

**IN THE CORONER'S COURT
HELD AT ROTORUA**

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquest into the death of
LOUISE EMMA JULL

Before: Coroner Wallace Bain

Date of Hearing: 21 October 2015

Appearances: Constable L Jackson for Police
A Jull – Father
A Hopkins – Environment Bay of Plenty
M Bennett
Detective Sergeant J C Wilson – Police
Constable M Burr
P Buell – Harbour Master Environment Bay of
Plenty
J Snook
B Lauder
T Lynch
L Jull - Mother

In Attendance: Witnesses
Family
Wide body of Kayakers

FINDINGS OF CORONER WALLACE BAIN

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INTRODUCTION

- (1) This Inquest raises important issues about:
- i) extreme sports
 - ii) kayaking safety and
 - iii) access to recreational areas regarded as jewels in the crown.

PURPOSE OF AN INQUIRY

- (2) The purpose of an inquiry is set out under Part 3 of the Coroners Act 2006 (Act). Section 57 of the Act defines the purpose of inquiries as follows;
- (a) A coroner opens and conducts an inquiry (including any related Inquest) for the 3 purposes, and not to determine civil, criminal, or disciplinary liability.
 - (b) The first purpose is to establish, so far as is possible-
 - That a person has died; and
 - The person's identity;
 - When and where the person died; and
 - The causes of the death; and
 - The circumstances of the death.
 - (c) The second purpose is to make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.
 - (d) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

EVIDENCE

- (3) The Court heard evidence from a number of witnesses concerning this tragic accident. The witnesses included, Detective Sergeant John Wilson, New Zealand Police; Constable Michael Burr of New Zealand Police Search & Rescue; Tom Lynch, who runs a boutique Eco-Tourism business; John Snook of White Water; Mathew Bennett - White Water NZ (past President); Bradley Lauder - White Water; Peter Buell - Environment Bay of Plenty, the Jull family and Ian Howden - Harbour Maritime expert.

Brief Facts

- (4) On the evening of the 11th march 2015, Detective Sergeant Wilson was the on-call Search & Rescue Coordinator for Rotorua. About 7:10pm he received a call to advise there was a kayaker missing presumed drowned in the lower Kaituna River. He immediately tried to assemble a Police Search & Rescue squad and the Police National Diving Squad.
- (5) He sent Police Search & Rescue members to the scene near Okere Falls and took some statements.
- (6) The area where the event had occurred was identified as being part of the river known to the rafting and kayaking fraternity locally as Gnarly Gorge. It is described as an area of white-water which is kayaked only by the very best and most talented and is known as "Grade 5" being the most difficult water to paddle. It became too dark to proceed with any further search for Louise Jull. He noted that emotions were running high amongst friends and rafting and kayaking colleagues and there was a concern that some may try to continue in the dark to look for her. He arranged for them all to meet at the Rotorua Police Station and explained the role of the Search & Rescue and what the proposed plan was the next day.
- (7) That plan was to have two rafts deployed down the river at first light after the river had been lowered which was arranged with Environment Bay of Plenty who controls the river level. In addition there were to be two teams of land based searchers to search both banks of the river in the vicinity where Louise had disappeared.
- (8) Further to this, the Police National Dive Squad were due to arrive in Rotorua by air and begin an underwater search if she had not been found.
- (9) Each of the rafts which were to be involved in the search had on them Police Officers specially trained and qualified rafting guides. The operation commenced as planned and by 10:00am Louise Jull had been located in the area where she was last seen.
- (10) She was located with her spray skirt caught on a branch which was protruding from a submerged log. Her body was recovered by the rafting teams who carried her out of the area.
- (11) The Detective Sergeant commented that he was involved in 2007 with another fatal kayaking incident which occurred in the same area, but upstream. That was the death of Matthew Stidham. The Detective Sergeant commented that the facts relating to the death of Louise Jull

had a striking resemblance to the Stidham death where he had drowned when his kayak became trapped between two submerged trees. He stated that this had happened and was two in the same area, and the common denominator was the submerged logs. He was of the view that the only remedy to mitigate the risk of this re-occurring would be the periodic removal of logs and other obstructions in the river.

