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

IN THE CORONERS COURT
AT HAMILTON
(IN CHAMBERS)

CSU-2020-ROT-000095

I TE KŌTI KAITIROTIRO MATEWHAWHATI KI KIRIKIRIROA
(I TE TARI)

UNDER **THE CORONERS ACT 2006**

AND

IN THE MATTER OF **An inquiry into the death of ETHAN DAVID FITZPATRICK**

Date of Findings: 9 May 2023

FINDINGS OF CORONER M BATES

Introduction

[1] Ethan David Fitzpatrick was 16 years of age when he died. He was a student at Tarawera High School (THS) and lived with whānau in Kawerau.

[2] On 19 March 2020 Ethan was participating with other students in an outdoor education session at Lake Rotoma, Rotorua. He got into difficulty while in the water and was taken to shore. He had become unresponsive and, tragically, could not be revived. He was pronounced deceased at the scene. Investigations revealed that Ethan's cause of death was consistent with drowning.

Decision to open and conduct a coronial inquiry

[3] A Coroner opens and conducts an inquiry for three purposes. The first purpose is to establish certain factual matters – that a person has died, the person's identity, when and where the person died, the causes of the death, and the circumstances of the death.

[4] In determining the circumstances of a death, it is important to realise that the Coroners Act 2006 ("Coroners Act") specifically states that a Coroner does not open an inquiry to determine civil, criminal, or disciplinary liability.[1] However, it is incumbent upon the Coroner, in concluding the inquiry to identify any contributing[2] or causative[3] factors in relation to the death which is being investigated.

[5] The second purpose is to consider whether recommendations or comments should be made. The purpose of recommendations or comments is that they may, if drawn to public attention, reduce the chances of the occurrence of other deaths in similar circumstances.

[6] The third purpose of a coronial inquiry is to determine whether the public interest would be served by the death being investigated by some other investigating authority.

[7] The standard of proof applicable to findings of fact in the Coroners Court is the civil standard, the balance of probabilities. In determining any matters before me in this case, I have applied this standard in a flexible manner, in accordance with the view expressed by the majority of the Supreme Court, in *Z v Dental Complaints Assessment Committee*. In that case, they refined the principle, established in earlier cases, that a trier of fact must be convinced by the evidence that the fact in issue is more likely than not. They clarified that:[4]

> ...the civil standard is flexibly applied because it accommodates serious allegations through the natural tendency to require stronger evidence before being satisfied to the balance of probabilities standard.

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[1] Coroners Act 2006, s57(1).
[2] A factor that contributed to the death occurring but one which, if eliminated, would not necessarily have prevented the death. There may be more than one contributory factor.
[3] A factor which, if eliminated, would have prevented the death from occurring. There may be more than one causative factor.
[4] *Z v Dental Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1 at [102]. See also *Anderson v Blashki* [1993] 2 CR 89 (SC) at 96.

[8] Pursuant to section 77 of the Coroners Act, I have decided to conclude this inquiry by holding a Hearing on the Papers. This is because there are no circumstances relating to this death which make an inquest necessary or desirable, and I am satisfied that no further relevant information to assist in this inquiry would be obtained through an Inquest or through evidence that is not already before me. I have concluded that I have sufficient evidence before me in documentary form to fulfil the purposes of opening and conducting an inquiry as set out in section 57 of the Coroners Act.

Matters already established

[9] Many of the matters required to be established under s 57(2) of the Coroners Act are not at issue, they are as follows:

(a) **That a person has died:** A Deceased Person's Certificate form has been signed by a medically qualified person. This has been accepted as establishing that a person has died.

(b) **The person's identity:** A Statement of Identification of the deceased person has been signed and has been accepted as establishing the identity of the deceased.

(c) **Where death occurred:** The Police report and statements provided during the investigation, together with the coronial post-mortem reports, have been accepted as establishing where death occurred.

(d) **Cause of death:** A pathologist has completed a post-mortem report on the deceased. This has been accepted as establishing the cause of Ethan's death as drowning.

