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COR REF: CSU-2019-ROT-000481

21 May 2021

NZ Mountain Safety Council
Level 1Harbour City Centre
29 Brandon Street
Wellington 6011

By email: Nathan.watson@mountainsafety.org.nz

Dear Mr Watson

Re: The Late Ji LI

Enclosed for your records is a copy of the Coroner's findings in relation to the above named.

Yours sincerely

Jennifer Chalklen
Coronial Case Manager
Email: Jennifer.Chalklen@justice.govt.nz

CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Ji LI**

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:	Ji LI
Late of:	China
Occupation:	Farmer
Sex:	Female
Date of Birth:	16 July 1968
Place of Death:	Red Crater Mt Tongariro Manawatu-Wanganui New Zealand
Date of Death:	On or about 19 October 2019
Cause(s) of Death	
(a). Direct cause:	Hypothermia
(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 Friday 18 October 2019, Ms Li was hiking with a group in the Tongariro National Park. After the group took the wrong path, Ms Li decided to continue to her destination, while the rest of the group decided to return to their accommodation.

When Ms Li did not return to the group's accommodation, she was reported missing. A search was undertaken, and Ms Li was found deceased later that day on the Red Crater on Mount Tongariro.

I make, under section 57(3) of the Coroners Act 2006, the following 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.

1. A personal locator beacon, is a type of distress beacon. It is a small, lightweight device that is easy to operate. When activated, it transmits a signal via satellite to tell rescuers you need assistance. A distress beacon allows a person to instantly signal for help. They work almost anywhere in the world. The beacon shows rescuers your approximate location and assists

search and rescue. The sooner rescuers can help you, the more likely you are to survive. I recommend that, when hiking alone (particularly outside the hiking season), personal locator beacons are considered an essential piece of equipment, and that they are described as such in publications intended to educate hikers. They can be readily bought or hired.[1] Had Ms Li been in possession of a personal locator beacon and activated it, she may be alive today.

2. Sudden changes to agreed hiking arrangements in unfamiliar environments, with limited or no planning, should be avoided. The present case included a change from the relatively safety of hiking in a group to hiking solo. The originally planned route was reversed due to an early error. If it becomes apparent the majority of a hiking party cannot or chooses not to continue, serious consideration must be given to whether the remainder of the party should continue, particularly if that remainder is a single individual.

3. For those unfamiliar with a hiking circuit, who may be inexperienced, or who may not have optimal fitness levels, I recommend hiking the Great Walks during the summer season, when additional facilities and assistance are available.

4. I understand from the NZMSC report that the navigation error made early on by Ms Li's hiking party is an easy one to make. That is, missing the Mangatepopo/Lower Taranaki Falls Track turn-off. I recommend that improvements are made to the signage at this turn-off to ensure it is easily identified.

5. I recommend that improvements to signage are considered to include greater use of widely spoken foreign languages.

6. Pursuant to section 74 of the Coroners Act 2006, I am satisfied it is in the interests of decency and personal privacy to prohibit the publication of photographs of Ms Li taken during the investigation into her 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: 20 May 2021.

Signed at Hamilton on 21st day of May 2021.

Coroner M Bates

[1] At https://beacons.org.nz/get-a-beacon/hiring-a-beacon/.

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-2019-ROT-000481

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 JI LI**

Date of Findings: 20 May 2021

FINDINGS OF CORONER M BATES

Introduction

[1] Ji Li was born on 16 July 1968 and was 51 years of age when she died. She lived in the People's Republic of China and had travelled to New Zealand for a holiday.

[2] On Friday 18 October 2019, Ms Li was hiking with a group in the Tongariro National Park. After the group took the wrong path, Ms Li decided to continue to her destination, while the rest of the group decided to return to their accommodation.

[3] When Ms Li did not return to the group's accommodation, she was reported missing. A search was undertaken, and Ms Li was found deceased later that day on the Red Crater on Mount Tongariro.

Decision to open and conduct a coronial Inquiry

[4] A Coroner opens and conducts an Inquiry for three purposes.

[5] 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 cause of the death, and the circumstances of the death.

[6] In determining the circumstances of a death, it is important to realise the 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.

[7] 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.

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[1] Section 57(1) Coroners Act 2006

[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.

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

[9] 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 *"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".*[4] (See generally *Anderson v Blashki* [1993] 2 CR 89 (SC) at 96).

Matters already established

[10] Some of the matters required to be established under section 57(2) of the Act are not at issue, they are as follows:

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

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

(c). **When, and where death occurred:** The Police reports and statements provided during the investigation have been accepted as establishing when, and where death occurred.