- (12) He noted however that this course of action was very dangerous in itself and he was led to believe that it was impractical for a number of reasons.
- (13) During his investigations he also met with the manager of the land which bounds the Kaituna River. Frustrations were expressed at some kayakers who were accessing the property without permission to facilitate the use of the lower Kaituna River. That had been happening for some time in spite of trespass signage along the banks of the river. He said that other land owners in the area had advised there is no formal agreement between either of them and the kayakers which allows kayakers to exit the river onto their land.
- (14) This trespassing was now exacerbated by the death of Louise Jull and the land owners were concerned as to the potential liability for a fatality brought about by persons crossing their land.
- (15) There were also concerns with people accessing what was a working farm with implications under the Health & Safety legislation and the hazards which exist.
- (16) Cultural issues were also raised because the land was owned by a Maori Trust and likely deaths from extreme kayaking were in effect bringing death into their environment.
- (17) They also expressed concern that they were getting criticism directed at them regarding the logging that was taking place on the river's edge. He noted that there is native tree cover from the distance of the water's edge which is to be 18 to 20 meters.
- (18) He also noted the inherent danger in an operation such as this to the rescuers which are generally the same dangers which brought about the need to rescue the person in the first place. He said anyone having to go into the Gnarly Gorge to effect recovery of a body is exposed to the same dangers as those which took the life of Louise Jull although that would be reduced by the closing off of the water flows to assist the operation.
- (19) He confirmed that most of the section of the river of the gorge is vertical with vertical sides of the river which were anything up to 70 to 80 meters high.

- (20) He confirmed that the rescue operation involved a large contingent of Police including the National Dive Squad which was flying in the next morning from Wellington. He thought they were about ten in number.
- (21) When questioned about removing the logs, he thought the only feasible way, and it would be extremely difficult to get access to the gorge, would be to drop the level of the river. He said that even then at a low flow it was still dangerous and the problem is finding people with the correct skill set to:
- a) be able to traverse the gorge to remove the logs and then,
 - b) have the required qualifications to use chainsaws and the like safely in that environment.
- (22) The other problem was having removed the logs or cut them up is how they were removed or were they flushed and sent down the river. In any event it would be a temporary fix because at any point trees can fall across the river.
- (23) In respect of the signage he confirmed there was only one road which provides access to the river areas which is off the Trout Pools carpark. He questioned whether the issue here would be signage or whether the river was accessed further up starting by the Okere Falls. If kayakers don't want to continue with the extreme areas they need to be able to walk back out and this is where problems occur with crossing private farms. The owners of the land were also concerned by the sudden influx of people through their property to try and access the area where the body was missing. This was a working farm, it had forestry and it had stock. Their concern also was at the criticism being directed at them regarding logging on their own land and whether it was too close to the river's edge.
- (24) Mr Hopkinson who was appearing for the Regional Council confirmed to the Court that there was a buffer area. The trees were planted 25 years in advanced for harvesting and whilst it may have been the permitted activity to have them closer to the river then and the planting was effectively unregulated, it was a matter that could be looked at presently.
- (25) The Detective Sergeant confirmed it was not possible to bring helicopters in to rescue because the tree coverage prevented the effective ability to winch people out of the area.
- (26) He noted that when there are incidents the kayaking community are good at dealing with their own incidents and there is considerable camaraderie within the fraternity.

