into deaths involving hiking. This may only happen if the coroner is satisfied the purposes of any coronial inquiry have been adequately established in respect of the death concerned in the course of criminal proceedings or other investigations.

Several external agencies are commonly subject to specified comment of recommendation under s57 of the Act. In the context of hiking deaths, coroners most commonly direct their recommendations to the Department of Conservation (DOC), MSC, New Zealand Alpine Club and Federated Mountain Clubs of New Zealand.

Themes in coronial recommendations and comments on hiking deaths

Human error

Human error is often a feature of deaths while hiking, particularly in circumstances where weather changes rapidly. While this can never be eliminated entirely, coroners have made recommendations to reduce the likelihood of human error being a factor. After assessing these recommendations and comments, several themes have emerged.

Safety awareness

Coroners have focused on improving the provision of accessible safety information distributed at visitor centres across New Zealand. For example, in one case a coroner recommended signage be placed on the popular Kepler Track alerting hikers of areas of acute risk of avalanches. The coroner also supported the recommendation directed to DOC to upgrade the ability of visitor centres to give current information to track users about avalanche hazards.⁴ Other cases have identified the need for general safety awareness and best practice for hikers, such as staying together in emergencies and safety at river crossings.

As well as being aware of the hazards of hiking in the mountains, several coroners have highlighted the importance of being prepared. Comments relating to the importance of suitable gear and sufficient food supplies clearly reveal the need for hikers to take safety gear suitable for all conditions. For example, the importance of having a reliable means of alerting rescue authorities in emergency situations, such as a mobile phone with fresh batteries or an emergency locator beacon, was considered by the coroner in a case where the death was a result of an alpine fall.⁵

Signage

A clear theme in hiking deaths is the lack of signage identifying and alerting hikers to risks and hazards. In one case, the coroner specified the importance of information and signage for tourists who don't know the danger of New Zealand's environment, particularly on the 'Great Walks' of New Zealand.

Experience

Inexperience and a lack of understanding of hazards have been cited as contributory factors leading to deaths while hiking. The coroners have expressed the importance of knowing your own limits when undertaking a hike.

⁴ Re Lessard and Lemieux – Coroners Findings, Coroners Court Queenstown, CSU-2015-DUN-000245 and CSU-2015-DUN-000246, 7 February 2015 at [63].

⁵ Re Buckley – Coroners Findings, Coroners Court Christchurch, CSU-2013-CCH-000513, 9 September 2014 at [63].

The consistent trend of deaths including experienced climbers and hikers highlights the unavoidable dangers of a mountainous environment and helps to reorient even the most experienced hiker towards safety and precautionary behaviour.

Key organisations

Department of Conservation

DOC plays a pivotal role in the protection and conservation of New Zealand's unique environment. DOC is responsible for the care and maintenance of walking tracks, huts and historical sites across New Zealand. A central aspect of DOC's role is to raise awareness and promote safety in the outdoors.

DOC has several brochures on their website and in DOC visitor centres, such as 'Planning a trip in the backcountry'. For more information, visit <http://www.doc.govt.nz/walkingandtramping>

New Zealand Mountain Safety Council

MSC is a national organisation with a mandate to encourage safe participation in land-based outdoor activities. It does this through the development and promotion of safety messaging, by identifying and responding to insights provided by the ongoing collection and analysis of data, and by building partnerships with relevant organisations.

Their website contains a significant amount of outdoor recreation guidance, advice, safety tips and access to tools and resources. These include:

- Outdoor Recreation Activity Guides for day walking, multi-day tramping, hunting (with more coming)
- Safety Tips
- Education videos across various activities including Alpine, Tramping, Hunting
- Links to training providers
- And manuals, pamphlets and free downloadable resources covering outdoor communication, outdoor first aid, avalanche awareness, snow code, firearms safety, river safety and survival essentials

The Outdoor Safety Code aims to provide five simple rules to help hikers stay safe, covering many of the themes the coroners have commented and recommended above:

- 1) Plan your trip
- 2) Tell Someone
- 3) Be aware of the weather
- 4) Know your limits
- 5) Take sufficient supplies

Their website also records their media releases over the past 7 years which deal with recent mountain tragedies and promote safety in all outdoor activities. For more information, visit <http://www.mountainsafety.org.nz/>

Federated Mountain Clubs of New Zealand

Federated Mountains Clubs of New Zealand provides outdoor advice for visitors and locals. They publish regular newsletters updating members about various issues and news regarding hiking in New Zealand.

They also sell an instructional booklet, 'Safety in the Mountains'. For more information, visit <http://www.fmc.org.nz/>

New Zealand Alpine Club

The New Zealand Alpine Club was founded in 1891 and is one of the oldest alpine clubs in the world. It actively promotes climbing in New Zealand and overseas, and publishes, in print and online, guidebooks to New Zealand's mountains and rock climbing areas. It also publishes the quarterly magazine, 'The Climber', and the annual 'New Zealand Alpine Journal'. For more information, visit <https://alpineclub.org.nz/>

Further reading

P G Firth, M P Grocott, H E Montgomery, G W Rodway and J S Windsor 'Mountain Morality: a review of deaths that occur during recreational activities in the mountains' (2009) 85 *Postgrad Med J* 316–321.

Recommendations made by New Zealand coroners

CASE Lessard [2016] NZCorC 21; Lemieux [2016] NZCorC 22

CASE NUMBER CSU-2015-DUN-000245; CSU-2015-DUN-000246

DATE OF FINDING 7 February 2016

CIRCUMSTANCES

Louis-Vincent Lessard and Etienne Lemieux, both of Quebec, Canada, died on 9 July 2015, on the Kepler Track between Hanging Valley Shelter and Luxmore Hut, of suffocation when they were engulfed in an avalanche.

Mr Lessard and Mr Lemieux were both 23-year-old tourist visitors to New Zealand. They had some experience in the outdoors including in the snow and mountains. On or about 6 July 2015, they began walking the Kepler Track in Fiordland National Park. In the days leading up to them commencing their tramp, they had talked with several local guides, tourist operators, and a Department of Conservation (DOC) ranger. The advice they received was not to attempt to walk the track due to the extreme bad weather.

Mr Lessard and Mr Lemieux went ahead with their tramp and on 9 July 2015 were caught in an avalanche that engulfed the track. When the two did not return, a search and rescue effort was launched and the bodies of the two men were discovered in avalanche debris on 26 and 27 July 2015.

The Coroner received expert evidence on the contributing factors to the deaths. These included Mr Lessard and Mr Lemieux's lack of experience tramping in New Zealand through terrain that featured known avalanche zones; a failure to change plans when advised of the hazards; and a failure to identify and avoid avalanche-prone slopes and employ safe techniques such as spreading out when crossing avalanche zones.

DOC carried out an internal review of the deaths; it has already begun implementing some of the changes identified. These include a review of its winter season brochures in order to highlight the message about avalanche danger and the need to have avalanche awareness; and the briefing of visitor centre staff to bring avalanche danger to the attention of potential track users.

Mr Lemieux's parents enquired about the feasibility of closing the Kepler Track in its entirety during periods of high avalanche risk. The response to this was that a combination of legislative provisions and DOC

policy mean that national parks remain open to the public with DOC providing appropriate and up-to-date information. Users are then responsible for making their own decisions. In addition, there is limited practical ability to close tracks whose entrances are often remote and unmonitored.

Mr Lemieux's parents also raised questions about the signage in place at the entrances to the track to warn of avalanche risk. The Coroner noted the difficulty in creating signage that will be clearly understood by persons for whom English is not their first language.

RECOMMENDATIONS OF CORONER D O CRERAR

- I. I adopt the recommendations suggested in the report completed for DOC by David Winterburn and Anita Middlemiss. The recommendations include an enhancement to existing practices at the visitor centre at Fiordland National Park, including future Kepler Track management and a focus on the management of avalanche hazards. I endorse the national recommendations made by the DOC report authors, including the proposal to investigate the rollout of security cameras to record staff/public interactions and I particularly support the recommendation for upgrading the ability of visitor centres to give current information to track users on avalanche hazard.
- II. In addition to the 'internal' recommendations of DOC, I adopt the suggestion by the parents of Etienne Lemieux and recommend that DOC investigate the installation of signage on the Kepler Track identifying to trampers the areas of the acute avalanche risk present by paths in the vicinity.