Circumstances of death: The circumstances of Ethan's death have been established through the Police investigation, and the WorkSafe NZ investigation, and are detailed in the Worksafe Investigation Report dated December 2021 and the Enforceable Undertaking Agreement between Tarawera High School Board of Trustees (THSBOT) and Worksafe NZ dated 8 April 2022.[5]

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[5] Enforceable undertaking expected to be discharged in or about December 2023.

Issues remaining to be determined by this inquiry

[10] The issue that I have considered in this Finding is:

1. Would comments or recommendations reduce the likelihood of further deaths in similar circumstances?

Evidence and additional information

[11] I have received and reviewed:

(a) **Medical evidence:** a report from Ethan's personal doctor; a post-mortem report from Pathologist Mark Wickham; a toxicology report from ESR; and a report from Auckland DHB Cardiac Inherited Disease Group (CIDG).

(b) **Police evidence:** the police investigation file containing witness statements, police jobsheets, and photographs.

(c) **Other evidence:** the WorkSafe investigation report and Enforceable Undertaking Agreement entered into between Worksafe and THSBOT.

Additional Information

[12] Responses from New Zealand Underwater Association (NZUA), THSBOT, Water Safety New Zealand (WSNZ), Worksafe NZ, and the Ministry of Education/Outdoor Education New Zealand (MOE/EONZ) to Provisional Findings made in this matter.

[13] Based on that evidence and information I have determined the matters set out below.

Medical history

[14] I explored whether Ethan may have suffered a medical event while in the water. He had no known ongoing medical conditions. He was not in receipt of any regular medication. He had not complained of feeling unwell.

[15] The report prepared by Auckland DHB CIDG did not reveal any matters that may have contributed to Ethan's death.

[16] A medical event was therefore ruled out as a cause of death.[6] I consider it unlikely that Ethan suffered a medical event prior to and contributing to his drowning.

Background

[17] Ethan was born on 2 October 2003 and was 16 years old when he died on Thursday 19 March 2020. He was a Year 12 student at Tarawera High School in Kawerau. He lived with his mother in Kawerau. His father passed away several years ago.

[18] Ethan was well-liked at school and loved by his whānau. His whānau have a long association with THS and the Kawerau community. One of his cousins is a teacher at THS. Ethan's death has been devastating to everyone who knew him.

[19] On 19 March 2020, Ethan was completing an outdoor education course as part of his NCEA school studies. This included student visits to Lake Rotoma to learn about and participate in open water snorkelling.

[20] Ethan was described as a competent swimmer. In February 2019, over a period of three weeks, he obtained unit standard credits for diving in open water. He was assessed by Dive Zone Tauranga and THS at the time. He achieved NCEA unit standard 91330 – Snorkelling Level II.

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[6] In response to Provisional Findings, THS Principal Ms Tuhoro raised the possibility of an epileptic event, noting Ethan's father had a history of epilepsy. I have not received any evidence to indicate Ethan had any medical history indicative of seizure activity/epilepsy. NZUA commented that, 'potentially Ethan got cramp in his legs, struggled to keep his head out of the water and panicked, leading to his drowning.' This is of course speculative. One suggestion made by NZUA is - to minimise the chance of such an event occurring, all snorkelling participants should be assessed as fit and well, and well-hydrated prior to snorkelling. I take no issue with this suggestion but there is insufficient evidence to find on balance that Ethan had experienced cramping. Even if he had, it does not alter the fact that Ethan drowned while participating in a supervised activity.

[21] Along with other students in his class, Ethan also completed a snorkelling education session at Lake Rotoma on 25 February 2020. This was part of the course Ethan was continuing on 19 March 2020.

Events on 19 March 2020

[22] 19 March 2020 was the second visit to Lake Rotoma for snorkelling instruction and assessment. A group of two teachers (referred to as Teacher A and Teacher B) and fifteen students, including Ethan, arrived there about 10.00am. The weather was fine, and the lake was calm.

[23] The students had received a safety briefing prior to leaving THS that morning. They received another safety briefing at Lake Rotoma prior to entering the water.

[24] Students wore goggles, a snorkel, fins, and full length wetsuits. Life jackets and first aid were available if requested. None of the students chose to wear a life jacket.

