IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CIV-2012-404-4779
[2013] NZHC 906

UNDER	the Judicature Amendment Act 1972
IN THE MATTER OF	a decision made by Coroner Peter Ryan following an inquest into the death of Iraena Rama Te Awhina Asher
BETWEEN	BOBBIE JOAN CARROLL, JULIA LETICIA WOODHOUSE AND HENRY JOHN WOODHOUSE Applicants
AND	THE CORONER'S COURT AT AUCKLAND First Respondent
AND	NEW ZEALAND POLICE Second Respondent

Hearing: 19 March 2013

Counsel: G N Gallaway for the applicants
G Coumbe as amicus
S W McKenzie for the Police

Judgment: 29 April 2013

JUDGMENT OF WINKELMANN J

This judgment was delivered by me on 29 April 2013 at 3.00 pm pursuant to Rule 11.5 of the High Court Rules.

Registrar/ Deputy Registrar

Chapman Tripp, Auckland
Crown Law, Wellington

Counsel
G Coumbe, Auckland

[1] In the early hours of 11 October 2004 Iraena Asher, a 25 year old woman, disappeared into the night at Piha, a rural beach side area west of Auckland. She was never seen again. The three applicants, Ms Carroll, Ms Woodhouse and Mr Woodhouse, cared for Iraena in the hours preceding her death, having earlier found her wandering near the road, semi-clothed and distressed. Immediately following a coronial inquest into her death, held in July 2012, the Coroner issued a finding in which he concluded that Iraena had walked into the sea at Piha Beach and drowned. In the course of his finding he discussed in some detail the applicants' decision not to call the Police when they came to Iraena's assistance. He concluded that the applicants' decision not to contact Police was a contributing factor in Iraena's death.

[2] The applicants challenge that finding on three bases. They say it was unreasonable because there was no evidence upon which it could properly be based. Secondly, it was made in breach of s 15(2)(b) of the Coroners Act 1988 (the Act), which obliged the Coroner to give the applicants prior notice of his intention to comment adversely upon their conduct and an opportunity to be heard in relation to that comment. Finally, they say that the finding was otherwise made in breach of the principles of natural justice because the applicants had no notice that their conduct was likely to be the subject of scrutiny at the inquest.

[3] The applicants seek to have the finding quashed and costs awarded in their favour.

[4] Because the first respondent, the Coroner's Court at Auckland, abides the decision of the Court, I appointed Ms Coumbe as amicus to assist the Court by raising arguments which could properly be made and which would not otherwise be covered in argument before me. The second respondent, the New Zealand Police (the Police), was joined to the proceedings by the applicants, as I understand it, because the Statement of Claim contains allegations concerning the conduct of the Police which it is suggested contributed to a breach of the applicants' right to fair procedure.

[5] I have concluded that all three grounds of review are made out. The Coroner's finding that the applicants' decision not to call the Police was a contributing factor in Iraena's death was unreasonable, as it had no proper evidential foundation. Rather, it was based upon speculation as to a possible outcome if events had occurred differently. Moreover, the requirements of s 15(2)(b) and natural justice as applicable in the context of a coronial inquest were not complied with. It is therefore appropriate to quash the Coroner's comments in relation to the applicants. I set out the reasons for this conclusion below.

Background

Iraena's Disappearance

[6] It is first necessary to set out some of the background to Iraena's disappearance, and for this purpose, convenient simply to adopt the summary of facts as set out in the Coroner's findings:[1]

> [2] [On] ... 10 October 2004, Iraena along with her boyfriend of approximately 10 days and two others, travelled by car out to an address at Piha Road, at Piha Beach. There were four people in that house that day, although others came and went at different times. There was Iraena and her boyfriend, [B], and the occupants of the house, [G and H]. During that day, the four occupants were drinking alcohol and acknowledged smoking marijuana. At one point during the day, Iraena left the house and went down to Piha Beach where she met a couple and their child who were walking around a headland. The couple spoke with Iraena and recalled that she was emotional, complained of being tired and cold and was muttering. They indicated that she appeared to be out of place and in her own world. This couple helped Iraena by assisting her to walk back to where their car was parked and then they gave a lift back to [the Piha Road address], where she told them she was staying.
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> [3] Ms Asher was wet from the sea and had a shower and a rest once she had returned to the house. She remained at [the Piha Road address] for the rest of the day, until approximately 8.00 pm that evening. At that point, [B] her boyfriend left the house and walked to his parents' address nearby. [B] states that Iraena asked him to leave the house and he was not worried about this request because, in his opinion, she had gone 'a bit funny'. Iraena remained at the house with [G and H] for approximately one more hour. She left the house after making a telephone call, and that subsequently turned out to be the emergency call that she made to the Police Communications Centre.

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1 *Re Asher* CSU-2004-AUK-000000.

[4] Between approximately 8.55 pm and 9.11 pm on Sunday 10 October 2004, there were three telephone calls between Iraena and the Police Communications Centre. After 9.11 pm, the Police were no longer able to contact Iraena on the cellphone and it transpired that when she left [the Piha Road address], she either dropped or threw the cellphone down on the driveway of the property.

[5] Between 9.20 and 9.30 pm on 10 October 2004, Iraena was seen walking up Piha Road by a Piha resident, Julia Woodhouse and her son, Henry Woodhouse. They were driving towards Piha on what was described as being a cold, wet night. They noticed Ms Asher walking through a secluded part of Piha Road in inclement conditions and they noticed that she looked [distressed], had bare muddy legs, with few clothes on. They stopped and talked to Ms Asher and ascertained whether she needed assistance. She indicated that she did; in fact she told them that she had been kidnapped. They offered her help and took her to Ms Woodhouse's home [...].

[6] Ms Asher spent approximately four hours in the house with Ms Woodhouse and her partner, Ms Bobbie Carroll, and Ms Woodhouse's son, Henry Woodhouse. [They] formed the impression that Iraena might be under the influence of drugs, because of her erratic behaviour. However, they also indicated that they felt that she was coming down from a high. What was not known to [them] was that Ms Asher suffered from bi-polar affective disorder. She was first diagnosed with this condition around the age of 16 and evidence establishes that the condition was very well controlled by medication.

[7] Iraena declined the offer from the people [...] to contact the Police or an ambulance and offered some resistance to their attempts to contact others on her behalf, although contact was made with the mother of Mr Dyson who had been Iraena's partner for approximately the last four years. Iraena had approximately a five minute conversation with Mr Dyson's mother.

[8] The [people] spent the next four hours with Iraena, and during that time they watched television, discussed the programmes that were on television and engaged in conversation with Iraena. At one point, Iraena told Henry Woodhouse things that had happened during that day. Mr Woodhouse was unable to remember in detail much of what she said to him, other than the fact that she said she had pictures taken of her by the people at [the Piha Road address] without her approval.