RESPONSE

- I. Response from DOC received on 29 June 2016. Please find annexed and labelled 'Annexure 1'.

CASE Viellehner [2016] NZ CorC 4; Viellehner [2016] NZ CorC 5; Bishop [2016] NZ CorC 6
CASE NUMBER CSU-2015-CCH-000088; CSU-2015-CCH-000089; CSU-2015-CCH-000090
DATE OF FINDING 11 January 2016

CIRCUMSTANCES

Johann Georg Viellehner and Raphael Viellehner of Germany and Michael Bishop of Australia died on 29 December 2014 at the Upper Linda Glacier, Aoraki Mount Cook National Park. The cause of death was likely to have been significant traumatic injuries and/or suffocation as the result of an avalanche.

Messrs Viellehner and Mr Bishop were mountaineering as a group. They were last seen at around 3.30am near Teichelmann's Corner in the Linda Glacier in Aoraki Mount Cook National Park. All three were experienced overseas mountaineers and had appropriate equipment.

When the group did not return, a search and rescue operation was launched. Despite extensive efforts including the use of a helicopter, this did not succeed in locating the group. Experts familiar with the area gave their opinion that the group were caught in an avalanche or ice fall. The weather conditions at the time of the group's disappearance were unusually warm which increased the risk of ice instability. Another group had turned back on the glacier that day due to assessing the conditions as unsafe for travel.

There was evidence of a recent avalanche in the area and on 7 January 2015, a piece of clothing or gear was observed near this ice fall but it could not be safely retrieved due to the continuing risk of avalanche.

It was unknown the extent to which the group had sought local knowledge or advice from those who were familiar with New Zealand alpine conditions.

Despite the absence of bodies, the Coroner found that all three men had died.

COMMENTS OF CORONER D O CRERAR

- I. I comment that deaths which have been the subject of this inquiry are further examples of mountaineers who are recent visitors to New Zealand failing to understand the fact that conditions in the alpine areas of New Zealand are different from conditions in the mountains in other countries. This failure to understand is exacerbated by the fact that such visitors fail to understand that they do not understand that New Zealand mountains present challenges which are different to those experienced elsewhere in the world.

CASE Willen [2015] NZCorC 108

CASE NUMBER CSU-2015-DUN-000138

DATE OF FINDING 13 November 2015

CIRCUMSTANCES

Allison Lynn Willen of Akron, Ohio, United States of America died on 25 April 2015 in the Young River, Mt Aspiring National Park of a head injury and drowning.

Ms Willen was a student visitor to New Zealand. On 25 April 2015 she was tramping with two friends – Kirsten Kampmeier and Ellen Stone – in Mt Aspiring National Park between Gillespie Pass and Young Hut.

It was raining and the weather was very cold. The track was flooded in places. The three women walked at different paces and became spread out. Allison Willen was in the rear, about 500 metres behind the other two. Ms Stone and Ms Kampmeier talked and decided to continue on to Young Hut because of the extreme weather. When they arrived at Young Hut, they met three other trampers. The five discussed how they could help Ms Willen but by that time it was dark and the weather was dangerous. They decided they could not safely return to Gillespie Pass to search for Ms Willen. In the morning, the five walked out to Makarora and raised an alert. Police launched a search and rescue effort.

Search and rescue teams located Ms Willen's body in the Young River on 2 May 2015. Sergeant Aaron Nicolson, the Police search and rescue coordinator and an experienced trumper and mountaineer, gave evidence that the likely scenario is that Ms Willen was either following the flooded track or making her way along steep ground to avoid the flooding. She likely lost her footing, slipped and fell into the water of the flooded Young River. A post-mortem revealed a head injury likely caused by hitting her head on a rock when she slipped.

Ms Willen and her companions were relatively inexperienced trampers. They had completed 'Great Walks' – which were walks of lesser difficulty on better-formed tracks. DOC described the Gillespie Pass area as suitable for experienced trampers.

The Coroner noted there was no evidence to suggest that the advice given by DOC to the trampers, or any warning signage and information was insufficient. The Coroner also noted that Ms Kampmeier and Ms Stone were, on 25 April 2015, in distress themselves. The Coroner did not attribute blame or responsibility to them.

COMMENTS OF CORONER D O CRERAR

- I. The Coroner described the following comment of Sergeant Nicolson as relevant: 'I would suggest in the circumstances that the [trampers] found themselves in it was best practice for groups to stay together. This leads to improved morale and less anxiety, better decision-making and provides some immediate assistance to a member of the party should there be an unexpected accident or incident.'
- II. The Coroner forwarded a copy of the finding to Federated Mountain Clubs of New Zealand in order that a synopsis of the circumstances of the death receives publicity through the Federated Mountain Clubs bulletin.

CASE Asmin [2015] NZCorC 91

CASE NUMBER CSU-2014-DUN-000181

DATE OF FINDING 9 October 2015

CIRCUMSTANCES

Yessica Asmin of Australia died on 19 May 2014 at the Pompolona Creek and Clinton River on the Milford Track as a result of cold water immersion when she was swept downstream in an attempted river crossing.

On 19 May 2014, Ms Asmin and two companions were tramping the Milford Track out of season. They had entered via Te Anau Downs. It was raining heavily and Pompolona Creek – an unbridged stream on the track – was flooded. Ms Asmin and her two companions attempted to cross Pompolona Creek. They wanted to progress to the next hut before the forecasted snow. Ms Asmin reached a rock in the middle of the river but slipped and was swept downstream out of sight of her companions. Her body was discovered on 21 May 2014. The cause of death was cold water immersion.

Because it was winter, many of the bridges on the track had been removed. At the time, there was no clear briefing from tramping transport companies for prospective trampers telling them some bridges had been removed and warning of the risks of crossing flooded streams. These have since been implemented. DOC did provide this information at their visitor centre and website.

DOC carried out an extensive review. As part of its assessment of levels of signage and information available to trampers, it observed that two signs warning of the danger of river crossings – one at the 'Bus Stop' shelter and one at the Glade House swing bridge – were not in place during the time Ms Asmin was walking the track.

As well as signage and the available information, the Coroner also considered the decisions the tramping group had made and their level of experience in tramping and river crossing.

RECOMMENDATIONS OF CORONER D O CRERAR

- I. I recommend that DOC take into account the observation of Sebastian Keilholz that the party had a preference not to use the 'Bus Stop' shelter because it was 'not healthy' due to poison bait being stored there.
- II. I adopt and endorse the other recommendations made in the [DOC] Visitor Incident Investigation Report ... specifically that DOC should:

- a. Review visitor information to make the hazards clear.
- b. Review the Milford Track brochure to show the reality of the hazards people can encounter, including possible adverse weather conditions.
- c. Review the DOC web page to ensure that the safety and preparedness information is readily discovered by visitors.
- d. Improve the consistency and simplicity of the information given by visitor centre staff on bridge removal.
- e. Review the Glade House swi[ng] bridge sign to give equal prominence to the hazards of crossing unbridged rivers and streams.
- f. Reinstate the hazard sign at the 'Bus Stop'.
- g. Install a winter conditions sign at the Te Anau Downs boat ramp where potential users have not then made the full commitment to walk the track in difficult conditions.
- h. Review the safety and preparedness information in the huts to ensure that it covers all hazards including information on unbridged river crossings.
- i. Post a pre-season forum with relevant stakeholders including transport providers and search and rescue organisations to ensure that each understand track management and operational needs.
- j. [Undertake] a review of the current visitor risk assessment ... with staff.
- k. Recommend a greater than two-yearly inspection of the critical hazard warning signs.
- l. Insofar as signage is concerned, it is a matter of regret that the specific signage which could have warned Yessica Asmin and her companions of the river crossing hazard and removed bridges had disappeared from critical points.