[25] A buoy was set in the water by Teacher A,[7] at a depth of about four metres, about twenty metres from the shore. This marked the edge of the swim zone and was able to serve as emergency flotation for anyone in need.

[26] Students were put into pairs as snorkelling buddies. They initially went into the water about waist-deep, then were called and waved out further by Teacher A who was about one metre in from the buoy. The lake was about 3.5 to 4 m deep at this point. In their pairs, the students made their way toward Teacher A while practicing duck diving.[8] They were reminded of the one up, one down safety rule requiring one partner to remain with their head above the water while monitoring the person diving.

[27] Students were asked to move closer to Teacher A and a head count was completed. They were treading water in half-circle formation facing Teacher A as Teacher A gave

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[7] Teacher A was the trip leader. In addition to teacher A's teaching qualifications, teacher A had a bronze certificate in lifesaving (obtained overseas), is qualified by PADI as an open water scuba-diving and had previously attended the year 11 and 12 snorkel dive course with students in 2019. Teacher A's professional development included 2018 courses in outdoor education and water safety.

[8] Duck diving is the process where a diver lies on the surface of the water, takes a final breath, equalises their ear pressure, tips their head down in the water, bends forward at the waist, raises their legs vertically, and swims straight down. NZUA advise that duck diving can be more difficult in a full length wetsuit if no weight belt is worn. However, if a weight belt is worn, too much weight could make a person negatively buoyant and create difficulty keeping the head above water. When assessed in February 2019 to achieve unit standard credits for open water diving, Ethan was considered a competent swimmer who worked well with duck diving. There is no reference to Ethan or the other students wearing weight belts for this course.

further instruction. Pairs then found their own space in the water to complete further exercises, including practicing clearing their masks while floating. Teacher A started assessing the pairs from left to right. Ethan and his snorkelling buddy were at the far right of the semicircle.

[28] Teacher B had remained on shore to provide some additional supervision of the students while preparing food for them.[9]

[29] Once Ethan and his snorkelling buddy were confident in their ability to duck dive and clear their masks, Ethan's buddy turned and swam toward Teacher B to ask whether they could be assessed next.[10] He did not leave the water, and estimates his back was to Ethan for approximately 15 to 25 seconds while he did this. During this time Ethan was not being observed by anyone.

[30] When Ethan's swimming buddy turned back toward Ethan, he saw Ethan had rolled onto his side under the water, appeared to panic, and started to kick wildly. Ethan returned to the surface gasping for breath, still kicking wildly.[11] Exactly how/why Ethan initially got into difficulty was not witnessed.

[31] One of Ethan's wild kicks struck the back of Teacher A's head as Ethan travelled past him. Teacher A estimates they had been in the water 5 to 10 minutes when he was kicked. Ethan's swimming buddy thought they had been in the water up to 20 minutes.

[32] Teacher A was assessing the fourth pair of students at the time the kick was felt, turning from his left to his right as the assessments progressed. Teacher A looked behind him and saw Ethan apparently swimming away. Teacher A grabbed Ethan's ankle and pulled him back. Teacher A then turned Ethan toward him and asked why he had kicked him.

[33] At the same time, Ethan's left arm swung away uncontrollably, and it became obvious that he was distressed. His eyes were fixed wide open and staring. Teacher A

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[9] Teacher B was attending that day to serve as a second van driver, supervisor, and chef. Teacher B had been a PE teacher at THS since January 2016, held current first aid certification, and had extensive knowledge of Lake Rotoma, and experience with free diving and snorkelling. Teacher B completed a Water and Swim Safety course at Otago University and in 2014 to 2015 was involved in a research paper studying gasp reflex and open water drowning.

[10] Teacher B does not recall this conversation taking place.

[11] Neither teacher saw Ethan gasping for breath.

thought Ethan's wetsuit may have been too tight around his neck, so he turned Ethan on his back and loosened it.

[34] The other students were ordered out of the water. Teacher B heard Teacher A shout for the students to exit the water and became aware one of the students required assistance.

[35] Teacher A and Ethan's snorkelling buddy took Ethan to shore. Ethan was unresponsive. Teacher A kept Ethan's head out of the water using the rescue tow swimming technique.