- (27) Thomas Lynch gave evidence to the Court. He ran a boutique eco-tourism business which had a rafting element and he utilised local Rotorua resources of waterways and forest. He held a senior rafting grade 5 award and is qualified in rescue to an international standard. He has rafted the Kaituna River initially in 1992 and has done nearly a thousand trips down the river. His rafting company has had four independent safety audits in the last three years and he has a degree in resource management including natural hazard mitigation/management. He is also a secondary school teacher. He did not presently raft or kayak the Kaituna River.
- (28) His submission to the Court was to remember friends who have died in preventable situations in the outdoors. He said professionally by choice he did not paddle Gnarly or Awesome Gorge. His two reasons were that both those sections of the Kaituna River were deadly and he commented:
- 1) There was a high chance of trees falling into the narrow gorge and creating entrapment risk.
 - 2) It was impossible to stop and scout rapids and set up effective safety cover or indeed pull out once the gorge had been entered.
- (29) In his view those factors combined elevate the risk to a degree where further deaths are not possible but probable.
- (30) He commented that Louise Jull was a gifted paddler and would have known the risk she was undertaking. He felt however that the extreme sport fraternity culture glamorises risk taking, changing this to being easier said than done.
- (31) He proposed the discussion of the following:
- i) To order of the swift river rescue training of the participants in this section of the river (including what rescue equipment they take with them) and what scenario planning they do (if any).
 - ii) There may be potential to fix ropes to allow better access/escape to/from dangerous points.
 - iii) It was very difficult to effectively scout the river and identify trees and minimise the most significant risk.
 - iv) He felt there should be signage warning of entrapment risk (as a deterrent).
 - v) There should be signage of recent changes possibly located at local entry.
 - vi) Should be more active tree removal by appropriately qualified people.

- (32) From a prevention point of view he felt scouting should be a mandatory sort of best practice. He questioned the effectiveness of signage and he felt if done properly and highlighting the risks it would be of benefit. Not everyone would obey it but at least it's bringing the risk to their attention. He was giving his evidence noting that some of the best kayakers in the world were present in the Courtroom.
- (33) He expanded on his view under questioning of what were preventable situations. He confirmed in his view that as day follows night there will be another death. He referred to extreme sports and the risk taking that occurs. He felt it was a big "big societal question" but that he had buried seven of his friends involved in outdoor activities. He said he didn't believe that we had to die doing things in the outdoors to enjoy ourselves. His analogy was that we don't let people drive on our roads at excessive speed simply because they are good drivers and the Court inferred from his evidence that he felt there should be some controls. He noted that the area where the kayaking occurred was regarded as "a jewel in the crown for kayaking and a treasure" and that kayakers don't want it closed. He felt there should be a forum to try and get resolution to these issues including access. It should be to encourage the safe use of the outdoors.
- (34) John Snook gave evidence to the Court. He resided locally at Okere Falls. He had been a kayaker since 1981 and represented New Zealand at white water slalom at four world championships. He's held a New Zealand National Champion titles for rafting, slalom and extreme racing. He's been a world champion of rafting and he has been through all the gorges of the Kaituna River on many occasions over the past ten years. He knew the corner and the log that Louise got stuck on. He said that the main risk on this narrow, inaccessible gorge is timber (trees) that have fallen or have been felled. He said the last two kayaking fatalities have been because of wood. In his view there were two possible solutions that would help prevent something similar occurring again.
- 1) EBOP to reduce the Kaituna water flow (down to a minimal) each spring for two days and allow crews and volunteers to go into the Awesome Gorge (site of the 2007 fatality), the Gnarly Gorge (site of the current fatality) and Smokey Gorge to remove logs.
 - 2) Enforce logging standards – he said over the past couple of years the river left and right banks had been logged. He felt the logging crews could have done better and a lot of felled pine was now a hazard in the river. He felt it was partly responsible for Louise's drowning.