RESPONSE OF THE DEPARTMENT OF CONSERVATION

The Department responded to the Coroner's provisional finding and the Coroner summarised the Department's response in his finding as follows:

- I. 'There [is] no evidence of poison being stored in or adjacent to the Bus Stop shelter at the time and there was no poisoning operation being conducted in May 2014. DOC states that it would never store poison in or near a shelter.'
- II. All other 'recommendations have been implemented or are being implemented by DOC. In particular all signage ... is now checked as part of the pre-season and post-season track inspections.'

CASE Buckley [2014] NZCorC 145

CASE NUMBER CSU-2013-CCH-000513

DATE OF FINDING 9 September 2014

CIRCUMSTANCES

Robert Buckley of Christchurch died on 14 September 2013 at Aoraki Mount Cook National Park, of injuries sustained in an alpine fall.

On 14 September 2013 Mr Buckley, along with three companions, arrived at the visitors centre at Aoraki Mount Cook. The group had decided to travel to Sefton Bivvy and hired crampons and ice axes as the route they were taking was challenging. Mr Buckley and one other person in the group had not used

crampons or ice axes before. It was anticipated that the route would involve an overnight tramp/climb to Sefton Bivvy.

The group started their climb and as the route became steeper and the conditions icy, the group started to experience some difficulties. At one stage, Mr Buckley made a comment that he was out of his comfort zone. As the climb continued, Mr Buckley had difficulty finding hand and foot holds. It was during this phase of the climb that he lost his footing and fell backwards, knocking over another group member. They both started to slide down the mountain. The other group member was grabbed by his companions and prevented from falling further, however Mr Buckley continued to slide down the slope and then over the edge of a rocky outcrop. Rescue services were alerted however, due to the conditions, the group was not uplifted until the next day, along with Mr Buckley who was located deceased.

COMMENTS OF CORONER R G MCELREA

- a) Regrettably the facts of this case are a salutary lesson of the danger of exceeding one's experience and capabilities in such an alpine environment. The route taken was a 'serious undertaking' in winter conditions and required mountaineering techniques and experience, which the party of four persons lacked.
- b) The case highlights the importance of having a reliable means of alerting rescue authorities in emergency situations, such as a mobile phone with fresh batteries or an emergency locator beacon, preferably with back-up between members of the party. In this case, the cell phone which they succeeded in using had batteries that were running low.
- c) An internal investigation by DOC has resulted in instructive and worthwhile recommendations which will result in better information being made available to would-be climbers of the route. Taking account of this outcome, I confine my recommendations concerning DOC to those set out below.
- d) As a result of this incident, Alpine Guides has developed and completed a formal public gear policy and guidelines for company staff. Taking account of this outcome, I make no recommendations concerning Alpine Guides.

The above comments are directed to the President, Federated Mountain Clubs of New Zealand and the President, New Zealand Alpine Club with respect to comments (a-b), the Department of Conservation, with respect to comment (c) and Alpine Guides (Aoraki) Limited with respect to comment (d).

RECOMMENDATIONS OF CORONER R G MCELREA

- a) I recommend that the findings in this inquest receive publicity through the Federated Mountain Clubs of New Zealand, New Zealand Alpine Club and like organisations with emphasis on the need for each member of a party to have the necessary skills and experience for any undertaking in alpine conditions and a reliable means of alerting rescue authorities in emergency situations.
- b) I recommend that DOC:
 - i. As a matter of priority, implement the 10 recommendations (relating to visitor information, visitor centre staff training, and track management) set out in the Visitor Incident Investigation Report, to the extent that such recommendations have not already been implemented. Priority should be given to achieve implementation as far as possible for the forthcoming spring/summer season.

- ii. In addressing recommendation 1 as to updating the 'Visitor Centre Sefton Bivvy file' that the document 'Sefton Bivy (sic) Route Guide' be updated in text as well as including spring/winter photos.
- iii. In reassessing whether the Sefton Bivvy route should be managed as an unmarked or marked route, that the Department takes account of the importance to this party of the orange markers in locating and following the route.

The above recommendations are directed to the President, Federated Mountain Clubs of New Zealand and the President, New Zealand Alpine Club with respect to the first recommendation and the Department of Conservation, with respect to the second recommendation.

CASE Taylor [2014] NZCorC 141

CASE NUMBER CSU-2012-CCH-000918

DATE OF FINDING 8 September 2014

SUMMARY OF RECOMMENDATIONS

Rex Leslie Taylor of Christchurch died between 23 and 25 October 2012 at South Westland of injuries he sustained when he accidentally fell down a steep slip in rugged bush terrain.

Mr Taylor had been working in the area clearing tracks as part of a group. He was known to enjoy his own company and spent a lot of his time in the hills working on upgrading and maintaining huts and tracks on a volunteer basis. He was last seen alive on 23 October 2012 at the Explorer Hut in an area known as the Mikonui River, South Westland. He had returned to the hut and found two hunters who had arrived by helicopter. Mr Taylor has quickly packed up his gear and left the hut saying that he was going to camp and noted in the logbook that he was 'out via Mikonui or Mikonui biv WX fine'. In the date out section he wrote '25 October'.

A police search commenced on 6 November 2012 and was suspended three days later. On 16 December a private helicopter operator located what they believed to be the body of Mr Taylor at the bottom of a steep slip.

Although Mr Taylor was dressed with multiple layers of outdoor clothing and carrying a GPS unit on a lanyard around his neck for navigational purposes, he was not carrying a personal locator beacon or equivalent device that might have enabled him to call for assistance in an emergency situation. The circumstances of his fall and injuries are likely to have prevented him activating such a device even if he had been carrying it. Although he appropriately completed the hut log with a projected date out (25 October) police did not learn of his being overdue until almost two weeks later as he had not given this information to anyone prior to going into the area, with clear instructions to call police should he not return by the given date.

COMMENTS OF CORONER R G MCELREA

- i. This case highlights the desirability of carrying a personal locator beacon or equivalent device in remote locations and of alerting a person or the police as to the date due out from a remote location. Neither of these factors would have altered the outcome given the circumstances of Rex Leslie Taylor's death which was instantaneous when he accidentally fell down a steep slip in rugged bush terrain in South Westland.

RECOMMENDATIONS OF CORONER R G MCELREA

- i. I recommend that the findings in this inquest receive publicity through the Federated Mountain Clubs of New Zealand and like organisations with emphasis on the desirability of carrying a personal locator beacon or equivalent device in remote locations and of alerting a person or the police as to the date due out from a remote location.

The above comments/recommendations are directed to the President, Federated Mountain Clubs of New Zealand and to DOC (for which Department Rex Leslie Taylor had at the time of his death been carrying out voluntary track maintenance work.)

CASE Rait [2013] NZCorC 144

CASE NUMBER CSU-2013-CCH-000511

DATE OF FINDING 9 September 2014

CIRCUMSTANCES

Duncan Rait of Victoria, Australia died on 13 September 2013 at Aoraki Mount Cook of injuries he sustained in an alpine fall.

On 13 September 2013 Mr Rait and his brother flew into Tasman Saddle Hut (altitude 2435 metres) by helicopter from the Aoraki Mount Cook airport. Shortly after arrival at the landing, Mr Rait was seen by his brother to slip and fall down a gully leading south westwards from the hut site and leading onto the Tasman Glacier. He was later evacuated by the rescue team but was pronounced deceased on his arrival at the airport.

Mr Rait was an experienced mountaineer and was familiar with the dangers of losing his footing in alpine terrain. The terrain on the day of the fall was a mixture of soft snow and “bullet-proof ice” making footing conditions difficult.

COMMENTS OF CORONER R G MCELREA

- I. The death of an experienced mountaineer who has slipped and fallen to his death in the environs of the Tasman Saddle Hut, Aoraki/Mount Cook National Park highlights the dangers of complacency in underestimating alpine terrain conditions. Had Duncan Rait, in attempting to traverse a distance of some 100 metres, in soft snow and then “bullet-proof ice” conditions (of which he was unaware) kept his hands free with an ice axe for self-arrest it is very probable that he would have avoided injury. Likewise if he had anticipated the possible need to fit crampons in the course of traversing the distance, and so fitted them when required, a safe outcome would have resulted.