[36] Once on shore, Teacher A lay Ethan down, pulled his wetsuit down to his waist, and commenced CPR.

[37] There was patchy cell phone coverage where the group was located, so Teacher B drove a short distance down the road (4-500 metres) to get reception and call emergency services.[12] St John Ambulance received the notification at 10:48 am. Members of the public already in the vicinity included an off-duty Emergency Medical Technician and a First Responder Fire Officer. They assisted with CPR while awaiting the arrival of emergency crew. No defibrillator was available at this stage.

[38] During initial CPR, it appeared that Ethan would breathe on his own for short periods then stop again. Ambulance crew arrived at 11:02 am and were first on scene with a defibrillator. Kawerau Fire Service, and an Emergency Rescue Helicopter team also attended. Resuscitation efforts continued for about an hour. Sadly, Ethan never regained consciousness and was pronounced deceased at the scene.

[39] The evidence suggests that while Ethan was briefly unobserved, for a period of approximately 15 to 25 seconds, he somehow got into difficulty and inhaled water. After inhaling water, he was unable to draw another effective breath. As a result, his heart eventually stopped beating.

[12] THS Principal Ms Tuhoro, also speaking for the THS staff involved in the matter, advises that Teacher B had been able to make phone contact with THS when standing near the rear of the school van, near the lakeside.

Comments and recommendations

[40] Following Ethan's death, several matters became known which merit comment and recommendations. I make the following comments and recommendations pursuant to s 57(3) of the Coroners Act.

General comments

[41] Through their investigation, WorkSafe NZ determined there had been contravention by THS of sections of the Health and Safety at Work Act 2015. Worksafe alleged Ethan's death was due to THS's failure to undertake effective emergency planning and to ensure effective supervision.

[42] THS cooperated fully with WorkSafe. Their education outside the classroom (EOTC) safety management systems were reviewed and either updated or amended where improvements could be made, and further staff training/up-skilling was completed. In my view, THS took appropriate steps following Ethan's death and there is no need for me to make further recommendations for them to alter current practices.

[43] I am aware that THS shared lessons learned with other schools in the region. Therefore, I do not intend to repeat the findings of the WorkSafe investigation. However, some matters merit further publicity.

Teacher to student ratios (supervision)

[44] There is no set ratio of teachers to students and all EOTC activities are assessed on a case-by-case basis. This includes an assessment of associated risks and the experience and number of supervising/instructing teachers. Level of risk between EOTC events can vary markedly.

[45] The MOE met with Education Outdoors New Zealand (EONZ[13]) to discuss my provisional comments in relation to supervision of snorkelling activities. Their response referred me to the EONZ Good Practice Guide – Snorkelling, Version 1, released in 2020 (the Guidelines). For the reasons specified at page 5 of the Guidelines, no specific ratios

[13] EONZ is a national professional organisation that leads, supports, and influences education outside the classroom and outdoors in New Zealand (EONZ website).

of leaders or supervisors to participants for snorkelling are mentioned. This is due to varying supervision needs according to age and ability of participants, the activity, the location and environmental conditions and the skill and experience of the leaders and supervisors.

[46] The Guidelines include statements that:

- Supervision in a water environment needs to include the ability for direct physical intervention. The question to ask is: *how quickly can a competent leader or supervisor get to someone in the water who needs immediate assistance?*

- When there is more than one supervisor, clearly defined roles and responsibilities should be delegated. This is particularly important when using assistant leaders, accompanying teachers (who are not the activity leader), student leaders or parent helpers.

- Supervision of larger groups of participants is likely to involve supervision from both in and out of the water e.g. a spotter on the shore or an ancillary vessel.

- For groups of six or more it is advisable to have someone overseeing and not involved in direct supervision. This person can step into a direct supervision role if a supervisor is required to give 1:1 assistance.

- In addition to having designated supervisors, a supervision structure should include a buddy system of having participants watch out for one other participant or buddy. The "one up one down" rule should apply to duck diving.

