CORONERS COURT
Te Kōti Kaitirotiro Matewhawhati

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CSU Number: CSU-2020-HAM-000077

08 August 2024

Fiona McDonald
Education Outdoors New Zealand Inc
298 Kennedy Bush Road
Christchurch 8025

By email: Fiona.mcdonald@educationoutdoors.co.nz

Dear Ms McDonald

Please find enclosed a copy of Coroner M Bates's finding into Jaden CHHAYRANN's death.

Yours sincerely

Jennifer Chalklen
Case manager
Coroners Court
Email: Jennifer.Chalklen@justice.govt.nz

CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Jaden CHHAYRANN**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Jaden CHHAYRANN
Late of:	81 Mount View Road Melville Hamilton
Occupation:	Student
Sex:	Male
Date of Birth:	17 January 2003
Place of Death:	North of Whiritoa Beach Thames New Zealand
Date of Death:	On or about 21 February 2020
Cause(s) of Death	
(a). Direct cause:	Drowning
(b). Antecedent cause (if known):	
(c). Underlying condition (if known):	
(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known):	

Circumstances of death: On 21 February 2020, Jaden was participating in a school geography field trip at Waihī Beach. Jaden went swimming but got into difficulties and was pulled away from shore by a rip current. Students and teachers tried to help him, but he was pulled underwater and disappeared. On 1 March 2020, after extensive search efforts, Jaden was found deceased on a private beach near Waihī Whangamata Road, north of Whiritoa Beach.

I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that, in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred. Refer to paragraphs 36 – 41 of the final finding.

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 Jaden Chhayrann taken during the investigation into his death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

Those findings, and my reasons for making them, are also set out in my written findings dated: 8 August 2024.

Signed at Hamilton on 8th day of August 2024.

Coroner M Bates

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-HAM-000077

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 JADEN CHHAYRANN**

Date of Findings: 8 August 2024

FINDINGS OF CORONER M BATES

Introduction

[1] Jaden Chhayrann was 17 years of age when he died. He was a student at Melville High School and lived with extended family in Melville, Hamilton.

[2] On 21 February 2020, Jaden was participating in a school geography field trip at Waihī Beach. Jaden went swimming but got into difficulties and was pulled away from shore by a rip current. Students and teachers tried to help him, but he was pulled underwater and disappeared. On 1 March 2020, after extensive search efforts, Jaden was

found deceased on a private beach near Waihī Whangamata Road, north of Whiritoa Beach.

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]

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[1] Coroners Act 2006, s 57(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.

> ...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.

[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] Some 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:** Jaden was identified by way of forensic odonatological examination and dental record comparison analysis. This has been accepted by me as establishing his identity.

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

(d) **Cause of death:** A pathologist completed a post-mortem report which has been accepted as establishing the cause of Jaden's death was drowning.

Circumstances of death: The circumstances of Jaden's death have been established through Police and WorkSafe NZ investigations. They are detailed in a WorkSafe Investigation Report dated 18 January 2021 and an Enforceable Undertaking Agreement

between WorkSafe and the Melville High School Board of Trustees (MHSBOT) dated 7 December 2021.

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

[11] I have received and reviewed:

(a) **Medical evidence:** A report from Jaden's personal doctor; a post-mortem report, and a forensic odontology report.

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

(c) **Other evidence:** The WorkSafe Investigation Report and the Enforceable Undertaking Agreement entered into between WorkSafe and MHSBOT.

[12] Based on that evidence I have determined the matters set out below.

Background

[13] Jaden was of Cambodian descent. His immediate family lived in Gisborne, but he lived with extended family in Hamilton while he attended Melville High School. He was a Year 13 student. Jaden was active and not known to have had any health concerns.

Events leading up to Jaden's death

[14] On 21 February 2020, Jaden was attending a two-day geography school trip with 27 other students and three teachers (referred to as Teacher A, Teacher B, and Teacher C).

The students finished their schoolwork activities and it was decided they could go swimming at Waihī Beach before returning to Hamilton.