- (35) In summary he felt kayaking an area such as this was up to the individual. It was responsibility on the individuals to know the river and to be technically competent and fit. There should be an awareness of known hazards and more emphasis on safety.
- (36) In questioning he didn't think there had been any question of trespassing in this particular incident because there are arrangements with land owners further down to exit.
- (37) In activities in removing logs in the past the method had been to cut them into smaller pieces so that they drift down the river. His concern was in Environment Bay of Plenty was not enforcing the Resource Consents about keeping logs a certain distance from the river.
- (38) When it was put to him about whether kayaking should be allowed to continue he felt it was important that it should be continued. He felt it was a matter of personal choice and he supported the call for some facilitation to have a discussion about these issues and access in the future. He felt it would be good if White Water New Zealand could oversee the management of such a process and for access negotiations with land owners.
- (39) A range of photographs were produced to the Court by Detective Sergeant Wilson showing the logs in the river and the difficulties with access.
- (40) It was also stated that if more controls were imposed it was likely that some experienced kayakers would start earlier in the morning and there would be some substitute way of sneaking into the gorge. He felt it would be useful to have a forum where all of these issues could be discussed.
- (41) The Inquest Officers advised the Court that the criticisms of the owners of the land and loggers had been forwarded to them with an adequate opportunity to respond and/or attend the Inquest but no response had occurred.
- (42) The Registrar has subsequently confirmed that the transcript of the proceedings which contain some criticism was sent to the land owners and to the loggers and they were invited to make submissions but none had been received.
- (43) Matthew Bennett gave evidence to the Court and at the time of Louise Jull's death he was the president of White Water New Zealand. He stated that their purpose was to "preserve New Zealand's White Water resources and to enhance opportunities to enjoy that". He has wide experience in white water activities.

- (44) It was his view that Louise Jull made a personal choice to kayak this section of the river known as the Gnarly Gorge. He felt she did so with full knowledge of the condition of the river, hazards that existed in the Gorge, and all other relevant information. He also felt that Louise Jull knew of the log and the hazard it presented with getting caught up on it as it appears had occurred with her spray deck. He noted that the logs in the river he felt were as a direct result of commercial logging on adjacent land. Only some of them presented hazards to kayakers and those paddling the river were aware of them. He said there were no formal and community based systems existing to communicate changes along with scouting practices.
- (45) He felt the logs that did present a significant hazard to kayakers could be mitigated through removal. He said the kayaking community can remove the logs of concern and that can be done without any compromise to the safety of those undertaking it and with cooperation.
- (46) He felt there should be a requirement for safety training and it should be of an independent nature. He noted that the independent nature of the kayaking community was a challenge but he felt it essential for kayakers to continue to get training. He felt it was beyond question that lowering the level of the river and removing as many logs as possible would increase the safety and lessen the hazard.
- (47) A data base of fatalities in kayaking showed eight fatalities involving white water kayaking or canoeing in the last ten years and 17 fatal accidents involving white water kayaking since the year 2000. There had been two on the Kaituna River. It was felt that there could well be a forum to discuss all of these issues and that White Water New Zealand definitely had a mandate to represent kayakers.
- (48) He also commented on the risk that kayakers take but that it can lead to other people being put at risk when there is an incident. In his view people had choices in what they do giving examples about how you drive. He felt that when you went kayaking with others it was very important there be a sense of community but the more you associated risks with kayaking and especially in extreme situations needed to be fully understood and considered.
- (49) Bradley Lauder gave evidence to the Court. He lives in the Okere Falls area and is the owner of Kaituna Kayaks running white water kayak trips on the Kaituna River. He commented on kayaking in the area and instances where they have been involved in trying to clear the logs and the various gears that kayakers can use. He felt Louise had made a mistake and had paid the ultimate price. He felt there was a definite possibility of going into places when the river was lowered with a good team to help moving logs. He also confirmed the previous operator had desisted because of concerns about the safety of kayaking in the area.