[9] At around 1 o'clock in the morning of 11 October, a bed was made up in the lounge for Iraena to spend the rest of the night at the property with the promise that the occupants would take her back to Auckland in the morning. Iraena was reluctant to sleep in the lounge by herself and in fact insisted that Henry Woodhouse stay in the lounge with her. A separate bed was made up for him on the other side of the room. Everybody in the house was either in bed or getting ready for bed at approximately 1.00 am, at which point Iraena got up out of bed and went to the door of the residence. Henry Woodhouse tried to persuade her to remain in the house, but Iraena left the house and disappeared into the night. She was wearing only a dressing gown that had been provided to her by Ms Carroll.

[10] Ms Carroll attempted to follow Iraena in her car and drove up the road where she discovered the discarded dressing gown lying on the road.

She drove around, heading up Piha Road, trying to find Iraena, but there was no sign of her. Ms Carroll then returned to the house, at which point the Police were notified and then Ms Carroll and Ms Woodhouse both went off in the car again to try and find Iraena.

[11] At around that time, Zachary Nixon and his partner, Simone Ross, were out walking their dog. As they walked along Garden Road in Piha, heading towards the Piha store, they saw a woman standing under a streetlight at the apex of Garden Road and Marine Parade or Seaview Road as it may have been; the apex of the corner nearest to the store. They noticed that this woman was completely naked, had her arms stretched up at one point and appeared to be engaged in some kind of ritual. She was observed to kneel down and kiss the ground possibly. This woman was subsequently identified as being Iraena Asher.

[12] Mr Nixon and Ms Ross then observed Iraena walk off down Seaview Road, heading towards Piha Beach. She disappeared from their view approximately halfway down the road, when the streetlight stopped. There were no further streetlights beyond that point. This couple continued to walk down Seaview Road to see if they could see where Iraena was going, but they were unable to sight her again once she walked out from under the streetlamp, but they are clear that she was heading down towards the beach, as opposed to turning off either to the left or to the right.

[13] Mr Nixon had a torch with him, and at one point he went down slightly off the road onto the sand dunes and shone the torch down onto the beach in an attempt to try and locate Iraena, but was unable to do so. Iraena has not been seen or heard from since that time.

The inquest

[7] The Police reported Iraena's disappearance to the Coroner, and an inquest was conducted under the provisions of the Act.[2] The Coroner has an inquisitorial function, and the purpose of an inquest is set out in s 15(1) of the Act as follows:

> (1) A coroner holds an inquest for the purpose of—
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> (a) Establishing, so far as is possible,—
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> (i) That a person has died; and
>
> (ii) The person's identity; and
>
> (iii) When and where the person died; and
>
> (iv) The causes of the death; and

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[2] The 1988 Act was repealed on 1 July 2007 by s 143 of the Coroners Act 2006. Because the events with which the inquest was concerned occurred in 2004, the 1988 Act continued to apply to the inquest into the death of Iraena.

(v) The circumstances of the death; and

(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.

[8] Section 37 of the Act provides that the Police are to assist at all inquests. Senior Constable Herman is the District Inquest Officer for the Waitemata Police District Coronial Services Unit. He has provided an affidavit in this proceeding in which he describes the Police's usual role in assisting with inquests, and what occurred in this case. He says that protocol requires the Coroner to direct who he or she wants to hear from. This direction is passed formally through the Coroner's coordinator to the relevant Inquest Officer. The coordinator prepares the summons, the Coroner signs them, and they are then sent to Constable Herman to serve (or he passes them to other Police members to serve).

[9] In this case, the officers in charge, Detective Senior Sergeant Sutton and Detective Sergeant Winikerei, prepared the file for the inquest. In accordance with usual practice, the Coroner, through his coordinator, sent Senior Constable Herman directions as to who the Coroner wanted to attend to give evidence and when. Summons for the witnesses were prepared by the Coroner's office for the day the witnesses were required to attend, and these were then sent to Senior Constable Herman for service. Although he served one summons himself, Senior Constable Herman sent the rest (including those for the applicants) to another officer for service. The applicants received their summons in late May 2012. The summons notified them of no more than that they were summoned to appear on 18 July 2012 before a Coroner to give evidence at the inquest into Iraena's death. The 18th of July was the second day of the inquest hearing.

[10] The Police also usually provide assistance during the inquest by calling any witnesses the Coroner wishes to hear from. The procedure followed at this inquest differed from the usual, however, because the Police were represented by Mr Simon Moore SC, from Meredith Connell. I assume Mr Moore had been instructed because it was known that the Police's conduct in the lead up to Iraena's disappearance

would be subject to scrutiny during the course of the hearing, because of the manner of their response to Iraena's calls to the Police Communications Centre on the night of her disappearance. Consequently, Mr Moore fulfilled a dual role at the hearing, assisting the Coroner by calling not only Police witnesses but also witnesses the Coroner had summoned to attend. The applicants fell into the second category.

[11] The applicants did not attend the first day of the inquest because their summons was for the second day. On that first day, Detective Senior Sergeant Sutton gave evidence. He initially read from his written brief which contained a statement of his opinion that a contributing factor in Iraena's disappearance was:

> The decision by the WOODHOUSES and Bobby CARROLL not to call emergency services in the context of a woman who was obviously showing signs of distress saying she had been kidnapped and drugged.

[12] He was then asked by Mr Moore to comment further upon any actions that the applicants could or should have taken. This was his response:

> Ah, yes sir, it concerns me that, um, this woman who had described either being kidnapped or drugged, and I think that the appropriate action should have been that the police or an ambulance at least [be] contacted, and that may have well resulted in Iraena being alive today, because she was there for a substantial period of time.

[13] Mr Moore further questioned the officer to clarify that Iraena had been at the applicants' house for nearly four hours prior to her disappearance.

[14] The next day Mr Moore called each of the applicants to give evidence. They each read out briefs of evidence prepared for them by the Police, and then answered questions from the Coroner. I describe some of the content of that evidence later in this judgment.

Coroner's decision

[15] The Coroner delivered his findings at the conclusion of the hearing. After setting out the factual background, recited above, he identified the following issues for himself:

1. Whether Iraena was dead or still alive;

2. If dead, whether Iraena's death might be a suicide or not;

3. The events that occurred at [the Piha Road address] on 10 October 2004;

4. Iraena's state of mind on 10 October 2004;

5. The decision by the applicants not to call Police when they came to Iraena's assistance on 10 October;

6. The actions by the Police Communications Centre when Iraena called the Police around 9.00 pm on the evening of 10 October;

7. The adequacy of the Police search that was instituted following Mr Woodhouse's call to the Police at approximately 1.20 am.