[15] About 11:30am, the group arrived at Waihī Beach. Teachers selected a place at the northern end of the beach about 100 metres from the ridgeline. The surf lifesaving club was located at the ridgeline. Although the beach was not patrolled by lifeguards at the time, three off-duty lifeguards were present in the surf lifesaving clubhouse.

[16] A local surfing instructor at the beach that day described conditions as wild, 'with strong swells and big surges that could knock you off your feet.' A lifeguard described huge three-metre swells and rough sea conditions. He thought the area the school group selected for swimming was unsafe due to these conditions and due to a permanent rip running along the area. A conflicting assessment of the conditions was reported by Teacher A who assessed conditions as mild for swimming with no signs of a rip or current of concern.

[17] Approximately 100 metres from the area selected by the group there is a Department of Conservation sign warning, "the coastline can be dangerous during onshore sea conditions." The sign was not obvious to casual observers and could be taken as referring to an area of coastline other than where the group were positioned. Except for this sign, no information was visible to the general public regarding dangers known to locals, in particular the almost permanent rip current at the north end of the beach which is formed due to large waves/swells coming ashore. A local surf instructor reported that, when waves are breaking, it looks like the calmest spot on the beach, even though it is the deadliest.

[18] Once the group were at their selected swimming spot, Teacher A placed two poles as markers for students to swim between. They were placed 20 metres apart. He also placed four cones in the middle of the poles to act as a guide for the students to stay in front of. The teachers told the students to swim only if they felt confident and to stay at waist depth. All three teachers stayed on the beach to supervise the students swimming.

[19] About 12:00pm, a group of 17 students went swimming, including Jaden and one of his friends. Jaden, his friend, and about six others went further out than the main group. The friend reported they were in waist-deep water when they got knocked down by a

wave. Both he and Jaden were pulled away from shore and caught in a rip current. They were separated from the main group quickly. Jaden called to his friend for help. The friend saw Jaden panicking and tried to calm him, telling him to ride the waves out. The water became deeper, and Jaden and his friend had to bounce off the seabed to keep their heads above the surface. They were struck by more waves and became separated by two to three metres. Jaden called to his friend, "Help me [name omitted] I can't swim very well." They both went under another wave and when the friend resurfaced, he could no longer see Jaden.

[20] Teachers were alerted to the situation by other students calling for help. Teacher A identified three students in trouble including Jaden and his friend. He saw Jaden was further out and his friend was trying to get to him. Teacher A entered the water to help and directed other students to get out. Teacher A reached Jaden's friend, who was by then moving to shore through the whitewash. The friend told Teacher A that Jaden was further out, but he could no longer see him. Teacher A told the friend to go ashore then started searching for Jaden. Sadly, Teacher A could not locate him. Jaden's friend managed to return to shore unassisted.

[21] Around the same time, Teacher B who was onshore observed Jaden's head in the water several times well outside the designated swimming area. She alerted Teacher A to this. She said Jaden's arms were not waving, indicating he was unconscious. Jaden eventually disappeared under water. Teacher B told Teacher C, also on shore, to phone emergency services and request urgent assistance. Teacher B also told a student to run to the surf lifesaving club and ask for help.

[22] A lifeguard immediately ran to the scene with a surfboard. He briefly spoke to Teacher B and entered the water heading in the direction where Jaden was last seen. Teacher A exited the water to discuss emergency protocols with Teacher B. The lifeguard stayed in the water searching for Jaden for around 30 minutes until additional lifeguards and emergency personnel arrived to assist.

[23] A full-scale search for Jaden quickly followed. Waihī Coastguard were mobilised and the Waihī Surf Club deployed jet skis and inflatable rescue boats. The Westpac Rescue helicopter also joined the search. Jaden was not seen again that day and the search was suspended for the night at 6:00pm. It resumed at 6:00am the following day.

[24] On 1 March 2020, after extensive search efforts, a body later identified as Jaden was discovered on a private beach near Waihī Whangamata Road, north of Whiritoa Beach.