[47] As noted by WorkSafe, there were two teachers to supervise fifteen students giving a ratio of 1:7 (if both were constantly supervising the group as a whole). This increased to 1:15 whenever Teacher B was attending to other tasks on shore (for example preparing food for the group). At times Teacher A was conducting individual assessments of students with his face below the surface of the water. When this occurred the

supervision ratio was, at times, 1:1 for the student being assessed, and may have been 0:14 for the remaining students if Teacher B was not purposefully watching them.

[48] When Teacher B was involved in preparing food for the group he was positioned near a fixed barbecue some 30 m away. Hardly an ideal distance from which to closely supervise, particularly when engaged in other activities at times.

[49] I accept that a buddy system and the "one up one down" rule were being applied. However, there was a period of approximately 15 to 25 seconds when this lapsed in Ethan's case and he went unsupervised.

[50] Had Teacher B remained closer to the students, maintaining constant supervision, or had there been additional supervision on 19 March 2020, in the water or from shore, the chance of Ethan being unobserved for 15 to 25 seconds would have reduced. Despite this, there are simply too many variables to make a determination that an additional supervisor, or someone overseeing and able to step in as a supervisor, would have noticed Ethan from the moment he got into difficulty, while Teacher A was engaged in 1:1 supervision with others. A different outcome for Ethan may not have been achieved.

[51] Obviously, the greater the degree of supervision the better. However, given the clear instruction provided to the students, the equipment worn by them (including buoyant full-length wetsuits), combined with Ethan's level of competency in the water and his familiarity with the exercises, and the skill sets possessed by Teacher A and Teacher B, I am not prepared to conclude that the supervisor to student ratio was clearly insufficient that day.[14] Had there been a third person supervising, either in the water or from shore, which would have represented a perfectly acceptable teacher to student ratio in the circumstances, the same tragic outcome would still have been possible. Again, it remains unclear exactly why and when Ethan initially got into difficulty.

[52] I have no concern regarding the level of qualification and general competency of the teachers accompanying the students on 19 March 2020. They appear to have been suited to the task. An additional set of eyes on the students, particularly when Teacher A

[14] THS was operating under Ministry of Education EOTC Guidelines (Bringing the Curriculum Alive, 2018), which do not specify a teacher to student ratio. I note, by way of contrast, the assessed ratio for a qualified dive instructor is 1 teacher to 10 students.

was engaged in the 1:1 supervision of others, or having Teacher B focused solely on the students, *may* have made a difference. I cannot put it stronger than that.

[53] In addition to the obvious need for vigilant supervision during EOTC water-based activities, several further matters arose that, if brought to wider public attention may prevent further loss of life in similar circumstances.

Communication

[54] The THS emergency communications plan approved by the EOTC Coordinator[15] for 19 March 2020 was to call 111 by cell phone. When Ethan's emergency arose, it became apparent there was patchy or no cell phone coverage, depending on exact location, and Teacher B had to travel by motor vehicle approximately half a kilometre before he could contact emergency services.

[55] Lack of reliable cell phone coverage should have been realised during a pre-activity site visit, as part of safety planning, and noticed upon arrival at the site on 19 March 2020, when communications should have been checked.[16]

[56] I note THS's communication plan has been updated and a satellite phone is now taken on all EOTC trips.

[57] On the evidence before me, I am unable to determine whether or not immediate communication with emergency services would have altered the outcome for Ethan.

[58] However, **I recommend** that prior to commencement of EOTC school activities, there is confirmation with the school EOTC Coordinator of the ability to establish and maintain communication from the activity site. If there is patchy or no cell phone coverage, as in the present case, this may necessitate use of a satellite phone.

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[15] Each school, including THS, has a designated EOTC Coordinator responsible for assessing risks associated with proposed EOTC activities, for satisfying themselves that it is safe for activities to proceed, with appropriate safety management systems in place, and finally for approving (or refusing as the case may be) the EOTC activities to proceed.

[16] Teacher A was aware cell phone coverage could be patchy in the area but may be available in certain spots. He had previously made phone calls and sent texts from the area. Unfortunately, he did not check reception upon arrival on 19 March 2020 and did not communicate to others potential issues with coverage.