[16] He concluded that Iraena had gone into the sea in the early hours of 11 October 2004 and subsequently drowned. He also concluded that her death was accidental. In relation to issue 5, the Coroner narrated the events which emerged from the evidence of the applicants as follows. When Mr and Ms Woodhouse came across Iraena, she seemed to be wearing only a "hoodie" sweatshirt and underpants. When they stopped to talk to her she was in a state of distress. The Coroner said that they "very nobly picked Iraena up and took her back with them to their house".[3] They offered to contact the Police or her family, but Iraena told them she had already informed the Police and they were not interested. She became very agitated when suggestions were made to her that the Police should be called.

[17] The applicants considered calling the Police on at least two separate occasions that night due to Iraena's state and her behaviour. In the meantime they provided her with food, shelter and "a great deal of emotional support".[4] They spent about four hours engaging her in conversation. At times she appeared to the applicants to be quite lucid but, at other times, she seemed to disappear into her own world. Because she complained of having been kidnapped and pressured for sex, they endeavoured to keep notes of what was said. The Police have lost those notes. The applicants wanted to ensure that someone close to Iraena knew where she was,

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[3] At [48].
[4] At [49].

and it was at their instigation that she made contact with the mother of her former boyfriend. She then also tried to contact her former boyfriend but was unsuccessful in doing so.

[18] The arrangement was made that she would stay at the house that night and the applicants would drive her back to Auckland City the following day. They tucked her up in a bed in the lounge and the evidence was that she seemed quiet, calm and collected at this point. They made sure that she was not left alone, one of the applicants staying in the room with her as she was settled for the night. The Coroner said:

> [51] The [applicants] that day were in the best position to assess Iraena's condition that day on a personal level, although of course, not medically or psychologically trained. They were also in the best position to obtain professional intervention for Iraena.
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> [52] It is not within this Court's jurisdiction to determine culpability or attribute blame for a person's death; but it is a necessary function of the Court to consider whether the actions or inactions of any person may have contributed to a person's death. The Police consider the fact that Ms Woodhouse, Ms Carroll and Mr Woodhouse did not notify the Police of Iraena's state that evening, was a contributing factor to Iraena's disappearance and subsequent death. This conclusion was strenuously refuted by Ms Carroll in particular, but also by Ms Woodhouse and Mr Woodhouse. They were of the view that the situation did not require Police intervention or other professional intervention and I suspect they were strongly influenced by Iraena's agitation at the prospect of Police intervention. The impression I gained was that they felt that possibly [the] cure may have been worse than the disease.

[19] The Coroner noted that the applicants had considered the situation carefully. He accepted as factors "mitigating" against calling the Police that Iraena was in a safe environment, that there was no immediate danger to her person and that, although she was exhibiting irrational and erratic behaviour, it was not of a level that they felt indicated she needed urgent medical attention. He said:[5]

> They were obviously concerned not to upset Iraena and they may have been anxious that, if they had insisted on calling the Police, then Iraena would have simply run out of the house.

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5 At [53].

He continued:[6]

> I accept also that they felt the need to respect Iraena's wishes not to involve the Police.

[20] However, the Coroner concluded as follows:

> [55] But in my view, I concur with the Police opinion that their decision not to contact the Police was a contributing factor in Iraena's death, because it was an opportunity for professional intervention that may have prevented the death. Now this comment is not a criticism of them or of their actions. It is simply an acknowledgement that there was an opportunity that was missed by people with the best of intentions, acting in what they considered to be Iraena's best interests, but still an opportunity was missed for professional intervention which may have affected the outcome.
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> [56] I stress the use of the word 'may' here because it is purely speculation. If, in fact, they had gone against Iraena's wishes and contacted the Police, either blatantly or surreptitiously, and if Iraena was aware of that, then she may well have bolted from the house and disappeared into the night.
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> [57] I consider that this is a learning experience that can only occur when scrutinised in the light of subsequent events; that is, an adverse outcome eventuates. If Iraena had not disappeared, then this decision that was undertaken by the [applicants] would not be under scrutiny. It is the adverse outcome which trains the spotlight of a coronial inquiry on such a decision for the purpose set out in the Coroners Act 1988, specifically s 15(1)(b) which states that:
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> > *(1) 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.*
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> [58] I consider it important that the public should learn any lesson that can be learned from a situation where a death occurs, and the lesson to be learned from this death is that it is better to err on the side of caution and contact the Police and let them decide whether intervention is warranted or not. Now as it turns out in this instance, the Police were given this decision earlier in the piece and they made a decision based on the information presented to them. I do not think that earlier occurrence should have influenced the decision to be made by Ms Carroll, Ms Woodhouse and Mr Woodhouse, because they still had the opportunity to talk to the Police

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6 At [54].

> themselves and discuss with the Police the circumstances of Iraena's condition. However, they were influenced of course, by what Iraena told them, that the Police were not interested.
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> [59] I still consider it would have been a better course of action for them to have contacted the Police as the Police are better equipped to handle the situation of a possibly mentally unwell person or a person who is affected by drugs and alcohol. Superintendent McGregor, who gave evidence, stated that many people call the Police emergency number when in fact, it is not an emergency. But similarly, they also call Police non-emergency lines when in fact, the circumstances warrant an emergency 111 call. This indicates to me that there is confusion in the minds of the public as to whether they should call the emergency line or whether they should just call Police on a non-emergency line, and so my comments are simply to highlight the need for the public to take the safe approach and to make an emergency call to Police, rather than try to deal with the situation which could result in an adverse outcome. If people do that, then at least if their decision-making is scrutinised, they are able to say that they took all reasonable measures, to ensure the safety of the people that they may be assisting.

First ground of review: Coroner's finding unreasonable

[21] It is common ground that the issue in relation to this ground of review is whether the Coroner's finding that the applicants ought to have called the Police was one that a reasonable Coroner could have made. A finding will be unreasonable if it is not supported by any probative evidence,[7] or if "the reasoning by which the decision-maker justified inferences of fact that he had drawn is self-contradictory or otherwise based upon an evident logical fallacy".[8] It is not enough for an applicant challenging the finding to show that there was evidence available that might reasonably have supported other findings.[9]

[22] The applicants argue that the Coroner's finding was unreasonable because it did not have a sufficient evidentiary basis. The only evidence upon which the Coroner could have relied in making this finding was that of Detective Senior Sergeant Sutton who said "the Police or an ambulance at least" should have been contacted and that "may have resulted in Iraena being alive today, she was there for a substantial period of time". The applicants say that did not provide a safe basis for a

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7 *Re Erebus Royal Commission; Air New Zealand Ltd v Mahon* [1983] NZLR 662 (PC) at 681; *Discount Brands Ltd v Northcote Mainstreet Inc* [2004] 3 NZLR 619 (CA) at [58].

8 *Re Erebus*, above n 7, at 681; see also *Wolf v Minister of Immigration* [2004] NZAR 414 (HC) at [68].