WorkSafe investigation

[25] Jaden's death was the subject of a WorkSafe investigation and a final investigation report ("the Report") was produced. The Report details the actions of MHSBOT leading up to and on the day of Jaden's death. I will not reproduce the whole Report, but I find the following points noteworthy:

(a) WorkSafe reviewed MHSBOT's education outside of the classroom (EOTC) procedures in place at the time of the incident and found they predated the good practice documents made available to schools in 2018.

(b) Parent/guardian permission slips were completed prior to the field trip but were not the current version in line with best EOTC practice. Consequently, they did not contain risk disclosure information. This meant parents/guardians were unable to give fully informed consent.

(c) Before the field trip, students completed a swimming self-assessment form. Based on the self-assessments, 14 of 28 students were considered high risk or needing close monitoring. This should have triggered a realisation that a detailed swimming supervision plan was required to ensure the safety of all students.

(d) Jaden's self-assessment swimming form was unsigned and undated. It had also been altered from "not confident" to "confident." Jaden appears to have written "I can float" under the additional comments section, raising uncertainty about his swimming ability. The way Jaden's form was completed should have been a red flag for staff and closer supervision of Jaden should have been in place.

(e) Teacher A was mistakenly believed to have been a trained lifeguard. Independent inquiries into Teacher A's competence were not completed by MHSBOT.

[26] WorkSafe identified several potential failures by MHSBOT, namely:

(a) Failure to implement updated systems to comply with current EOTC guidelines. MSHBOT's EOTC procedure was written in 2008 and was last reviewed in 2016. It predated good practice documents made available to schools in 2018. Good practice documents articulate in EOTC safety management templates a much greater emphasis on roles and responsibility, staff competence, and risk management.

(b) Failure to ensure staff competence. At the time of the incident, MHSBOT was reliant on anecdotal evidence provided by Teacher A regarding his own competence.

(c) Failure to notify the local (Waihī) surf lifesaving club that Melville High School would be conducting a field trip at Waihī Beach.

(d) Failure to make enquiries with the local (Waihī) surf lifesaving club as to the safety and suitability of swimming that day and specifically in the location selected.

[27] Ultimately, WorkSafe determined there had been a breach by MHSBOT of a number of provisions of the Health and Safety at Work Act 2015. WorkSafe found MHSBOT's standard of managing the health and safety of students engaged in an EOTC activity was far below what is required by health and safety law and then current EOTC guidelines. The non-compliance resulted in Jaden's death.

[28] Following a recommendation by WorkSafe to prosecute MHSBOT, an Application for an Enforceable Undertaking was proposed by MHSBOT as an alternative.[5] The Enforceable Undertaking set out several actions MHSBOT was to undertake and complete in response to its contravention of the Health and Safety at Work Act, namely:

[5] An enforceable undertaking is an agreement between WorkSafe and a duty holder made under the Health and Safety at Work Act 2015. It is entered into voluntarily by the duty holder following a breach of the Act and, once in place, is legally binding. It is generally used as an alternative to prosecution. An enforceable undertaking should not be viewed as an easy option. The agreement details the actions the duty holder will undertake and complete in response to the contravention.

(a) MHSBOT was to review and improve EOTC documents and procedures, so they aligned with current EOTC guidelines. That included specific safety measures relating to water based activities such as, having a qualified lifeguard present at EOTC swimming activities to help supervise students and talking to students about water safety; assessing students' swimming abilities through practical exercises in a local pool; implementing a supervision structure that included having a flotation device in the water, having three or four teachers (depending on the number of students) in the water forming a perimeter around the students; and ensuring multiple staff assess weather conditions and visit the site prior to an activity.

(b) MHSBOT was to introduce and commence increased professional development for all staff to ensure they are informed of best practice EOTC guidelines. As a result of this requirement, a significant number of staff were required to undergo and update their first aid training.

(c) Lessons learned by MHSBOT were to be communicated to several schools and other learning centres, mainly those located in the Central North Island region and some in the Wellington region.

(d) MHSBOT was to make financial amends to Jaden's family.