RECOMMENDATIONS OF CORONER R G MCELREA

- I. I recommend that the findings in this inquest receive publicity through the Federated Mountain Clubs of New Zealand, New Zealand Alpine Club and like organisations with emphasis on:
 - a. The underfoot dangers of this approach to the Tasman Saddle Hut with potential loss of footing in glaciated terrain and the need to be in a position to self-arrest;
 - b. The need for planning and safe execution of even the most basic of tasks – in this case ferrying supplies from a helicopter pad to a hut some 100 metres away.

- II. I recommend that the Department of Conservation gives publicity through its website and visitor information pertaining to the Tasman Saddle Hut of the underfoot dangers of this approach to the hut with potential loss of footing in glaciated terrain and the need to be in a position to self-arrest.
- III. The above recommendations are directed to the President, Federated Mountain Clubs of New Zealand and the President, New Zealand Alpine Club with respect to the first recommendation and the Department of Conservation, with respect to the second recommendation.

CASE Spychalski [2013] NZCorC 137

CASE NUMBER CSU-2012-DUN-000508

DATE OF FINDING 4 October 2013

SUMMARY OF RECOMMENDATIONS

Frank Spychalski, late of Germany, died on 29 November 2012 at Mt Aspiring National Park of severe injuries sustained in a fall.

Mr Spychalski was a tourist travelling around New Zealand and had been keeping in contact with a friend via a social media Google page he had created. His last entry was on 28 November 2012, the day after he had checked out of his accommodation, where he had communicated his intention to go trekking around Mt Aspiring National Park.

He had had a discussion with another hiker about climbing towards a point known as 'the Pylon'. However the last section of such an ascent is very steep and commonly snow- and ice-covered, and he was recommended not to attempt it given his inadequate equipment. He went with the intent of scoping out the route and said that he would not attempt it if he felt it unsafe.

According to the evidence, it is likely that on his ascent to the Pylon, he slipped on the steep snowy track and fell some distance into a gully. When his friend had not heard from him by 23 December 2012, she informed Police that he was missing. A Search and Rescue team was dispatched to Mt Aspiring National Park, and a helicopter crew located Mr Spychalski's body below the Pylon, some four weeks after his fall. He had died immediately of the injuries he sustained.

Notwithstanding the fact that Mr Spychalski was a fit and experienced climber, the shoes he was wearing were inappropriate for the conditions in which he climbed. Additionally the Pylon is in an area known as 'the Cascade Saddle', which is known to be hazardous and has been the site of multiple fatalities. There are a number of signs in the area warning of the multiple hazards, but this signage could be enhanced to include stronger wording or more obvious warning colours like red or black. A Consultative Group, comprised of Police, Search and Rescue experts, recreational users, and DOC representatives was convened on the subject.

RECOMMENDATIONS OF CORONER D O CRERAR

To: The Department of Conservation

- i. That comprehensive reappraisal of all the safety aspects of the Cascade Saddle crossing is undertaken. The Consultative Group mention the possibility of an engineer/mountaineer Derek Chinn being approached for a report. DOC have of course the internal resource of Don Bogie as its Technical Advisor on safety matters. Either or both should be commissioned to review the several alternatives now raised and consider other alternatives. I at present remain of the belief that enhanced signage is a minimum but I will await further submission.

CASE Stukenborg [2012] NZCorC 66

CASE NUMBER CSU-2011-DUN-000273

DATE OF FINDING 30th April 2012

SUMMARY OF RECOMMENDATIONS

Julian Stukenborg of Delmenhorst, Germany, an aircraft engineer and a tourist to New Zealand, died on 17 June 2011 near the Cascade Bluffs in the Fiordland National Park. Whilst tramping alone, he left the track and slipped and fell over steep bluffs. The cause of his death was severe extensive head and brain injuries with spinal fractures and femoral fractures.

COMMENTS MADE BY CORONER D O CRERAR

- i. This death is another tragic example of a visitor, to our country from overseas, underestimating New Zealand alpine conditions, particularly winter conditions.
- ii. Julian Stukenborg was under-prepared for the tramp he embarked upon. [His] light tramping boots may have been suitable for the Cascade Saddle, or for less difficult tramping trips in summer conditions, but allowed no margin for error. He left a well marked and safer track and traversed to an area of steeper bluffs, no doubt to scope areas for photographic opportunity. His lack of experience in some conditions allowed him to underestimate the slippery footing and it is this which has proved fatal.
- iii. He was tramping on his own. Whilst solo tramping is an acceptable concept, it does carry with it greater risks. Trampers on their own do not have the opportunity to discuss potential hazards with others and as such the decision making of solo trampers may be compromised. It has been suggested that a solo trumper is more likely to err by not making a decision through failing to recognise that they need to stop and make a decision. If he had not been alone he may not have taken the route which he did.

RECOMMENDATIONS MADE BY CORONER D O CRERAR

- I. I recommend that a copy of this Finding be forwarded to Federated Mountain Clubs for a synopsis to be published in the Bulletin of the organisation to draw to public attention, and specifically the attention of mountain users, the dangers associated with tramping, whilst alone, with inappropriate footwear and without appropriate experience in our mountain regions.

CASE Taylor [2012] NZCorC 109

CASE NUMBER CSU-2012-DUN-000004

DATE OF FINDING 13 September 2012

SUMMARY OF RECOMMENDATION

Michael Gillard Taylor of Wellington, a computer operator, died on 31 December 2011 on the western slopes of Mt Twilight in the Mt Aspiring National Park. When ascending steep tussock slopes, above bluffs on the western ridge of Mt Twilight, Michael Taylor has slipped, or tripped, and fallen a significant distance onto rocks. The cause of his death was severe extensive injuries consistent with a fall.

RECOMMENDATIONS MADE BY CORONER D CRERAR

- I. That a copy of this finding, which I will ensure is forwarded to the Federated Mountain Clubs for publication in its Bulletin, receive appropriate publicity to warn those travelling in the mountains of the absolute need to pay attention to their equipment, especially their boots and to concentrate fully on their footing at times where they are exposed to serious or fatal consequences in the event of a fall.

CASE Ong [2012] NZCorC 52

CASE NUMBER CSU-2010-DUN-000455

DATE OF FINDING 30th April 2012

SUMMARY OF RECOMMENDATIONS

Eng Wu Ong of Melbourne, Australia, a student, died on 15 November 2010 when, whilst climbing on the Southwest ridge of Mt Aspiring he stumbled or slipped from a position very high up on the mountain and slid and fell approximately 500 metres down the West face of the mountain before coming to a stop in a bergschrund. The cause of his death was extensive traumatic injuries, haemorrhage, hypothermia and shock due to a severe impact to the chest.

After traversing the Bonar Glacier, during which time they were roped together to guard against problems which could have arisen from a fall into a crevasse on the glacier, Eng Wu and his companion Richard Bassett Smith agreed to take of the rope and each then “solo climbed” up the lower portion of the Southwest ridge towards the summit of Mt Aspiring. It was at this point that Eng Wu slid 500 metres to the bergschrund in the glacier below, this being over slopes of between 50 and 60 degrees of hard snow and ice, followed by steep rock bluffs before the final fall into the crevasse/ bergschrund.

COMMENTS MADE BY CORONER DAVID CRERAR

- I. The facts surrounding the tragic death of Eng Wu are unfortunately similar to the facts in the death of John Bernard Pawson who died on 27 November 2008 after a fall from approximately the same position as the fall by Eng Wu from the Southwest ridge of Mt Aspiring. Although an exact cause for the loss of balance and the fall of John Pawson has been unable to be confirmed, it takes only a momentary loss of concentration or a minor stumble to have tragic consequences on a steep and exposed slope.
- II. In the inquest into the death of John Bernard Pawson, the evidence required that I consider the possibility of ketoacidosis which was suggested by abnormally high acetone levels which had been measured. Ketoacidosis and low blood glucose levels can result in fatigue, dizziness and disorientation. In the case of John Bernard Pawson, there was insufficient evidence for it to be found that this was a cause or a contributor to his loss of balance and slip, but evidence was given that a failure to take adequate food, fluid and rest is likely to be more commonly encountered in the case of younger mountaineers involving a multi-day ascent (walking from the valley floor to a hut and then embarking on the climb). All climbers should learn to rehydrate and take nutrition as necessary.
- III. I adopt the comments of the former Coroner for Westland, Anthony Sullivan, when in his Finding in respect to the death of Alistair Stevens, Coroner Sullivan said, when referring to a decision by climbers to descend without the protection of a rope:

The issue with this is that climbing is the balance of calculating the risk at any particular point as opposed to the need to keep moving and make progress towards your goal.