9 *Re the State Coroner, ex parte The Minister for Health* [2009] WASCA 165 at [57].

finding that the decision not to call Police contributed to Iraena's death; it was opinion evidence and the officer had no particular expertise that qualified him to provide such an opinion.

[23] Ms Coumbe, on the other hand, submits that the Coroner's finding did not rest solely on the evidence of Detective Senior Sergeant Sutton, but was rather based on all the evidence presented, including the evidence of the applicants about Iraena's behaviour and their own thought process in connection with the decision not to call the Police or other emergency services. She says that the following conclusions were available on the evidence and, combined, these were sufficient to support the ultimate finding that the applicants' conduct contributed to Iraena's death:

(a) It would have been a "better course of action" for the applicants to have telephoned the Police. Iraena was a young woman, found alone at night in a distressed state. Despite evidence that Iraena had "calmed down", it was reasonably open to the Coroner to find that she remained in an unstable and unpredictable state, which the Police would have been better equipped to deal with than the applicants.

(b) The applicants had opportunities over the course of the four hours to make such a telephone call without alerting Iraena.

(c) The Police would have responded if they had received a call from one of the applicants. Ms Coumbe submits that it was reasonable to conclude that, had the applicants telephoned Police and described Iraena's mental state, the circumstances in which they found her and her allegations of being drugged and kidnapped, the Police would have responded, even though the Police had previously declined to assist her.

[24] Ms Coumbe also submits that the Coroner did not need to find a direct or causative link between the decision not to call the Police and Iraena's death. He did not find that the applicants had caused Iraena's death in terms of s 15(1)(iv) of the Act; rather, he found that the cause of death was accidental drowning. The

applicants' conduct was instead highlighted as one of a number of background contributing factors. This secondary finding was made in the context of the Coroner's function of establishing the circumstances of Iraena's death, as he was required to do, and was more in the nature of making a general observation under s 15(1)(b). This distinction, she says, is relevant to the evidential foundation required.

[25] The officer's evidence was, as the applicants point out, only opinion evidence. As such, it was probably entitled to little weight because the Police were personally interested in the inquest, and because the officer had no particular expertise that qualified him to express that opinion. However, it is the case, as Ms Coumbe submits, that the Coroner was not constrained to the evidence of Detective Senior Sergeant Sutton when making his findings in relation to this issue. He was entitled, in fact obliged, to look across all of the evidence in reaching his conclusions.

[26] This is the point at which I part company with Ms Coumbe's arguments. There can be no doubt that a finding that the applicants' decision not to contact Police contributed to Iraena's death will be read as a finding that there was a causal connection between that decision and Iraena's death. To contribute to something is to be partly instrumental in or partly responsible for it. I accept that the point of this finding was to highlight the importance of calling emergency services in such circumstances – thus fulfilling the function of the Coroner under s 15(1)(b). Nevertheless, there needed to be a proper evidential foundation for such a finding.

[27] It may be that, as Ms Coumbe submits, there was evidence available upon which the Coroner could properly have based the conclusions outlined at [23(a)] and [23(c)] above. It appears from his findings that those are conclusions he did reach. But the Coroner did not conclude that the applicants could have called the Police without alerting Iraena (conclusion at [23(b)] above). On the contrary, the Coroner identified the risk, as did the applicants, that if the applicants had attempted to make such a call, Iraena could simply have "bolted".

[28] There is then a gap in the evidentiary foundation for this finding. The Coroner was candid that he filled that gap with speculation, saying in connection with his finding that calling the Police "may" have prevented her death:

> [56] I stress the use of the word 'may' here because it is purely speculation. If, in fact, they had gone against Iraena's wishes and contacted the Police, either blatantly or surreptitiously, and if Iraena was aware of that, then she may well have bolted from the house and disappeared into the night.

[29] This ground of review succeeds. There were other arguments advanced in support of it such as that the Coroner unreasonably singled the applicants out for this criticism, when there were others who could have intervened on the night and who did not. Inconsistency can evidence unreasonableness in decision making. But such a ground of review would be difficult to make out in a case such as this where the factual situation confronted by each person who saw or engaged with Iraena on the night was different. In any case, I do not need to consider the argument, the ground of review having been made out.

Second and third grounds of review: breaches of s 15(2)(b) of the Act and natural justice

[30] Before addressing the detail of the arguments advanced in connection with these grounds of review, it is necessary to describe briefly the statutory provisions and common law principles the applicants seek to invoke.

Legislative framework

[31] The legislation provides a framework of procedural rights for those whose interests are affected or potentially affected by a Coronial inquest. Section 23(1) of the Act imposes on the Coroner a requirement to give notice of the date, time and place of the inquest to every person who has a sufficient interest in the inquest or its outcome, or who the Coroner has directed to be notified. Section 23(2) provides a non-exhaustive list of people who are entitled to notice under s 23(1):

> (2) Those to be notified under subsection (1) of this section shall include—

(a) The immediate relatives of the person concerned; and

(b) Any doctor who attended the person—

(i) Immediately before death; or

(ii) In the case of a person who had been ill before death, during the illness; and

(c) Every person whose conduct, in the opinion of the senior member of the Police in the place where the inquest is to be held or the coroner, seems likely to be called into question; and

(d) Every life insurance company known by the member of the Police concerned or the coroner to have issued a policy on the person's life; and

(e) The Life Offices Association of NZ Inc; and

(f) Where the person's death appears to have arisen out of the person's employment,—

(i) Any industrial union registered under the Labour Relations Act 1987 of which the person was a member; and

(ii) The Secretary of Labour; and

(g) Where section 206 of the Mining Act 1971 or section 177 of the Coal Mines Act 1979 or section 71 of the Quarries and Tunnels Act 1982 applies to the death, an Inspector of Mines, Coal Mines, or Tunnels (as the case may be).

(emphasis added)

[32] Those captured by s 23 are afforded certain rights at the inquest by s 26(4), which provides:

(4) Any person specified in section 23(2) of this Act, and any person with a sufficient interest in the subject or outcome of the inquest may, personally or by counsel, attend an inquest and cross-examine witnesses.

[33] Section 15(2)(b) of the Act imposes an additional notice requirement. It provides:

(2) Notwithstanding subsection (1) of this section, but subject to section 28 of this Act, a coroner may in the course of or as part of the findings of an inquest, comment on the conduct, in relation to the circumstances of the death concerned, of any person; but –

…..

(b) Shall not comment adversely on any living person without taking all reasonable steps to notify the person of the proposed comment, and giving the person a reasonable opportunity to be heard in relation to the proposed comment.