(e) MHSBOT was to complete a series of activities to promote the objectives of health and safety legislation that would deliver benefits to the wider industry and/or sector, including, developing a "lessons learned" workshop to be included in the one-day "Embedding Good Practice Systems for EOTC" course run by Education Outdoors New Zealand (EONZ); fund three additional EOTC and effective management workshops in Hamilton, Taupō and Tauranga; and fund a new online course by EONZ in EOTC safety management in and around water.

(f) MHSBOT was to complete activities promoting the objectives of the health and safety legislation that would deliver benefits for the community including funding Surf Lifesaving Northern Region to run its summer beach

education programme and partner with Drowning Prevention Auckland to run three water circuit training programmes in the Waikato.

[29] MHSBOT had fully cooperated with WorkSafe throughout its investigation. As a result, on 7 December 2021, WorkSafe accepted MHSBOT's application for an Enforceable Undertaking. The prosecution proceedings were withdrawn. The agreed enforceable undertaking was made public.

[30] I have received confirmation from WorkSafe, dated 23 November 2023, that MHSBOT complied with the enforceable undertaking, and it was therefore discharged. The Health and Safety at Work Act 2015 requires WorkSafe to make the outcomes of enforceable undertakings publicly available on its website. Due to MHSBOT having complied with the enforceable undertaking, no prosecution was advanced.

[31] Following direction by the Minister of Education, Melville Highschool permanently closed on 8 December 2023 and ceased to exist as an entity on 31 December 2023.

Comments and recommendations

[32] Following Jaden's death, several matters became known which merit comments and recommendations pursuant to section 57(3) of the Coroners Act.

Comments pursuant to s57(3)

[33] In my view, MHSBOT took appropriate steps following Jaden's death. Had Melville Highschool continued to exist as an entity, there would be no need for me to make recommendations directed at MHSBOT, other than to remain current with any updates to 'best practice' guidance.

[34] I record that MHSBOT adopted a robust EOTC Safety Management Plan following Jaden's death. It included specific safety measures relating to water-based activities. This plan was based on the EONZ EOTC Safety Management Plan Template, which was updated in November 2023. Due to the November 2023 update, the plan developed by MHSBOT would no longer be considered current 'best practice.'

[35] SLSNZ and EONZ commented that Jaden's death may have been avoided if the surf lifesaving club had been consulted about the suitability of swimming in that area on that day. Due to heavy surf conditions that day, the lifeguard's response would likely have been not to swim in the area at all, certainly not without lifeguards present. I reinforce the message that individuals responsible for overseeing EOTC activities should, as a matter of course, notify local surf lifesaving clubs of an intention to engage in water-based activities and follow any advice received.

Recommendations pursuant to s57(3)

[36] The following recommendations, if drawn to public attention, may reduce the likelihood of further deaths in similar circumstances.

[37] I recommend ongoing wider publication of current examples of EOTC Safety Management Plans which meet best practice standards. For example, by inclusion in the suite of EOTC documents presently available, or via the Ministry of Education website. This would raise further awareness of the need for robust EOTC safety management plans.

[38] I recommend that all school boards should ensure their EOTC systems are reviewed regularly against the EONZ EOTC Safety Management Plan template and associated EOTC Toolkit and the Ministry of Education EOTC Guidelines to ensure they meet legal requirements and current good practice, and that school boards encourage staff with EOTC responsibilities to regularly attend EOTC safety management professional development to support this process.

[39] As part of the WorkSafe investigation, opinions were obtained from Surf Life Saving New Zealand (SLSNZ) and EONZ. These opinions note:

> Previous Coronial inquests have recommended the establishment of warning signs at the site of this drowning. Had suitable signs been erected warning the school of the permanent rip current when surf is present, this may have prevented this fatal drowning.

[40] I recommend the Western Bay of Plenty District Council/Waihī Beach Community Board erect warning signs at Waihī Beach to alert all beachgoers of the permanent rip current in the area.