Issues remaining to be determined by this Inquiry

[11] The issues that I have considered in this Finding are:

1. What were the circumstances of Ms Li's death?

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[4] *Z v Dental Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1 at [102].

2. What was the cause of Ms Li's death?

3. Can any cause or contributing factors for Ms Li's death be identified?

4. Would comments and/or recommendations reduce the likelihood of further deaths in similar circumstances?

Evidence

[12] I have received and reviewed: the post-mortem report; a toxicology report; the Police investigation file which includes witness statements, jobsheets and photographs; and a report prepared by the New Zealand Mountain Safety Council (NZMSC). Based on that evidence I have determined the matters set out below.

Background

[13] Ms Li was from the People's Republic of China and lived in Beijing. Her occupation is listed as 'farmer.' Her son, Red Chen, told Police she had 'a lot of experience hiking, including hiking in the mountains.'

[14] Ms Li arrived in Auckland, New Zealand on 15 October 2019. She was travelling with three other women. They planned to travel around New Zealand for approximately three weeks. On 16 October they drove to Rotorua and on 17 October to Owhango, about 20km north of National Park Village.

Events of 18 – 20 October 2019

[15] On 18 October 2019, the four women set out from Whakapapa Village in the Tongariro National Park. Their intention was to spend two days hiking the Tongariro Northern Circuit. This hike is also known as the Tongariro Northern Circuit Great Walk when traversed between Labour Weekend (the end of October in 2019) and the end of April. The group planned to travel the circuit in the recommended, clockwise, direction. On the first day his would have taken them via Mangatepopo Valley and past the Mangatepopo Hut. They would have then hiked over Red Crater, down Oturere Valley and past the Oturere Hut, before hiking to the Waihohonu Hut. On the second day they

intended to hike from Waihohonu Hut, past Tama Lakes and Taranaki Falls to Whakapapa Village.

[16] The Great Walk season was due to start about a week after the hike by Ms Li and her companions. Because their hike fell outside the season, hut facilities were reduced. The timing of the group's walk meant that Department of Conservation Rangers were not based at the huts. During the season Rangers are resident in them and able to offer weather and track information and assist should an emergency arise.

[17] Off-season there are no emergency radio facilities along the way, hikers are required to be totally self-sufficient. It is recommended they carry a personal locator beacon. Ms Li had all essential equipment and clothing, including a bivouac emergency shelter. She did not have a locator beacon.

[18] After setting off from Whakapapa Village on their way to Mangatepopo Valley the group missed the Mangatepopo/Lower Taranaki Falls Track turnoff, on the northern side of the road. I understand from the NZMSC this error is easily made if hikers are not paying careful attention to track signage. The group failed to discover their mistake for several hours, even passing through a signposted junction pointing to Tama Lakes and Waihohonu Hut, which should have informed them they were heading in the wrong direction. They travelled a considerable distance before finding themselves at Tama Lakes. It is unclear whether language barriers may have affected the group's ability to correctly read the signs. The fact that they travelled approximately a further hour in the wrong direction, having passed through the sign-posted junction that should have alerted them to change their course, suggests they did not have the appropriate navigation skills to complete the intended hike.

[19] Ying Dong, one of the women travelling with Ms Li, told Police that when they arrived at Tama Lakes around 10am, three of them decided to return to Whakapapa Village. Ms Dong did not feel fit enough to complete the hike, and another person in the group felt unwell. At that point, Ms Li decided to continue and complete the hike alone, albeit in the reverse direction of the original plan. She told the other women she intended to stay the night in the Waihohonu hut, and they all agreed to meet at Whakapapa Village the following day, on 19 October 2020.

[20] Ms Li did not return to Whakapapa Village on 19 October and was reported missing to the Chinese Embassy. Around 9am on 20 October 2019, Ms Dong reported Ms Li missing to the Department of Conservation. Police were contacted, and a search was conducted.

[21] At 11:10am on 19 October, Police asked Sarah Cate, Tour Guide, to search the Northern Circuit tracks by helicopter. Ms Cate was unable to find any trace of Ms Li on the established tracks and began to search the Red Crater ridge. She observed an orange colour at the bottom of Red Crater.

[22] Upon closer inspection this appeared to be a person, so Ms Cate landed nearby. When she reached the area where she had seen the orange object she realised it was a person matching Ms Li's description. It was subsequently confirmed to be Ms Li. She was unresponsive when examined. Ms Cate informed the helicopter pilot, who contacted Police.

[23] Ms Cate told Police she thought Ms Li was well dressed and equipped for the conditions. She saw no signs indicating that Ms Li had fallen into the crater. Ms Cate thought it likely Ms Li had entered the crater lower down and had walked to where she was found.