Common law principles of natural justice

[34] These provisions do not on their face purport to be a code and therefore do not exclude the common law requirements of natural justice except to the extent that the requirements of the common law are inconsistent with the provisions of the Act. They are therefore to be construed as stipulating the applicants' minimum rights, not the full extent of them. As Joseph says:[10]

> Statutory protections are minima not maxima, and the courts will supplement the procedures by reference to common law standards of fairness. For supplementation, it must be shown that the statutory procedures are insufficient to do justice and that common law procedural protections would not frustrate the statutory purpose.

[35] The common law requirements of natural justice are context specific – a "flexible concept which aims to achieve across an infinite spectrum of situations both the actuality and the perception that things have been done justly and fairly".[11] They will vary depending upon the nature of the proceeding, the gravity of the matters at issue, and can be shaped by express statutory provision as to the procedure to be followed. In determining whether natural justice has been complied with, the courts look at the matter in the round to determine whether the process was fair.[12]

[36] Generally natural justice is thought to require at least advance notice of the subject matter of the hearing,[13] advance notice of the risk of findings adverse to the person's interests[14] and the right to be legally represented if the circumstances

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10 Phillip A Joseph *Constitutional and Administrative Law in New Zealand* (3rd ed, Brookers, Wellington, 2007) at [24.2.3].

11 *Director of Civil Aviation v Paterson (No 3)* HC Wellington CIV-2005-485-606, 23 June 2005 at [98]; see also *Canterbury Pipe Lines Ltd v Christchurch Drainage Board* [1979] 2 NZLR 347 (CA) at 357.

12 *Dandelion Investments Ltd v Commissioner of Inland Revenue* [2003] 1 NZLR 600 (CA) at [59].

13 *Coles v Miller* CA25/01, 8 November 2001 at [43].

14 *Re Erebus Royal Commission*, above n 7, at 671.

require it.[15] People are entitled to a fair opportunity to be heard[16] which necessarily includes a reasonable amount of time in which to prepare a case.[17] What constitutes a reasonable amount of time will depend upon the complexities of the issues involved.[18]

Arguments advanced in support of second and third grounds of review

[37] The second and third grounds of review are conveniently addressed together as, in essence, both allege that the Coroner did not observe the requirements of natural justice, causing substantive unfairness which justifies quashing the Coroner's finding.

[38] The second ground of review concerns s 15(2)(b), the provision requiring prior notice of adverse comment. In this regard, the applicants say that the Coroner's "contributing factor" finding amounted to an adverse comment, and that the Coroner failed to take all reasonable steps to notify the applicants of his intention to make the finding, and to give the applicants a reasonable opportunity to be heard in relation to the finding. Not only did this amount to a breach of s 15(2)(b), but also of the principles of natural justice.

[39] The third ground of review is that the requirements of natural justice were not met because the applicants had no advance notice of the case they had to meet.[19] In the coronial context, fairness requires that persons be put on notice if their conduct is likely to be called into question during the inquest, so that they may have time to prepare for the inquest hearing and arrange legal representation if they so choose.

[40] The applicants point to the notice requirements in s 23 and say that they were entitled to notice of the date, time and place of the inquest under that provision as persons whose conduct seemed "likely to be called into question" in terms of

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15 *R v Secretary of State for the Home Office; ex parte Tarrant* [1985] 1 QB 251 at 285 - 286.
16 *Furnell v Whangare High Schools Board* [1973] 2 NZLR 705 (PC) at 720; *Stininato v Auckland Boxing Association (Inc)* [1978] 1 NZLR 1 (CA) at 28.
17 *R v Thames Magistrates Court Ex parte. Polemis (the Corinthic)* [1974] 1 WLR 1371 at 1375.
18 *Lindemans Wines Pty v Woodward* (1981) 46 LGRA 14.
19 Relying on *Royal Australasian College of Surgeons v Phipps* [1999] 3 NZLR 1 (CA) at 16.

s 23(2)(c). The applicants further say that to comply with the requirements of s 23, and with the obligations of natural justice, those who are entitled to notice under s 23(2)(c) should also be told the reason they are being notified: because their conduct is likely to be called into question. This is necessary because one of the reasons for requiring the s 23 notice is to enable the exercise of rights provided for by s 26(4). Because the applicants were not told that their conduct was likely to be called into question, they did not attend the inquest in full nor arrange legal representation for themselves, and were thereby prejudiced.

[41] In this case, no s 23 notice was served on the applicants. The only notice they received of the inquest was the summons requiring them to attend on the second day. The applicants say that this failure to give notice in accordance with s 23 and/or the principles of natural justice compounded the failure to comply with s 15(2)(b) and as a result, they were substantially prejudiced. This they say is relevant to the relief to be granted.

[42] The applicants acknowledge however the effect of s 23(3), which provides that a failure to comply with subsection (1) of that provision does not affect the validity of any action. Consequently, in dealing with these grounds for review, it is helpful to consider first whether an adverse comment was made for the purposes s 15(2)(b). If ultimately no adverse comment was made in connection with the applicants then, of course, the applicants would have no ground for complaint as their interests would not have been affected by the outcome of the inquest. Whether or not the Coroner made an adverse comment for the purposes of s 15(2)(b) is, therefore, a threshold question.

[43] For the reasons discussed below, I consider that this threshold has been crossed. I therefore also address the applicants' submissions in respect of s 23 and then s 15. I adopt this order because s 23 rights arise before s 15 rights chronologically. Moreover, procedural failings may compound one upon another. Any procedural failings in respect of s 23 may impact upon any assessment of what was later required to notify the applicants of a proposed adverse comment for the purposes of s 15(2)(b), and to provide them with a reasonable opportunity to

comment. The issues that arise in respect of the second and third grounds of review are therefore:

(a) Did the Coroner's finding amount to adverse comment for the purposes of s 15(2)(b)?

(b) Did the Coroner fail to comply with the requirements of natural justice prior to the hearing?

(c) Did the Coroner comply with his obligations under s 15(2)(b)?

(a) Did the Coroner's finding amount to adverse comment for the purposes of s 15(2)(b)?

[44] Ms Coumbe submits that, properly read, the Coroner's remarks did not amount to adverse comment about the applicants. She accepts that a finding that a person's action or inaction contributed to a death may in some circumstances amount to adverse comment, and refers to the comments of Brennan J in *Annetts v McCann* that a "coroner's finding as to 'how, when and where the deceased came by his death' is plainly apt to affect adversely the interests of any person upon whom the finding would reflect unfavourably".[20] She also accepts that the person's interests include their personal and professional reputation.[21] However she submits that it is necessary to read the finding in question in its context. In particular the Coroner expressly stated in respect of the applicants that his finding was:[22]

> ...not a criticism of them or their actions. It is simply an acknowledgment that there was an opportunity that was missed by people with the best of intentions, acting in what they considered to be Iraena's best interests, but still an opportunity was missed for professional intervention which may have affected the outcome.