Defibrillator

[59] There was no immediate access to a defibrillator to assist with resuscitation efforts. A defibrillator became available with the arrival of St John Ambulance crew at 11:02 am, 14 minutes after they received notice of the incident. Notice was given only after a teacher travelled approximately half a kilometre in a vehicle to get phone coverage. Obviously, there was delay from the time Ethan was removed from the water until a defibrillator was available. Although it is a possibility, it remains unclear whether more immediate access to a defibrillator might have changed the outcome for Ethan.

[60] THS recognised the need for timely access to such a vital piece of emergency first aid equipment. As a result, THS purchased a defibrillator and transportation pack, which are now taken to EOTC activities and school camps.

[61] MOE and EONZ responded to my provisional comments that 'Access to a defibrillator has been highlighted in the revised toolkit and the safety management plan template for schools. The advice is for schools to be aware of the closest available AED where practical. There is also an app that identifies the location of the closest AED that staff are advised of in First Aid courses.'

[62] **I recommend** that EOTC and school camp activities include as part of safety planning confirmation of quick access to a defibrillator for the duration of the activity. It may be that some locations have a defibrillator installed. Other locations, such as in the present case, may require the school to provide one.

Bottled oxygen

[63] As noted in the WorkSafe report[17], Ethan drowned by inhaling water and being unable to draw another effective breath from that point onward.

[64] The presence of bottled oxygen for EOTC water activity in remote locations is not required in EONZ guidance. However, I note the presence of bottled oxygen and a trained provider is dive industry best practice in New Zealand. In my view, this should be considered when planning for EOTC events. I endorse WorkSafe NZ's comments in this

[17] WorkSafe NZ report dated December 2021, page 17 from paragraph 3.

respect. The New Zealand Underwater Association (NZUA) express a view that "it is essential that any activities involving snorkelling or scuba diving have an appropriate amount of emergency oxygen immediately available."[18]

[65] MOE and EONZ responded to my provisional comments that when developing the Snorkelling – Good Practice Guide, the experts discussed bottled oxygen. It was decided that whilst it would be essential for commercial activity, it is not a 'must have' for this level of activity. If it were brought in as a 'must have' it would mean these activities could only be done through commercial providers and schools would not be able to run activities such as snorkelling themselves.

Specific guidance for open water snorkelling in New Zealand

[66] Perhaps the uncertainty described in this Finding in relation to whether the teacher to student ratio was adequate (ratio not specified in Ministry of Education Guidelines), and in relation to whether safety management planning for the activities on 19 March 2020 met acceptable standards, would be avoided if there was specific guidance adopted by the Ministry of Education and incorporated in its guidelines.

[67] WorkSafe identified that New Zealand does not have any specific guidance for open water snorkelling. WorkSafe also identified that Workplace Health and Safety Queensland has a code of practice for recreational snorkelling which states:

> 'If a duty holder is providing recreational snorkelling for one or more persons they must have at least one person as a lookout, or the snorkelling is done with a guide and 10 snorkellers or less, and the guide has conducted a proper assessment of risks involved in not having a lookout, and it is reasonable having regard to those risks not to have a lookout.'[19]

[68] The Queensland code of practice is a practical guide to achieving regulated standards of health, safety, and welfare in relation to Recreational Diving, Recreational Technical Diving and Snorkelling. It applies to anyone who has a duty of care in circumstances described in the code. Duties require duty holders to consider all risks

[18] 23 March 2023 response to Provisional Findings, Mr Andy Stewart, NZUA Board Member.
[19] Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2018, Office of Industrial Relations, Workplace Health and Safety Queensland, at 4.4 page 28.

associated with the recreational activity. In Queensland, the code is admissible in corporate settings and courts may regard it as evidence of what is known about a hazard, risk or control and may rely on the code in determining what is reasonably practicable in the circumstances to which the code relates. Inspectors may refer to the code when issuing an improvement or prohibition notice.

[69] WorkSafe also referenced Workplace Health and Safety Queensland's practice guide: Snorkel safety, a guide for workers.[20] The lookout role is described within this document as a critical role, most effective when the lookout is at an elevated and distraction free location. Before being allocated the role, the lookout should be assessed for their ability to scan effectively.[21]

[70] Essentially, the Queensland example provides practical guidance and sets out minimum standards for the health, safety, and welfare of persons engaged in open water snorkelling activities (amongst other water-based activities). It centralises and simplifies the obligations of duty holders. In the present example that would capture the school BOT, EOTC Coordinator, and instructors/teachers/supervisors.