In other words, if climbers took the safest and most conservative option at every point to ensure their safety, they would not succeed in climbing very far.

- IV. The dilemma faced by climbers, in balancing the need to gain the summit with the need to achieve this safely, ought always to be resolved with the emphasis on safety.
- V. As a cause or contributor to the fall reference must be made to the crampon fitting adopted by Eng Wu. Whilst, it is stressed, that there appears nothing inherently wrong with the design and application of the crampons used by Eng Wu, it is a responsibility of a Coroner to draw to public attention the circumstances of a death to ensure that such circumstances are not repeated. Enhancement to crampon strap and attachment design ought to be drawn to public attention.
- VI. Many, if not most, mountaineers will have experienced a crampon detachment, sometimes during periods of difficulty. This creates a significant hazard to the crampon wearer and to his, or her, companions. Every effort should be made to adopt the best and safest and most modern technology and enhancements to avoid any possibility of problems occurring as a result of such a failure. There is a relatively straightforward solution available to any potential problem.

RECOMMENDATIONS MADE BY CORONER DAVID CRERAR

- I. I recommend that mountaineers consider carefully their nutrition and hydration requirements for what is clearly a very strenuous and energy intensive sport. Publicity should be given by mountaineering clubs and tramping clubs to their members, and others, and, if appropriate, advice should be sought from expert nutritionists.
- II. Mountaineers should consider carefully their experience and ability and should adjust their ambitions appropriately. Climbing solo is acceptable but carries grave dangers. Novice climbers should learn appropriate rope handling and belaying techniques and compromise their objectives if their techniques are unsound. Mountain users ought always to conduct appropriate research on their objectives, take local advice when given and be prepared to adjust their destination according to advice given.
- III. Mountaineers ought to carefully consider appropriate methods to affix crampons to their boots in the most appropriate, secure manner. It is necessary to adopt, not only the manufacturers recommendations on sale, but also such enhancements as have been established by subsequent usage.

CASE Yun [2010] NZCorC 217

CASE NUMBER CSU-2009-DUN-000022

DATE OF FINDING 15 March 2010

SUMMARY OF RECOMMENDATIONS

Irina Yun late of Auckland died on 31 December 2008 at the Dart River Catchment in Mt Aspiring National Park of drowning.

Ms Yun left Aspiring Hut in the national park early in the morning on the day of her death. The conditions that day were poor with heavy rain. At the time she would have been negotiating the side creeks above Dart Hut there was a tenfold rise in water levels. It is considered most likely that while crossing the larger stream, she slipped and got caught, was washed into the Dart River and drowned.

She had been expected to arrive at Dart Hut to spend the night there, when there was no sign of her in the early evening, police and search and rescue were notified. A search began the next day, and on 5 January her pack was found in a gorge, 300 metres from Dart Hut, having apparently been ripped from her. A body was eventually found in Dart Gorge by a search dog in November 2009, and was able to be identified as that of Ms Yun.

Ms Yun was well-prepared for a straightforward tramp, but not for the conditions that occurred. The guide book she was using was not sufficiently detailed and did not include appropriate warnings of potential hazards. The searchers that eventually found Ms Yun's body were volunteers that returned to the area after the official search had ended.

COMMENTS OF CORONER D O CRERAR

- I. Irina Yun, although obviously fit, and experienced in easier tramping areas, had little experience with mountain torrents in high flood. She has made, in attempting to cross the river, a fatal error of judgement.
- II. It is hoped that publicity given to the causes and the circumstances of the death of Irina Yun draw to public attention the need for trampers and climbers to take extra care in such places. If there is any doubt as to the ability of a tramping party to cross a flooded river, the best alternative is to sit and wait for river levels to fall as they invariably do. Trampers and climbers ought never to be on such strict time constraints that it becomes imperative for them to cross a flooded river in dangerous conditions.

RECOMMENDATIONS OF CORONER D O CRERAR

- I. That this finding be given publicity throughout the tramping and mountaineering community.

To: The editor of the Federated Mountain Climbers Bulletin

- I. That a copy of this finding be forwarded to them so that the causes and the circumstances of the death of Irina Yun receive publicity as a warning to others.

To: The Commissioner of Police

- I. That the Commissioner reimburse the expenses of the search team who located the remains of Irina Yun in November 2009. Their work was a necessary task to bring finality to this sad event and the location and identification of human remains is an essential function of Police/Coroner responsibility.

CASE Jackson [2010] NZCorC 215

CASE NUMBER CSU-2009-PNO-000378

DATE OF FINDING 15 March 2010

SUMMARY OF RECOMMENDATIONS

Marcella Margaret ('Rosie') Jackson and Seddon Leonard Bennington both late of Wellington died on 12 July 2009 near Kime Hut in the Tararua Forest Park, Wellington of hypothermia.

Ms Jackson and Mr Bennington left Wellington on 11 July 2009 to tramp in the Tararua ranges to the Kime Hut. They left in fine weather, but it worsened during the day. They made their way past Field Hut, and tramped past the bush line, where the terrain was sub-alpine leading up to Kime Hut. By the time they had

reached this terrain, the conditions had grossly deteriorated and the usually moderate-level tramp became quite challenging. They mistakenly started down a track that did not lead to Kime Hut and took what shelter they could over the night of 11 July. They died early the next morning.

When the two did not return Search and Rescue were contacted. But because of the conditions a search was not started until 14 July. A search could have been commenced with some difficulty on 13 July, but the Coordinator considered that either the two individuals had made it to Kime Hut and would be safe for another day, or having been out in the conditions for such a length of time, they were already deceased.

They were reasonably well-equipped for the tramp they undertook, but not prepared for the conditions they ultimately encountered. Had they been better equipped, say with a tent, they might have survived in the conditions longer. They also lacked any means of ascertaining where exactly they were, or signalling or calling others for help.

COMMENTS OF CORONER T SCOTT

- I. Essentially a Search and Rescue Coordinator needs to make a number of very important decisions quite quickly and on the spot. There are always judgement calls. Two of the most important decisions clearly must be when to start and when to stop the search. I do not know that this should necessarily be a one person job, or a one person decision. It does not even seem to me particularly fair on the person required to make that decision that it is, and I have thought long and hard about this issue before coming to the conclusion in this decision.
- II. I am not here thinking in terms of convening a committee and having lengthy delays whilst in the middle of needing to make prompt decisions on commencing a search or terminating a search and other important decisions of the same nature, but I ponder whether there should be some protocol that at least key decisions like commencement and termination should be briefly, and I mean briefly, peer reviewed by some other competent person, say within 30 minutes or an hour after the initial decision.
- III. It would seem to me that this would be a check and a balance and a safeguard, even a safeguard taking what might perhaps be an unfair responsibility from one person solely. I advance this as a suggestion for Police and search and rescue to consider when undoubtedly they will review this decision of mine, and all of the events surrounding the tragedy.

CASE Miranda [2010] NZCorC 196; Miranda [2010] NZCorC 197

CASE NUMBER CSU-2009-CCH-000078 (Akshay); CSU-2009-CCH-000024 (Ashish)

DATE OF FINDING 29 November 2010

SUMMARY OF RECOMMENDATIONS

Ashish Miranda and Akshay Miranda, both late of Melbourne, Australia died, aged 24 and 22 respectively, on 8 January 2009 at the Fox Glacier of crush injuries when glacial ice collapsed on them.

Ashish and Akshay were on holiday with their parents and cousins. That morning the family had driven up Fox Glacier and they began walking as a group up the walking track towards the glacier. When they came to a steeper section of track, the two brothers and two of their cousins walked ahead, leaving their parents and another cousin to slowly follow them. The two men continued alone across a riverbed at the bottom of the gully, and made their way together across the terminal face. They passed several signs warning that the terrain was potentially unsafe and for experienced persons only. While posing for a picture together at the terminal face, a large section of ice collapsed upon them. Ashish's body was able to be recovered that day, but Akshay's was not recovered until 15 January 2009.