[45] As stated by Ms Coumbe, a comment will be adverse where it would reflect "unfavourably" on a person. More is required than merely linking the person's

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20 *Annetts v McCann* (1990) 17 CLR 597 (HCA) at 608.
21 *Annetts*, above n 20, at 608.
22 At [55].

conduct to the death of another; the link made must reflect negatively on that conduct. To find otherwise would give a right to be heard in respect of proposed findings to persons whose actions were, and were recognised as being, entirely blameless. I also accept the submission that comments must properly be read in context. But no matter how the Coroner sought to characterise his own comments, when they are placed within the context of his overall discussion of issue 5 (the decision by the applicants not to call the Police) I have no doubt that they are comments which attract the procedural requirements of s 15 of the Act.

[46] As already observed, in this case the Coroner found that the applicants' decision not to contact the Police was one of a number of factors responsible for Iraena's death. I have considered whether his comment that it would have been "better" if the applicants had called the Police was one made, and to be understood as made, purely with the benefit of hindsight. It is possible to conceive of such a hindsight comment being made without implying that the decision made was the wrong one at the time. That is not how the findings are expressed here. The Coroner conducted a close analysis of the applicants' decision-making process. As the Coroner said, it was their decision-making that was under scrutiny in the light of subsequent events. In undertaking that analysis, he assessed the information that was available to the applicants at the time. The overall tenor of the Coroner's finding is that the applicants could, and should, have called the Police in light of the information they had available to them. I have no doubt that this is how either a casual or careful and reasonable reader would construe the Coroner's comments.

[47] The Coroner's finding thus amounted to an adverse comment, affecting the interests of the applicants. It follows that the Coroner was obliged to comply with the requirements of s 15(2)(b).

(b) Did the Coroner fail to comply with the requirements of natural justice prior to the hearing?

[48] Ms Coumbe first submits that the Coroner did not have to provide notice to the applicants under s 23(2)(c) because notice under that sub-section is only required in respect of persons whose conduct is likely to be called into question by the

Coroner *in his findings.* At the time the applicants were summoned, it was not clear that the Coroner was likely to question their conduct in his findings; their conduct had only been identified as one of a number of possible contributing factors. For that reason s 23 did not apply.

[49] This argument raises questions of the proper construction and interpretation of s 23 of the Act. The starting point with any question of statutory interpretation is s 5 of the Interpretation Act 1999 which provides that the meaning of an enactment is to be ascertained from its text and in light of its purpose. The courts begin by searching for the grammatical meaning of the text in the context of the other words of the section in which it appears and the Act. Where that does not give effect to the purpose of the legislation, it must give way to the construction which will promote the purpose or object of the Act.[23] Similarly, if the wording of a provision is ambiguous, it should be interpreted so as to further the legislative purpose.[24]

[50] The wording of s 23(2)(c) is sufficiently unclear so that the construction suggested by Ms Coumbe is at least a possible reading of the provision. But I think it an unlikely reading in light of the language employed and the purpose of the provision. The expression "called into question" is more apposite to describe that which occurs at the hearing rather than the making of findings by the Coroner. It is also very significant that it is not just the Coroner's opinion which can enliven this provision. It also applies if the region's Senior Police Officer forms the opinion that the conduct is likely to be called into question.

[51] The provision's statutory context is also inconsistent with the interpretation for which Ms Coumbe contends. Procedural protections for those affected by the likelihood of adverse findings are set out in s 15. Further, Ms Coumbe's construction would at least appear to involve the Coroner in some pre-determination.

[52] Nor does the interpretation Ms Coumbe suggests sit well with the purposes of s 23. When s 23 is viewed in the context of the Act as a whole it is apparent that it has several purposes. It is, in part, simply a notice provision, ensuring that those

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[23] *McKenzie v Attorney-General* [1992] 2 NZLR 14 (CA) at 17.
[24] *Commission v Fonterra Co-operative Group Ltd* [2007] 3 NZLR 767 (SC) at [24].

who have a very direct interest in the proceedings are given notice of it. But it does more than that. It is also part of a statutory scheme designed to provide procedural protections to those with a sufficient interest in the proceeding to be entitled to be represented and cross-examine witnesses. Some who fall into that category will be persons entitled to procedural protection because of ties of blood to the deceased.[25] Some, because of financial interest.[26] But some, as is the case here, will have an interest because their conduct is likely to be scrutinised in the course of the inquest.[27]

[53] It is true that s 23(2)(c) captures a potentially wider group of people than s 15. However, that is inevitable if appropriate procedural protections are to be available to the s 15 group. Unlike in proceedings conducted in accordance with the adversarial model, it will often not be plain until well into an inquest hearing that adverse comment about a person's conduct is likely. Perhaps not until the draft findings. But procedural rights not provided until that point in time will often be too late as to the opportunity to challenge prejudicial evidence will have been lost. At the least, this may cause disruption to the proceedings, and worst, unfairness or injustice.

[54] The next issue is, then, whether s 23(2)(c) applied to the applicants in the circumstances. That is, were the applicants persons whose conduct, in the opinion of a senior member of the Police or the Coroner, was likely to be called into question at the inquest? In January 2012, the Coroner received a report from Detective Inspector Bruce Scott, Manager of Criminal Investigations for the Waitemata region, in which the Detective Inspector identified what he categorised as "the somewhat unusual behaviour" of the applicants in not calling the Police as one of six possible contributing factors to Iraena's disappearance. It was thus clear to the Police and, in light of that report, the Coroner, that the applicants' decision-making process in connection with contacting emergency services would be subject to critical scrutiny and, it follows, would likely be called into question at the inquest. I infer from this that either or both the Senior Police Officer or the Coroner had, prior to the request,

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[25] Section 23(2)(a). See *Annetts v McCann*, above n 20, for discussion of a family's interest in the deceased's reputation.

[26] Section 23(2)(d) and (e).

[27] See also s 23(2)(c).

formed the relevant opinion for the purposes of s 23(2)(c). That being the case, the applicants were entitled to notice.

[55] As mentioned above, the applicants argue that s 23 requires more than notification of the time, date and place of the inquest. They say it also requires advice to those falling within s 23(2)(c) of the fact that their conduct is likely to be questioned during the inquest. Ms Coumbe submits that it does not, and that it imposes nothing more than an obligation to advise of the date, time and place of the hearing. That is what s 23(1) requires, and no gloss should be placed upon that. She refers to a number of cases where at issue was whether there is an obligation to advise of the right to legal representation and/or cross-examination, but that is a different issue to that arising here.