- (50) Mr Buell who is the Bay of Plenty Regional Harbour Master gave evidence to the Court. He had looked at the safety functions and powers of the Regional Council and set those out in detail. In summary he said that the Regional Council can make navigation bylaws to regulate the control of kayaks in the rivers. He can close access to any area of water for a specified time and could designate an area as a “special designated area”. He said that the Regional Council was currently reviewing the bylaw and a new navigation bylaw was likely to be made in respect of this area.
- (51) He was concerned that within an eight year period there were two fatalities in these two gorges and both were of experienced kayakers who had kayaked the area of the river in which they died on a number of previous occasions.
- (52) He said that given that two experienced kayakers with local knowledge had drowned in the upper section of the river he had doubts that it is safe for anyone to do this in future. He confirmed that because of those safety concerns he was considering prohibiting the use of these areas of the river.
- (53) He commented that consideration had been given to the option of removing trees from the river. He did not however consider that this was feasible and that it held considerable risks. It would involve ground crew, the lifting of logs by helicopter and the land owners’ consent and there were a number of serious concerns about safety risks for volunteers.
- (54) He also addressed the issue of signage at the Okere gates. He noted that the previous Inquest had recommended there be signage at this gate. He noted also that this recommendation had not been followed. He was not sure signs would have made any difference and understood that Louise Jull was very familiar with these relevant sections of the river and its dangers. He also noted that if he prohibited access the signage would communicate that.
- (55) However, he was open to further consideration and noted that before he or the Regional Council made any decisions on further steps to be taken to ensure Maritime safety in the upper section of the Kaituna River he would consider the Coroner’s Findings and recommendations and feedback from kayakers or White Water New Zealand about safety issues that may be highlighted from the Inquest. Issues were raised with him as well in questioning that there had been a breach of logging consents with logging too close to the river.
- (56) Adrian Jull gave evidence and made a submission to the Court on behalf of the family. It was a beautiful submission remembering the wonderful qualities of Louise, how much she loved extreme kayaking, her fitness, good health and positive attitude. He noted she had very good

gear. He agreed however it would be useful to have a discussion between paddlers and owners of adjacent forestry areas and others about safety concerns. He said he would like that as a recommendation. He also supported continued kayaking safety courses. He raised concerns over logging too close to the waterway and would like that to be addressed. He supported the submissions given by John Snook and of Tom Lynch that there should be active tree removal. He also supported the submission from Matthew Bennett for White Water New Zealand that there be continuous education and the Court took from that he would support the forum as being useful.

- (57) Finally Mr Ian Howden gave evidence to the Court as an expert in this area. He is employed by Maritime New Zealand and he is a special investigator. He set out his full qualifications and the Court accepts him as an expert and the matters before it. He had carried out the investigation of the previous accident in the Kaituna River involving the death of Mr Stidham and gave evidence to that Inquest.
- (58) In respect of that final report he had identified the hazard of trees falling into the Kaituna River as a danger of entrapment to kayakers. That report had recommended that signage be erected by Environment Bay of Plenty at the river entry warning kayakers of the dangers likely to be encountered. He was clearly disappointed that his recommendation at that time to place warning signage to river users was not taken up by the then Environment Bay of Plenty Harbour Master.
- (59) In respect of Mr Buell's evidence he did share the safety concerns with people who were navigating the area. He also agreed with other witnesses about the hazards from trees in the river.
- (60) He was adamant that he would still recommend signage and he felt that was a most effective warning system.
- (61) In respect of the right of extreme sportsmen and kayakers etc., knowing fully all the risks, to take on activities, he noted it was a perennial problem. The question was at what point, risk or hazards in adventure activities, become unacceptable. It was very difficult for a regulator to make a determination at what point promulgation of regulations in this area are to apply. He noted that you cannot keep people in cotton wool. But a regulator has to take all practicable steps, be it signage, meetings with persons involved etc. to look at enhancing safety. On that basis he did support a future forum.

FORMAL FINDINGS

- (62) I find that Louise Emma Jull died in the Kaituna River, Okere Falls on the 11th March 2015, her cause of death being drowning.

COMMENTS AND RECOMMENDATIONS

- (63) It remains to be considered whether any recommendations or comments should be made in terms of Section 57(3). In so doing the Court refers to the consideration given to this section by Heron J in Matthews v Hunter [1993] 2NZLR 683. Any recommendations or comments, in terms of the Section are to be for the avoidance of circumstances similar to those in which the death occurred. Section 51(7) of the Coroner's Act 1988 provides:

“A Coroner holds an inquest for the purpose of:

- (b) Making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the Coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances.”