The fast-running river parallel to the terminal face caused the face to cut away. Heavy rains in October and November of the previous year had increased the risk of ice collapse. Despite daily checks staff do not have the ability to predict on which days ice from the shelf will collapse.

The warning signs used at the glacier were intended to provide members of the public with information, allowing them to make choices regarding how close to get according to their own ability. Individuals without guides are not restricted from potentially hazardous areas. At the time of these events the hazard warning signs were the same colour of the direction signs; they have since been made red.

COMMENTS OF CORONER R MCELREA

- I. The Miranda brothers ignored some warning signs. Their actions in venturing beyond the lookout point several hundred metres to the Fox Glacier terminal face, can perhaps be understood when the context of the decision-making is analysed and taking account of factors influencing such behaviour, as identified by experts. There were people beyond the barrier in the open riverbed area. It had the appearance of safety. The brothers' decision seemed pre-determined. It may have been a common practice. At least one other person was there "touching the ice" a few minutes before them.
- II. I was impressed with the professionalism of the Department of Conservation and its staff in the management of the Fox Glacier Valley. The outcome is not their responsibility. I make some recommendations and observations that should not be taken as suggesting fault on the part of the Department or its employees.

RECOMMENDATIONS OF CORONER R MCELREA

To: The Department of Conservation [to be applicable if the Department's monitoring of visitor safety directions since these fatalities indicates non-compliance (even at a low level) with the hazard warning signs designed to prevent persons approaching the Fox Glacier terminal face.]

- I. That the Minister of Conservation takes steps by creation of a bylaw or bylaws to restrict or close public access to part of the National Park at the terminal face. I recommend that such action allows access in limited circumstances such as when a person is in the presence of an accredited guide, or a park ranger, or is authorised by a park ranger.
- II. That such measures apply at times when the Fox Glacier terminal face is considered particularly dangerous such as occurs when the glacial terminal face is upright as was its state in January 2009.
- III. That coupled with the making of such bylaws enforcement processes such as those included in a draft Bill known as the Conservation (Authorisations Compliance and Enforcement) Bill be considered with particular reference to the imposition of infringement fees ("instant fines") for non-compliance.
- IV. That the Department of Conservation ensures through its accrediting procedures that guided groups in the Fox Glacier Valley be distinctively clothed so that at a distance it is clear that they are under the control of an accredited guide.
- V. The above recommendations might also have application at the Franz Josef Valley and terminal face.

CASE Pawson [2009] NZCorC 78

CASE NUMBER CSU-2008-DUN-000695

DATE OF FINDING 29 July 2009

SUMMARY OF RECOMMENDATIONS

John Bernard Pawson late of Wanaka died on 27 November on Mt Aspiring of impact injuries sustained in a fall.

Mr Pawson left Todd Hutt with a climbing companion, traversing the Bonar Glacier and making his way up the southwest ridge. The two men climbed the ridge separately, and Mr Pawson was ahead when he fell, sliding down past his companion. His attempts to self-arrest were unsuccessful. His companion called for help and was heard by a nearby climbing party. The party advised Search and Rescue of Mr Pawson's whereabouts, and an alpine team was dispatched. They found Mr Pawson deceased.

When recovered his boot was missing a crampon, which was found further up the ridge, from where he apparently fell. Though he may have tripped or fallen, this equipment failure cannot be discounted as a possible cause of or contributing factor to his fall. Earlier that day, a guide had expressed concerns about his crampons.

An unusually high level of acetone was found in his blood stream, suggesting that he might have not had an appropriate amount of carbohydrates, but there is no indication that he was adversely affected.

RECOMMENDATIONS OF CORONER D O CRERAR

- I. That mountaineers consider carefully their nutrition and hydration requirements for what is clearly a very strenuous and energy intensive sport. Publicity should be given by mountaineering and alpine clubs to their members and others and expert nutritionist advice should be sought.
- II. All mountaineers should be made aware of the fact that they are most vulnerable to the circumstances of a fall when pausing between activities or adjusting equipment. At such times of vulnerability a secure stance ought to be established and protection, such as tying on to a snow stake or ice screw, should be adopted. A step, or steps, should be cut.
- III. That climbers using crampons consider the length of points of the crampons, particularly the available length of the front points as they protrude forward of the boot toe – and noting that shorter front points necessitates a climber dropping his/her heels to ensure securer placement such lowered heels creating discomfort by way of calf burn.
- IV. Mountaineers ought to carefully consider methods to securely affix crampons to their boots and adopt not only the manufacturers' recommendation on sale, but also such enhancements as have been established by subsequent usage
- V. I will arrange to have a copy of this Finding forwarded to the editor of the Federated Mountain Clubs Bulletin in order that publicity in relation to the circumstances of the death be given to all mountain users.

CASE Okin [2009] NZCorC 76

CASE NUMBER CSU-2008-DUN-000270

DATE OF FINDING 27 July 2009

CIRCUMSTANCES

Liat Okin, late of Israel, died between 26 and 27 March 2008 in Roaring Creek, Fiordland as a result of injuries sustained when she slipped and fell in a creek, and secondary immersion hypothermia and positional asphyxia.

Ms Okin, a tourist in New Zealand, left for a tramp late on 25 March 2008, and stayed the night at MacKenzie Hut. There she collected the ticket she had bought to walk the Routeburn Track from the other tourist she bought it from. However she undertook the tramp alone, leaving the next day at an hour the hut warden considered 'late'. The man she had bought the ticket off noted that he didn't see Ms Okin at the Routeburn Falls Hut that night, but thought she must have turned back and didn't report anything to the hut warden. When she didn't return as expected on 27 March it was initially assumed she was staying with other people. DOC was approached about her whereabouts on 31 March, and a formal missing persons report was made on 2 April. On 15 May her pack was found by Roaring Creek in an area of difficult terrain and later, on 17 May, her body was located about 80 metres downstream of that point.

The Routeburn track is considered to be well-defined and maintained, and not a track on which people are known to get lost. There is another track in the area known as the 'Avalanche Route' – a route through a zigzag area above MacKenzie hut. It is not formally marked, and it is likely that even an experienced trampster would not be able to find it from Routeburn track without being shown. At some point Ms Okin left Routeburn track and entered the Avalanche Route; it is considered possible that another person showed her an entrance to the Avalanche Route. After continuing for some time, it is likely that she decided to retrace her steps back to MacKenzie Hut, but got disorientated and lost in the terrain, eventually finding herself at Roaring Creek. There she would have taken shelter for the night but, exhausted, slipped on rocks by the creek and became immobilised. Then she would have been washed further downstream, eventually dying of her injuries.

Ms Okin tramped alone and was possibly unappreciative of the time it would take, or the possibility of treacherous or difficult terrain. She made a number of poor decisions that she might not have, had she had the support of a companion. The Routeburn Track is known as one of the six 'Great Walks' of New Zealand; a potentially deceptive name for someone for whom English is not their first language.

Ms Okin did not have on her a locator beacon of some kind with which she could have alerted others that she was lost or in trouble.

RECOMMENDATIONS OF CORONER D O CRERAR

To: The Department of Conservation, the outdoor recreation retail industry, clubs and others with an interest in outdoor safety

- I. That they promote more widely the benefits of Personal Locator Beacons, particularly for solo trampsters and trampsters embarking upon trips that are at the limit of their experience or fitness. I observe that the rental cost of personal locator beacons from retail and DOC outlets is expensive when compared to the capital cost of purchase. Consideration could be given to subsidising the cost of hire because greater use of Personal Locator Beacons could result in fewer extended and expensive searches.

To: the Department of Conservation and the Mountain Safety Council

- II. That further consideration be given by them to the establishment and administration of a universal 'check-in/check-out' form for users of the bush and mountains in New Zealand. I accept that it is inappropriate for DOC to be tasked with the responsibility of administration of such a system and that the prime responsibility for a search and a rescue rests on the individual venturing into the outdoors.