[56] The starting point is again the language of s 23. The express wording of the section only requires that those falling within s 23(2)(c) be notified of the date, time and place of the inquest. There is no obligation to provide information that they are receiving that notice because they fall within s 23(2)(c). However, if no more is required by s 23(2)(c) than notice of date, time and place, many such recipients will not know why they are receiving the notice. This is not true of the other categories identified in s 23(2) for whom the reason for receiving notice will be immediately apparent. Generally, if persons falling within s 23(2)(c) do not know that their conduct is likely to be called into question, then the notice will likely be ineffective for one of the purposes for which it is given – that is, to enable the person whose conduct may be called into question at the inquest to decide whether they wish to exercise their s 26 rights.[28]

[57] For these reasons I am inclined to think that to read s 23 as imposing a requirement to notify a person that they, in effect, fall within s 23(2)(c) is to give the section a purposive reading, and one not inconsistent with the language employed. Once notified, the onus would then pass to the recipient of the notice to seek any

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[28] For the same reason, advice as to why notice is being given will be necessary in respect of persons falling within both s 23(2)(c) and one of the other s 23(2) categories.

further clarification, and to decide whether or not to exercise the right to attend, and be represented at the hearing.

[58] If I am wrong and the legislation does not require notice of the fact that a person's conduct is likely to be called into question, I consider that the applicants are correct in their analysis that, in the circumstances of this case, the common law should supplement the words of the statute to ensure that the requirements of natural justice are met. There is nothing in the wording of s 23 that ousts the requirements of natural justice. In this case, fairness required that the applicants be told that their conduct in not calling emergency services would likely be called into question. The Police had already criticised their conduct in briefs of evidence and reports, and the Coroner was aware of this.

[59] The role played by the Police in this inquest is also relevant to this issue. It was known that Police conduct would be subject to scrutiny, likely intense scrutiny, so that the Police had a particular interest in the outcome of the inquest. It was no doubt for this reason that they instructed their own counsel. But, here, the Police had a dual role. They were statutorily obliged to assist the Coroner with the conduct of the inquest. They were also a party independently represented at the inquest. This meant that, in the absence of the applicants having their own legal representation, the Police, another interested party, prepared the applicants' briefs of evidence and called them as witnesses. In these circumstances, it was particularly important for the applicants to know that they were people falling within s 23(2)(c) so that they were able to make an informed decision in respect of their right to legal representation.

[60] In making these observations, I do not criticise the Police. The obligation to notify the applicants was the Coroner's.

(c) Did the Coroner comply with his obligations under s 15(2)(b) to notify the applicants of the proposed comment and give them a reasonable opportunity to be heard in relation to it?

[61] The applicants say that the obligation imposed by s 15(2)(b) was not complied with. When the applicants gave their evidence, they had no understanding that they were at risk of adverse comment. Although they acknowledge that the

Coroner gave Ms Carroll and Ms Woodhouse (but not Mr Woodhouse) the opportunity to comment on Detective Senior Sergeant Sutton's evidence, they say this was not notice for the purposes of s 15, nor was there a reasonable opportunity to be heard. Given the unsatisfactory procedure up to that point it would have been appropriate for the Coroner to have released his finding in draft form and then considered any submissions they wished to make in respect of that draft.

[62] Ms Coumbe submits that natural justice simply requires that a person about whom an adverse comment may be made "should not be left in the dark as to the risk of the finding being made".[29] As to the absence of advance notice, she says that the applicants ought to have been aware of the possibility that the Coroner would find that their decision not to contact Police had contributed to Iraena's death. They ought to have foreseen that their actions would be scrutinised at the inquest due to their involvement in the events on the night Iraena disappeared. Further, the applicants learned of Detective Senior Sergeant Sutton's evidence the night before they were due to give evidence, and the Coroner gave them an opportunity to respond to that evidence the next day. Consequently, the applicants were not "ambushed" by the Coroner's finding, and the substantive requirements of s 15(2)(b) had been complied with.

Factual background

[63] Ms Carroll and Ms Woodhouse have each filed affidavits as to the events leading up to their giving evidence at the inquest. They say that approximately two weeks before the hearing they were contacted by Detective Sergeant Winikerei, one of the officers involved in the original investigation, and asked to go to the Henderson Police Station. At that time the officer gave them copies of their statements to read through to refresh their memory.

[64] The applicants did not attend the first day of the inquest. Nevertheless the evidence given by Detective Senior Sergeant Sutton in which he expressed the opinion that the applicants' failure to call the Police had contributed to Iraena's death

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[29] *Re Erebus Royal Commission; Air New Zealand Ltd v Mahon* [1983] NZLR 662 (PC) at 671.

was the subject of quite extensive media coverage that evening. The applicants heard of his evidence through that press coverage, and both Ms Woodhouse and Ms Carroll were distressed by it.

[65] The next day they attended the inquest. Before giving evidence, Ms Woodhouse and Ms Carroll introduced themselves to Mr Moore, counsel for the Police, and a conversation then took place. Both Ms Woodhouse and Ms Carroll have referred to the content of this conversation in their affidavits, and Mr Moore has also filed an affidavit in which he sets out his recollection. Ms Woodhouse says that during that conversation Mr Moore indicated that he did not think they needed a lawyer. Mr Moore says that he has no specific memory of discussing the need for a lawyer but says that he may well have said that the applicants did not need one as described by Ms Woodhouse. That would, he says, have reflected his own assessment at that time, and his understanding of the coronial process and the requirements imposed on the Coroner by the Act.

[66] All three agree that Mr Moore told Ms Carroll and Ms Woodhouse that they would be warned if adverse comment was to be made about them, and would be given an opportunity to respond to it. Ms Woodhouse and Ms Carroll also recall Mr Moore saying that he would have a word with the Coroner regarding their concern about adverse comment. Mr Moore says he does not believe he would have offered to "have a word" with the Coroner, and suggests that Ms Carroll and Ms Woodhouse misunderstood their discussions in this regard. Given the candid way in which each of these three described events, I am confident that any conflict between the applicants and Mr Moore's evidence on this point is attributable to a misunderstanding. In any event, I do not need to resolve this conflict in evidence, as nothing turns upon it.

[67] During the inquest the three applicants were each called by Mr Moore and read out their briefs of evidence. They were then questioned by the Coroner. Ms Woodhouse began by expressing a desire to comment on Detective Senior Sergeant Sutton's evidence, saying "It wasn't us, we were not the people who failed Iraena". The Coroner further questioned her regarding the decision not to call the Police, asking her to re-visit the issue with the benefit of hindsight:

Q. ...one of the comments that was made by Detective Senior Sergeant Sutton referred to his belief that the failure from anybody in your house to notify the police earlier was a contributing factor.

A. Well, I mean, the thing is that Iraena had actually contacted the police earlier and they had failed her.

Q. Mmm. In hindsight, and hindsight is a wonderful thing. What would you do differently, presented with the same situation?

A. Well I would ring the police straight away because, you know, and it has happened since. […] we get all sorts of people coming to our place at all hours of the night for help for one thing or another and it has happened with another woman who was in trouble and we called the police straight away. I said, "I'm not getting involved in this at all." So, I mean of course we would get involved but we would call the police next time.