[24] NZMSC have considered several possible scenarios in relation to how Ms Li came to be in Red Crater. They consider the most likely is that, after the rest of the group had turned back from Tama Lakes, Ms Li continued along the track as discussed and reached Waihohonu Hut. If she had left Tama Lakes about 10am, she would have reached the hut about 1pm. Because she was alone, and because the hike on the second day would have been very long, there is good reason to believe she may have changed her plan again and, instead of staying the night at that hut, continued that afternoon to Oturere Hut. That would have taken about three hours, with Ms Li arriving there about 5pm. No one signed the Oturere Hut book that night, so if she was there she may have been alone.

[25] Overnight and during the morning of 19 October 2019 Tongariro experienced blizzard conditions. The weather eased throughout the morning on 19 October, but wind strength increased, continuing at gale-force throughout the day and into the evening, with gusts of up to 150km/h. The temperature remained low throughout the day. Weather data

obtained for Tongariro on 19 October 2019 suggests the air temperature would have been between 1.7 and 4.5 degrees Celsius (C). With wind chill taken into account, the average temperature would have been -4.4 C. According to NZMSC, if Ms Li had set out from Oturere Hut that morning, continuing up the track towards Red Crater, and factoring in the wind chill, she would have encountered a 'feels like' temperature of about -20 C. She would have been very cold, despite being well-dressed.

[26] It is unknown whether Ms Li or anyone in her original travelling group had reviewed the weather forecast prior to setting out on their hike or during it. There is patchy mobile phone coverage in the area and it would have been possible for Ms Li to check the forecast while hiking alone but it is unknown whether she did this.

[27] NZMSC advise that in the conditions Ms Li was experiencing she would have become hypothermic as she continued to hike. That would have resulted in a decline in her cognitive ability and rational decision making capacity, and walking would have become progressively more difficult. It is likely Ms Li began to stumble and fall, as evidenced by minor scratches and bruises observed on her body.

[28] The extreme winds at the time would have made ascending Red Crater Ridge impossible. Whether intentionally or accidentally, Ms Li descended into Red Crater. Human instinct would suggest she was seeking shelter from the wind and cold. Given how she was found, it appears she intended to warm herself by getting into her sleeping bag. Unfortunately, due to the effects of hypothermia, she was likely mentally and physically impaired to such a degree that she was unable to get in the sleeping bag. In those conditions, she would have lost consciousness quickly and eventually died.

[29] Police attended the scene and confirmed Ms Li was fully dressed in appropriate clothing for the environment. Her backpack was tucked under the edge of a large rock, and her sleeping bag and bivouac bag were lying beside her, as was a woollen hat. A lightweight nylon jacket was found a few metres away. Ms Li was partially tangled in a cord from her bivouac bag and her head was partially in her sleeping bag. She was not wearing gloves or a hat. Although Ms Li had a mobile phone in her pack, she was not carrying a personal locator beacon.

[30] There was no evidence to suggest Ms Li had fallen from the high bluffs nearby. She did have minor injuries, which suggested she may have tripped or slipped on rocks.

What was the cause of Ms Li's death?

[31] A post-mortem examination of Ms Li was completed on 25 October 2019 by Pathologist Dr Elaine Bekker. Ms Li had some bruising and superficial abrasions, but there were no significant injuries or fractures found. An internal examination revealed small gastric erosions. One of the coronary arteries showed a possible fresh haemorrhage. However, there was no evidence of remote or recent myocardial infarction (heart attack).

[32] As part of the post-mortem process, toxicology analysis was undertaken by ESR. It did not reveal any alcohol or drugs, with the exception of caffeine, in Ms Li's blood. Alcohol was detected in Ms Li's urine at a level of 23 milligrams per 100 millilitres.

[33] Acetone was detected in Ms Li's blood at a level of less than 10 milligrams per litre (mg/L), and in her urine at an approximate level of 30 mg/L. ESR advise that in healthy individuals blood acetone levels are usually lower than 10 mg/L. Elevated acetone concentrations most commonly arise from uncontrolled diabetes or a prolonged period of fasting, starving or exercise. Chronic alcohol use and hypothermia may also result in elevated acetone levels. After acetone passes from the blood into the urine, it stays in the urine unchanged. Therefore, in cases involving elevated acetone levels, an elevated urine acetone level may exist after acetone in the blood has fallen to a normal level.

[34] Dr Bekker noted that small gastric erosions, such as those discovered at post-mortem, are a soft sign of hypothermia. As already stated, acetone in the blood and urine can also be an indicator for hypothermia. Although Ms Li's exact cause of death could not be ascertained, hypothermia was the most likely cause.

[35] Having considered the circumstances of Ms Li's death and Dr Bekker's evidence, I find it highly likely that the cause of Ms Li's death was hypothermia.