To: Federated Mountain Clubs, Department of Conservation and the Mountain Safety Council

- III. That they institute a programme giving publicity to the dangers of solo tramping and the advantages of tramping with a group. Although the fundamental right of an individual to visit mountains and bush on an unrestricted basis must always be preserved, solo tramping by inexperienced trampers in unfamiliar areas could be discouraged.

To: The Department of Conservation

- IV. That the Department review its branding and marketing of the tramping tracks it terms '*Great Walks*' to more accurately describe the serious and potentially dangerous terrain the Tracks traverse and the tramping experience required to accomplish the journey safely. This recommendation is on the grounds that visitors, for whom English is not their first language, may consider the expression '*walk*' describes the '*tramp*' to be undertaken.
- V. That the Department conduct a reappraisal of signage, particularly on tracks with higher usage by less experienced trampers. Signage should be erected to protect those most inexperienced in the outdoors.

CASE Phease [2009] NZCorC 68

CASE NUMBER CSU-2008-DUN-00095

DATE OF FINDING 21 July 2009

SUMMARY OF RECOMMENDATIONS

Leonard ('Leon') Alexander Cao-Yi-Chen Phease late of Dunedin died on 26 July 2008 in Mt Aspiring National Park of severe impact injuries sustained in a fall.

While traversing the upper section of the Liverpool track with friends in Mt Aspiring National Park, Mr Phease slid on an ice slope and fell down an 80-100 metre 'gut'. One of his party immediately ran to the nearest homestead to telephone for help. An Alpine Cliff Rescue Team was dispatched, and Leon's body airlifted to Wanaka Police Station.

At the time the track was icy and covered in deep snow. DOC had posted a sign that the track was not recommended in these conditions. Mr Phease wore light footwear as was common for this type of climbing; however in these conditions the footwear was not appropriate.

COMMENTS OF CORONER D O CRERAR

- I. Leon Phease did not appreciate the seriousness of his situation in attempting to traverse steep and slippery terrain, carrying a heavy pack and wearing only running shoes. It was appropriate for him to have changed into his climbing boots and perhaps put on

crampons. Leon Phease chose not to do so and, unfortunately, has paid the ultimate price.

- II. It is hoped that the publicity given to the circumstances of Leon's death will alert others to the potential dangers in tramping in snow, ice or slippery terrain wearing inappropriate footwear. This warning is particularly taking into account that as the Liverpool Hut is to be upgraded it will attract more users. I will ensure that a copy of this Finding is sent to DOC to point out the dangers of the access route and I will forward a copy to Federated Mountain clubs so that a summary can be published in its Bulletin.

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29 June 2016

Office of the Chief Coroner
DX Box CX10079
Auckland


Attention: Leah Taylor

Email: leah.taylor@justice.govt.nz

**Re: Department of Conservation's response to Coroner's Recommendations
Coroner's Inquest into deaths of Louis-Vincent Lessard and Etienne Lemieux
CSU-2015-DUN-245; CSU-2015-DUN-246**

I represented the Department of Conservation at the Inquest before Coroner Crerar into the sad deaths of Messieurs Lessard and Lemieux. On behalf of the Department, I advise the following responses to the Coroner's findings and recommendations:

- A. At paragraph [62] Coroner Crerar adopted the recommendations in the Department's Visitor Incident Investigation Report, noting these included an enhancement to existing practices at the Fiordland National Park Visitor Centre, including future Kepler Track management and a focus on management of avalanche hazards. The Coroner also endorsed the national recommendations in the Report, including the proposal to investigate the rollout of security cameras in visitor centres and particularly supported the recommendation to upgrade visitor centres to give current information to track users on avalanche hazard. The particular recommendations in the Report, and the Department's response to these, is as follows:
- Recommendations 1 – 9 have been assessed by the Director Southern South Island Region and Fiordland District Office staff and, as per the attached comment from that office. Apart from recommendation 6, all of these recommendations have been accepted and are either implemented or implementation is underway. This includes reviewing the Department's brochures and Fiordland NP Visitor Centre displays, a greater focus on avalanche hazards, and ensuring up to date avalanche hazard information is available year round at the Fiordland NP Visitor Centre.
 - Recommendation 6 proposed a review of the current 'split' seasonal management of the Kepler Track to change it to be managed as a Backcountry Comfort Seeker track year round. As is set out in more detail in the District Office comment attached, this recommendation was not accepted on the basis that this was not a viable option given: the alpine nature of part of the Track, the Department's limited winter staffing on the Track compared with the Great Walks summer season, and low use of the Track in winter.
 - Recommendations 10 – 15 have national implications and were considered by the Deputy Director-General Operations and the Director – Operations National Support. These were accepted or not accepted, and where accepted are in the process of implementation, as follows:

 Department of Conservation *Te Papa Atawhai*
Ōtepoti / Dunedin Office
PO Box 5244, Dunedin 9058
www.doc.govt.nz

10. *Consider the roll out of fit for purpose security cameras in appropriate Visitor Centres ...*

Response: The Department does not consider that security recording, video or video/ audio is a feasible approach to reviewing visitor information delivery. In particular, while such recordings could provide information after an incident, they would not contribute to prevention.

11. *Ensure Risk Assessment reviews are automatically scheduled through the Asset Management Information System (AMIS).*

Response: An Information Technology project is underway to provide visitor risk management within AMIS. This will include automatic reviews of various track categories; with Back Country Comfort Seeker sites to be reviewed every 3 years, and Back Country Adventurer sites to be reviewed every 5 years. Where, as for the Kepler Track, there is a split management of a functional site the review will occur in the applicable shorter time frame. This system is expected to 'go live' on 31 October 2016.

12. *Review advice in DOC information "Managing Avalanche Risk on DOC Tracks and Roads" to clarify an apparent contradiction ...*

Response: When the document is read as a whole, the apparent contradiction doesn't apply as the statements referred to are dealing with different situations. However, this document is due for review in the 2016-17 year, and this concern will be borne in mind as part of that review.

13. *Finalise the development of a long term sustainable funding model for the production of the Backcountry Avalanche Advisory.*

Response: The Department and New Zealand Search and Rescue (NZSAR) are co-funding the Backcountry Avalanche Advisory for 3 years, from 2015-16 until 2017-18. Then the intention is that NZSAR will take over responsibility for this.

14. *Review the practice of having an "Alerts" brochure nationally considering its current format, what is the most effective media, and whether there should be standardised wording.*

Response: A full review of the Department's Backcountry Visitor Information Standard Operating Procedure and Alerts/Important Notices systems is programmed for the 2016-17 year. The Department will work closely with partners (including the Mountain Safety Council) to ensure consistent information is provided to visitors.

15. *Review the use of the phrase "alpine and avalanche awareness" in promotional material to better reflect the skills needed instead of the currently used term "alpine experience".*

Response: As set out above in the response to recommendation 14, a full review of Backcountry Visitor Information is programmed for the 2016-17 year. Wording in all promotional material such as this will be reviewed as part of this programmed work.

HW

- B. At paragraph [63] the Coroner adopted the suggestion by the parents of Etienne Lemieux and recommended that “... *the Department investigate the installation of signage on the Kepler Track identifying to trampers the areas of acute avalanche risk presented by (avalanche) paths in the vicinity*”.

Response: In addition to the warning signs about Avalanche Hazard on the Kepler Track entrance points, the Department has now installed avalanche warning signs at the two points on the alpine section of the Track between which all avalanche paths occur. Due to the open terrain of the alpine part of the Track and the number of paths crossing the Track, it is not feasible to individually sign post each avalanche path.

This addresses all recommendations made by Coroner Crerar in this matter, and may be included in any Coroner’s Office “Recommendations Recap” prepared by the Ministry of Justice.

Kind regards,



Pene Williams
Senior Solicitor – Legal Services
Department of Conservation
DDI: (03) 474 6902 | Email: pwilliams@doc.govt.nz

Encl.

DOC-2818202

Te Anau District Response to the recommendations from the Visitor Incident Investigation for the Death of two Trampers on the Kepler Track

Background

Following the deaths of Two Canadian tourists in a avalanche on the Kepler Track, both a coronial investigation and an Internal (DOC) Visitor Incident Investigation (VII) were undertaken. The VII then became part of the Department's submission to the Coroners Court process.