[71] The MOE, as the body responsible for setting requirements and processes for school EOTC snorkelling activities, were provided with my Provisional Findings and afforded an opportunity to comment. MOE and EONZ discussed the Provisional Findings and, in addition to their responses specific to snorkelling supervision ratios, access to a defibrillator and bottled oxygen (detailed earlier in these Findings), have commented that the Good Practice Guide – Snorkelling presently outlines the scope for snorkelling and is accessible to schools for EOTC activities at EONZ: EOTC Management – Good Practice Guidelines.

[72] In response to my Provisional Findings, WSNZ describe the Queensland code of practice for open water snorkelling as a 'thorough, practical document that has potential benefits for New Zealand.' WSNZ advise that, although a project to create a similar code for New Zealand has value, WSNZ would need to consider its current priorities and resources before taking on any new projects. WSNZ is a small team of ten people, with limited time and capability. It prioritises work carefully to effect the biggest change

[20] Snorkel safety. A guide for workers. Office of Industrial Relations, Workplace Health and Safety Queensland.
[21] Snorkel safety, a guide for workers, at page 14.

possible. Interventions, small or large, require ongoing support from WSNZ. My recommendation for development of a New Zealand open water snorkelling code is acknowledged by WSNZ, who advise they are able to enter into conversation with the NZUA to provide assistance when resources are available. WSNZ acknowledge that every fatality is devastating. However, given the relatively small proportion of snorkelling deaths in New Zealand[22] and WSNZ's limited resources, their focus is currently on the bigger risks affecting many people each year, seeking behavioural change in those key areas, and developing water skills for tamariki.

[73] WorkSafe NZ considered my Provisional Findings and responded that my recommendation for the development of an open water snorkelling code for New Zealand, akin to the Queensland code, has been considered by the relevant areas in WorkSafe NZ responsible for supporting the development of guidance, regulations, or other regulatory tools. No advice was received regarding whether WorkSafe NZ intend to progress the matter further.

[74] Until such time as a New Zealand code for open water snorkelling is developed, I encourage those responsible for facilitating open water snorkelling activities in New Zealand (including those facilitating EOTC snorkelling) to consider the Queensland code of practice and practice guide and turn their minds to the matters explained therein. They are excellent resources. More specifically in the school setting, they may assist schools with effective safety management planning and compliance with the provisions of the Health and Safety at Work Act 2015. Hyperlinks to these resources are footnoted below.[23]

[75] **I recommend** the development of a code of practice and practice guide in relation to snorkelling in New Zealand, similar to those developed and utilised in Queensland, Australia.[24]

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[22] 23 March 2023 correspondence from Ms Felicity Fozard, Senior Advisor – Information and Research. Ms Fozard advises that, on average, there are 82 preventable drowning deaths in NZ per year; of those, 2.5% are snorkelling deaths. Deaths from swimming are 23% of the drowning fatalities, with boating deaths a further 22%.

[23] Recreational Diving Recreational Technical Diving and Snorkelling Code of Practice 2018 (worksafe.qld.gov.au)
Snorkel safety: a guide for workers (worksafe.qld.gov.au)

[24] In response to my Provisional Findings, Mr Andy Stewart, NZUA Board Member, confirmed that NZUA welcomes the recommendation that a code of practice for snorkelling in New Zealand is developed and that, in the interim, the Queensland code is supported as providing guidance.

Findings

[76] I find that Ethan David Fitzpatrick died at Lake Rotoma, Matahi Road, Rotorua, on 19 March 2020, from drowning.

Restrictions on publication

[77] Pursuant to section 74 of the Coroners Act, I am satisfied it is in the interests of decency and personal privacy to prohibit the publication of photographs of Ethan David Fitzpatrick taken during the investigation into his death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

Condolences

[78] I take this opportunity to extend my condolences to Ethan's whānau and friends for their loss.

CORONER MATTHEW BATES