Q. All right. Well that is one of the messages I feel needs to come out of this inquest, that the public should realise they need to call the police if they have any concerns for the safety or wellbeing of a person who falls into their care and I am pleased to hear you say that you have come to that realisation yourself and so this may well be a positive that we can bring out of this rather tragic set of circumstances. The particular comment that Detective Sutton said, that may have caused you concern is under the heading of, "Possible contributing factors to her disappearance" he states, "In my view the following factors may have either individually or collectively contributed to Iraena Asher's unstable state and disappearance" and he lists 10 factors, one of which is the decision, "By the Woodhouses and Bobbie Carroll not to call the emergency services in the context of a woman who was obviously showing signs of distress saying she had been kidnapped and drugged." Now that was the detective sergeant's evidence. Do you still refute that that is a contributing factor?

A. Um, look I don't know if it's a contributing factor, but we would do it differently and we have done it differently. But, in the safety of our home, she calmed down so much that – I mean she was much calmer than when we picked her up off the side of the road. So, that – you know, I mean we're not, we were quite considered about whether we should call the police or not, it wasn't that we just didn't bother.

[68] Ms Carroll was likewise asked to comment on Detective Senior Sergeant Sutton's evidence. When doing so she refuted the suggestion that the decision not to call the Police contributed to Iraena's disappearance, and insisted that, in the circumstances, the applicants made the right decision.

[69] Mr Woodhouse was not asked to comment on Detective Senior Sergeant Sutton's evidence, although he had been present when his mother and Ms Carroll

were questioned. He was asked whether he agreed with Ms Carroll's evidence that they had made a considered decision not to call the Police:

> Q. You would have heard Ms Carroll's evidence, in particular but also your mother's evidence, that consideration was given to calling the police during the course of the evening?
>
> A. Yep.
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> Q. And that it was a carefully considered decision that it was not necessary to call the police. Did you agree with that assessment?
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> A. From my perspective, I didn't think it so much that it wasn't necessary, it's that, um, she was in a state where she would and could potentially become quite volatile, and I don't believe that we – I just felt protective of this place and my mother and her partner, and I wanted to try and diffuse the situation as best I could, and given that I had thought that she was on drugs, I thought that eventually it would – as long as everything was kept calm – resolve itself. Had I known that she was mentally unwell, confirmed, of course, things would have been done probably a little differently.
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> Q. So, her behaviour was not so alarming that you felt that you should go off and surreptitiously make a call to the police without her knowledge and then just suddenly they would turn up and take her away?
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> A. Ah, I don't think that, as I mentioned, um, the creation of some way of a rouse of being able to do that is easier said than done, with respect, Sir, in that sort of situation, um. I, she was very alert to that and she was very alert to anyone leaving the room. Now, if I'd known, as I said, other things at the time, then, then maybe....

Decision

[70] I begin with the requirements of s 15(2)(b). The simple point to be made is that the Coroner was obliged to notify the applicants that he proposed to find that their decision not to contact the Police was a contributing factor in Iraena's death. This required him to do more than notify the applicants of the existence of adverse evidence given during the course of the inquest. Issues raised during the course of a hearing may not ultimately be picked up in the Coroner's findings in the light of additional evidence and submissions made (hence the requirement for the s 23(2)(c) notice).

[71] In the present case, the applicants had notice of the content of the Police evidence, although, it must be observed, the only advance notice was through media reports. They did not have notice of the proposed adverse comment. The closest the Coroner came to giving such notice was his comment that he felt one of the messages that needed to come out of the inquest was that the public should realise they need to call the Police if they have any "concerns for the safety of wellbeing of a person who falls into their care". That finding is substantially different in content to the finding he did make. It is a generalised comment, not linked to the particular decisions made by the applicants on that night.

[72] Relevant also is the reassurance the applicants received from their conversation with Mr Moore. I have no doubt this would have allayed the applicants' concerns that the Coroner might comment adversely upon their conduct. I make no criticism of Mr Moore in this connection. He was not privy to the Coroner's thinking on the issue and he has been commendably frank in the evidence he has provided in this proceeding.

[73] What should have been done to provide reasonable notice of the proposed comment, and reasonable opportunity to be heard? Care must be taken to avoid imposing rigid requirements. What is required to comply with s 15(2)(b) will depend upon the particular circumstances of the case. Although the provision of draft findings is not a statutory requirement, I am satisfied that would have been the appropriate step in this case. The following factors indicate that this approach would have been appropriate:

(a) The absence of any notice to the applicants under s 23, which meant the applicants did not have sufficient information to decide whether or not to engage legal representation or to exercise their rights to attend the hearing.

(b) The absence of any notice of the Police criticism of their conduct.

(c) The applicants were not present on the first day of the inquest and did not have the opportunity to hear the Police evidence or challenge it via cross-examination.

(d) Immediately prior to giving evidence they were reassured that they did not need to be legally represented, and that they would be warned if any adverse comment was proposed and given an opportunity to respond to it.

Result

[74] Each of the three grounds for review have been made out:

(a) The Coroner's finding that the applicants' decision not to call the Police was a contributing factor in Iraena's death was unreasonable; because it was based upon speculation as to what might have happened if the applicants had called the Police.

(b) The Coroner's finding was made in breach of natural justice because the Coroner failed to:

(i) Notify the applicants of the fact that their conduct was likely to be called into question during the inquest; and

(ii) Notify the applicants of the proposed adverse comment and to provide them with a reasonable opportunity to comment upon it.

[75] Relief in judicial review proceedings is discretionary. Relevant to the exercise of the discretion here is whether the applicants have been prejudiced by the absence of appropriate procedural protection. I am satisfied that they have been for the reasons set out at [73] above. I therefore grant the relief sought in the amended statement of claim and quash paragraphs [55] to [59] of the Coroner's findings.

[76] I have given consideration to whether I should also direct the Coroner to reconsider this part of the decision. I have concluded that I should not. Were I to

refer this back to the Coroner for rehearing, there is a risk that further scrutiny of the actions of the applicants will deter others from intervening in similar circumstances, because of the knowledge of the extent of scrutiny and even criticism those actions might ultimately attract. It also risks causing further distress to Iraena's family. Although I am conscious that I do not know their attitude to this proceeding, it seems to me that these issues are collateral to the key issue the Coroner had to decide, and did decide. That being the case, I am reluctant to see the proceeding further prolonged, so many years after Iraena's disappearance.

[77] That leaves the issue of costs. The applicants seek costs, but costs would not in the normal course be awarded against the first respondent, a person performing a judicial function. If the applicants wish to be heard in support of an application for costs they should ask the registry to organise a telephone conference before me.

[78] Finally, I note that suppression orders were made by the Coroner. Those orders have been continued by me. This judgment does not contain any of the suppressed material or suppressed names.