Coroner Crerar's recommendations in his provisional findings are to ***"Adopt the recommendations suggested in the report completed for DOC by David Winterburn and Anita Middlemiss. The recommendations include an enhancement to existing practices at the visitor centre at Fiordland National Park, including future Kepler Track management and a focus on the management of avalanche hazards. I endorse the national recommendations made by the DOC report authors, including the proposal to investigate the rollout of security cameras to record staff/public interactions and particularly support the recommendation for upgrading the ability of visitor centres to give current information to track users on avalanche hazard."***

The purpose of this document is to individually respond to each recommendation from an operational perspective from the Te Anau District Office. Responders name is underline beside each recommendation.

The report focuses on the recommendations in the VII that were specific to the Director, Southern South Island, Allan Munn.

DOC Report Recommendations for the Te Anau District Office & Fiordland VC **Visitor Information:**

1. Undertake a complete review of the Fiordland VC information displays specifically looking at:
 - a) Ease that customer will receive key messages.
 - b) Clear highlighting of relevant safety messages.
 - c) Relevance of the message to all customers.
 - d) Use of consistent language and terms.

Helen Dodson, Supervisor, VC **Response**

A complete review of the Fiordland VC displays and publications relating to winter tramping and avalanche awareness will be undertaken in April/May 2016 prior to the start of the winter season particularly focusing on the above issues. This will include working with the Brenda George, Avalanche Ranger to ensure we have accurate, relevant and succinct key messages.

In addition we will continue to work with NO to ensure that our Great Walks marketing (brochures, website and track guides) relating to the Kepler, Milford and Routeburn uses images that accurately reflect weather conditions walkers may encounter on the tracks and the clothing and equipment visitors should use and help to build a more accurate perception of what the tracks might be like in winter.

Recommendation Accepted

- 2. Review the practice of staff recommending trips to Luxmore Hut during the winter, or develop some guidelines around promoting if this is retained**

Grant Tremain, Principal Ranger

Response

The Luxmore Hut overnight experience has been recommended for a number of years through our visitor centre. Due to the track's location, with no avalanche risk, it is considered a safe option. The opportunity to provide an safe winter tramping option, means we reduce the potential for people to head up and further enter unsafe areas.

This has proved popular over the last few years, and we have further enhanced the experience by adding volunteer Hut Wardens over the winter period. This means they have been on site and able to pass on up to date safety information and monitor visitors. This has proved successful, and we get many positive reports from both the volunteers and visitors on this service. There is no evidence to suggest that this is in any way introducing visitors to increased risk, or encouraging any winter use in unsafe conditions as opposed to not having this service.

The recommendation is accepted. A review has been undertaken and guidelines, already in place, have been reviewed

- 3. Undertake an immediate review of Fiordland NP documents/brochures to ensure that the Departments ATES classifications are accurately relayed.**

Brenda George, Avalanche Ranger

Response

The ATES classifications are accurate for FNP. The Kepler alpine area (between Luxmore Hut and the bushline adjacent to Hanging Valley Shelter) is stated as complex terrain in the FNP ATES website information. The winter tramping brochure states that *"The Kepler Track has a lot of challenging and complex avalanche terrain. Avalanches are frequent. There are 9 avalanche paths, some of which may bring avalanche debris to the valley floor and have the potential to cross the track."* The Backcountry Avalanche Advisory (BAA) for Fiordland has not been available. This is an important part of the Avalanche Exposure Scale (ATES) system and accessed through the MCS website.

Expert advice (Brenda George – Ranger- Avalanche) indicates that a review has been undertaken and the classifications are correct

The recommendation is accepted and has been actioned already.

- 4. For consistency, immediately adopt the nationally recognizable MSC Backcountry Avalanche Advisory (BAA) signage system to display BAA daily advisory in the VC.**

Helen Dodson, Supervisor, VC

Response

With an Avalanche Ranger in place year round, we will be able to display the BAA daily advisory over winter (as already happens at the start of the Great Walk season). This has not been possible previously as a daily advisory was not available in winter.

We accept the recommendation

Staff Training:

5. Review the Fiordland specific avalanche training programme for Visitor Centre and recreation staff to ensure that staff clearly understand.

- a) the purpose of ATES and how it is used i.e. the relationship between terrain and avalanches ,
- b) the role of the BAA to the public when gathering avalanche information i.e. provides a snow stability forecast,
- c) the role and importance of party 'self rescue' equipment e.g. probe, avalanche beacon and shovel,
- d) the limitations of a PLB and the intentions system in an avalanche context

Brenda George, Avalanche Ranger

Response

We accept the recommendation that some formal training should be developed for the VC staff regarding ATES, the role of the BAA and the two together. This will happen prior to winter. It would be beneficial to have a practical element to the training, including self rescue and equipment.

Kepler Track Management:

6. Undertake a review of the 'split' seasonal management practice for the Kepler Track i.e. given the relative low skill of many off-season users consider whether the Kepler Track should remain as a *Backcountry Comfort Seeker* track year round and managed appropriately.

Grant Tremain, Principal Ranger

Response

The Kepler Track is managed for two different user groups over a twelve month period. The Fiordland National Park Management Plan outlines the walking (as part of the Great Walks network) season as being from the Tuesday after last weekend in October to the 30th of April, where it is managed for the Backcountry Comfort Seeker user group (BCC). For the winter period, this is then managed to the Back Country Adventurer group (BCA).

On the ground this BCA category means trampers are advised to be more self- reliant, facilities at huts are reduced, and a lower level of active visitor safety is in place. Avalanche and snow safety wise this means that during the walking (BCC) season we may actively close a section of track for a short period of time, in recognition of assumed lesser abilities and awareness of trampers. This level of management is not undertaken over the winter (BCA) period.

Although we would be able to monitor and recommend these closures as we do over summer, the actual implementation of this over the winter period would be difficult. During the BCC /Great Walks summer season we have staff at each hut at each end of the alpine section. They are able to put on signs, and then reinforce the closure on site with trampers, explaining the reasons etc.

Over winter, when Iris Burn is unstaffed, and Luxmore has volunteers, the actual implementation of closures would be difficult. Observations around summer closures are people are often unwilling to head simple sign closures, and without direct interaction with

staff with not observe closures. This would be more so without staff there to reinforce the message.

As use is so low also, it would be a very high cost to monitor the conditions daily, with observations etc to best guide the closures.

To consider a higher degree of winter management on the Kepler Track during to “off-season” (BCA) would also have implications for other Great Walks tracks with alpine sections such as the Routeburn.

Therefore the Te Anau District Office does not believe that this is a viable option and thus does not support its adoption.

Kepler Avalanche Management:

7. **When orientation signs are replaced ensure that avalanche paths are added to maps as recommended by *SOP: Managing Avalanche Risk on DOC Tracks and Roads*.**

Grant Tremain, Principal Ranger

Response

This makes sense, and **we accept this recommendation**. It will be implemented by May 2016. This will bring this in line with best practice for the Management of Back Country Comfort Seeker (BCC) sites, whereas in the past it has been managed to Back Country Adventurer (BCA) standard.

8. **Review current practices for avalanche management on the Kepler Track against the best practice in the Visitor Risk SOP. Record rationale in AMIS if practice is to be different from best practice.**

Grant Tremain, Principal Ranger

Response

We accept this recommendation, and will complete over the winter period

9. **Recommendations from this report be added to the list of prioritized avalanche-related work identified *Fiordland Avalanche Hazard Management Programme (2013)***

Grant Tremain, Principal Ranger

Response

We accept this recommendation as the best place to record and track these recommendations.

Prepared by Grant Tremain (Principal Ranger – Recreation/Historic) with input from Helen Dodson (Te Anau Visitor Centre Supervisor) and Brenda George (Ranger – Avalanche Management)

Operations Manager (Greg Lind) recommendation:



Seeking your Approval for the Responses to the Coroner's Request for the adoption of the Visitor Incident Investigation Report Recommendations

1. Accept
2. Accept
3. Accept
4. Accept
5. Accept
6. Not accept
7. Accept
8. Accept
9. Accept

Decision by Southern South Island Director (Allan Munn)

Signed

Date