[41] I recommend that whenever practicable, any beachgoers having doubts about the safety of swimming conditions or locations either avoid swimming altogether or take advice from local surf lifesaving services/clubs before deciding to proceed.

Response to comments and recommendations

[42] A copy of my provisional findings in this matter, containing the aforementioned comments and recommendations, was provided to interested parties for comment. The following responses were received:

Surf Life Saving New Zealand

[43] Surf Live Saving New Zealand supported the recommendations in this finding.

Western Bay of Plenty District Council

[44] Western Bay of Plenty District Council confirmed it has engaged with the head of Coastal Safety Research from Surf Life Saving New Zealand and the Waihī Beach Lifeguard Service regarding installation of safety signage and public rescue equipment at Waihī Beach and other Bay of Plenty coastal locations. Coastal safety assessments have already been completed at a number of locations, including Waihī Beach. The intention is to have new signage and rescue equipment in place for the 2024/25 summer season.

Ministry of Education

[45] The Ministry of Education met with the CEO of EONZ to discuss my comments and recommendations. All recommendations were accepted with one exception. It was suggested that one of my provisional recommendations may be strengthened through revised wording. I have incorporated the revisions suggested by the Ministry of Education and EONZ into paragraphs [34] and [38], as they read presently.

WorkSafe NZ

[46] My provisional recommendation at paragraph [37] of this finding included the possibility of publishing robust examples of safety management plans on WorkSafe's website, amongst other locations. WorkSafe responded that the Health and Safety at Work

Act 2015 required it to publish on its website notice of a decision to accept an enforceable undertaking and reasons for the acceptance. Additionally, although that legislation did not require WorkSafe to publish the enforceable undertaking itself, WorkSafe's own policy directs that it should publish the enforceable undertaking agreement in full. However, WorkSafe does not publish material developed as part of the activities contained within enforceable undertakings.

[47] WorkSafe further responded that the website repository for EONZ/EOTC specific information and resource links is best led and owned by the Ministry of Education who should maintain any direct links to EONZ guidance. WorkSafe approach is to refer/point to where guidance and resources can be found. Its expectation is that schools should complete their own due diligence and working out what is required and provide that information to parents. Schools are best placed to navigate source websites directly.

[48] WorkSafe points out that further guidance may be available from Support Adventure NZ[6] whose website includes good practice guidelines – www.Supportadventure.co.nz. My search of Support Adventure NZ's website confirms it contains an overview of good practice, links to Activity Safety Guidelines and a full list of good practice guidelines. Although this is no doubt a valuable resource, I emphasise that in the EOTC setting priority should be given to my recommendation at paragraph [38] of this finding.

[49] Finally, WorkSafe advises that its ongoing engagement and broader conversations with the Ministry of Education has resulted in the Ministry of Education 'looping in' EONZ, the Education Review Office, and the NZ School Boards Association. It is suggested that I may wish to disseminate my findings and recommendations to these agencies for their awareness. WorkSafe acknowledges that awareness of these findings may highlight risks associated with outdoor education activities and the availability of safe practice guidance.

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[6] Support Adventure NZ's website homepage advises that it provides guidance to adventure tourism and commercial outdoor recreation and education operators whose activities fall under the Adventure Activities Regulations. Further, providers who provide other organised adventure activities should find the guidance helpful. The website includes practical resource is and she has good practices to help strengthen safety across the adventure activity sectors.

Findings

[50] I find that Jaden Chhayrann died north of Whiritoa Beach, Thames on 21 February 2020 from drowning.

Restrictions on publication

[51] 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 Jaden Chhayrann taken during the investigation into his death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

Condolences

[52] I take this opportunity to extend my sincere condolences to Jaden's family and friends for their loss.

Directions

[53] In addition to the interested parties in this matter,[7] I direct that a copy of this finding is to be provided to the Coronial Media Liaison, WorkSafe, Western BOP District Council, the Ministry of Education, the Education Review Office, and the NZ School Boards Association.

CORONER MATTHEW BATES

[7] Identified in my Minute of 21 February 2023.