- (64) In *R v. South London Coroner ex p Thompson* (1982) 126 SJ 625 Lord Lane CJ said of Coroner's inquests (emphasising the important distinction that exists between *accusatorial* and *inquisitorial* processes):

“Once again it should not be forgotten *that an inquest is a fact finding exercise and not a method of apportioning guilt.* The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the Judge holding the balance of the ring, which ever metaphor one chooses to use.”

- (65) The Brodrick Committee (Report of the Committee on Death Certification and Coroners, dated September 22, 1971, CMND. 4810, chaired by Mr (later Judge) Norman Brodrick QC) exhaustively considered the role of the Coroners inquest in modern society and identified the following grounds of public interest which it believed a Coroner's inquiry should serve:

- “(i) To determine the medical cause of death;
- (ii) *To allay rumours or suspicion;*
- (iii) *To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;*
- (iv) To advance medical knowledge;
- (v) To preserve the legal interests of the deceased person's family, heirs or other interested parties.

¹As stated in *Inquest AJD Paterson*, Finding 31 May 2000 (Coroner Garry Evans) citing Anderson v Blashki [1993] 2VR 89; The Secretary of the Department of Health and Community Services v Gurrick 1995 2 VR 69; see also Phipson on Evidence (15th ed.), paragraph 4-31 at p. 81.

- (66) Furthermore case law amplifies how a Coroner should act and in the case of *Luow v McLean* C.P. 445/87 Hardie boys J, cited with approval excerpts from the following case which sets out the Coroners roles: -

In the case of Ex Parte Minister of Justice re *Malcolm* [1965] NSW 1598 at 1602

“they can, and should, afford a quick and cheap method of drawing public circumstances attaching to a death, even though there is no suggestion of murder of manslaughter, are one example. Thus the relatives of a deceased person may feel that the deceased died owing to the negligence or inefficiency of medical authorities: there have been, for instance, several recent cases connected with the admission of patients to mental or other hospitals. If there has been any dereliction for duty, the facts are brought out into the open for all to judge; equally if the suspicions are unjustified, this also can be exposed and the persons cleared of unjustified suspicion. A properly conducted inquest has advantages in speed and cheapness over alternative judicial proceedings.”

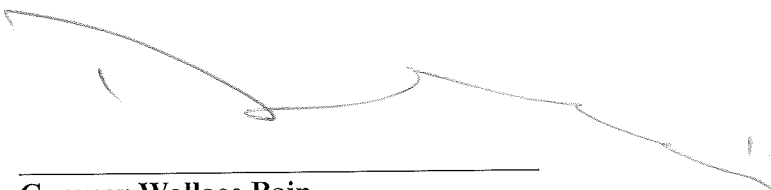
- (67) The Court has heard a good deal of evidence concerning kayaking in this dangerous section of the Kaituna River and extreme sports, the effect of logs in the area, access, cultural issues and what can be done in the future.
- (68) The Court agrees primarily with the general unanimity of all of the witnesses that there should be a forum of all the users of the river and particularly those with extreme kayaking experience, and that all these issues be addressed. Clearly Mr Buell from Environment Bay of Plenty would play an integral part of that and in the Court’s view that would make perfect sense.
- (69) The issue of extreme sports has arisen in this Inquest. It is a difficult area as the Court’s expert witness Ian Howden has referred to. The question is at what point are these prohibited. Mr Buell in his evidence has identified his concerns particularly that in a relatively short period of time two very experienced extreme kayakers have died in these sections of the river.

RECOMMENDATIONS

(70) Accordingly the Court recommends that a forum be held of all interested people and users of the Kaituna River and those involved in extreme sports be held. The facilitation of this can possibly be organised by Environment Bay of Plenty and in liaison with White Water New Zealand. In so far as it involves the Kaituna River it should involve the land owners and the loggers and those involved with granting permits for logging and with compliance.

(71) The Court extends its sympathy to the family of Louise Jull.

Signed by the Coroner at Rotorua on this *9th day Feb* 2016



Coroner Wallace Bain

Regional Coroner - Bay of Plenty