Can any cause or contributing factors for the death be identified?

[36] According to the NZMSC "the groups decision to attempt this three-day trip in two days applied an unnecessary and unrealistic element of complexity and pressure,

essentially resulting in the trip becoming an overambitious choice that was unsuited to the weather and timeframes. This, combined with the decision to split up and for Ms Li to go it alone, were the two primary causation factors." I agree with that assessment.

[37] Department of Conservation information states the Tongariro Northern Circuit usually takes between two and four days to complete. While it is possible to complete the circuit in two days, each day would have at least eight hours of hiking. When hiking the Northern Circuit in two days, it becomes significantly more difficult and a high level of fitness is required.

[38] Ms Li and her travelling companions realised on day one of their walk that they had taken a wrong turn. They could have chosen to carry on together, turn and go the originally intended way together, or return to Whakapapa Village together. Any of these three options may have resulted in a different outcome for Ms Li. Instead, three of the group elected not to continue and returned to Whakapapa Village and Ms Li continued alone. Ms Li's decision to continue alone meant she no longer had others to assist with decision-making, to support her, or to express thoughts or concerns.

[39] As confirmed by the NZMSC, even for the most experienced New Zealand hikers, solo journeys have their risks. The situation would have been considerably more challenging for a recent New Zealand arrival with no experience of the area. Although Ms Li had a mobile phone with her, if travelling solo it is advisable to have a personal locator beacon.

[40] By the time Ms Li reached the Oturere Hut on day one, she would have been hiking for approximately eight hours. As previously noted, her approximate arrival time would have been 5pm. She may have stayed the night in Oturere Hut, the most likely scenario. However, it is also possible Ms Li decided to continue further to Mangatepopo Hut and stay there.

[41] If Ms Li had chosen to continue to Mangatepopo Hut, a less likely scenario given the time of day and how far she would already have hiked, then by the time she reached Red Crater on her way, she would have encountered darkness, extreme cold, fatigue, and

disorientation. This could also explain her leaving the established track and travelling into Red Crater where she was eventually found.

[42] Uncertainty will remain regarding Ms Li's exact route, timing of rest stops and use of huts along the way. On either scenario, the weather was the immediate cause of Ms Li becoming hypothermic and passing away.

[43] NZMSC advise that three key decisions appear to have contributed to Ms Li's death. They were:

- Not choosing a trip that was right for her/the group;
- Not checking the weather forecast to see what effect that would have on their hike; and
- Not taking care of each other by staying together.

Findings

[44] Ji Li died at Red Crater, Mount Tongariro, Tongariro National Park, New Zealand sometime between 18 and 20 October 2019. The most likely scenario finds Ms Li staying the night in a hut on 18 October and continuing her travels on the 19th, when she encounters extreme weather conditions. It is therefore likely she died on 19 October 2019 and that is the date I fix for her death. I find that Ms Li died on 19 October 2019 due to hypothermia.

Comments and recommendations

[45] Ms Li's death is a tragic reminder of the risks inherent in solo mountain hiking. Pursuant to s 57(3) of the Coroners Act 2006, I make and adopt the following comments:

[46] The Department of Conservation offers safety advice for the Tongariro Northern Circuit:[5] It is important to plan your trip thoroughly to make sure you stay safe. Before

[5] Department of Conservation "Plan and prepare: Tongariro Northern Circuit". See also https://www.doc.govt.nz/parks-and-recreation/places-to-go/central-north-island/places/tongariro-national-park/things-to-do/tracks/tongariro-northern-circuit/know-before-you-go/

you go, know the Outdoor Safety Code – 5 Simple rules to help you #MakeItHomeNZ. The rules are:

1. **Plan your trip.** Choose a trip that fits your abilities. Make sure you have enough time to do your walk, plus extra time. Book accommodation, transport and transfers to the start/end of the track early.

2. **Tell someone your plans.** Tell someone where you are going and when you'll be back. Ask them to call emergency services if you haven't returned on time. Consider carrying a personal locator beacon, as there is no cell phone reception on most tracks.

3. **Be aware of the weather.** New Zealand's weather is very changeable. Even if it's summer or the forecast is good, you should always carry a rain jacket and warm clothing. Check metservice.com for the most up-to-date forecast.

4. **Know your limits.** A good level of fitness is needed to walk the track. Read about the track carefully to make sure it suits your abilities. Always follow the track markers and signposted tracks – going off-track can be hazardous, even for experienced walkers. Don't be afraid to turn back.

5. **Take sufficient supplies.** Take the right gear, including extra food, clothing and equipment in case something goes wrong. You'll have to carry everything you need, as you can't buy food or equipment at Great Walks huts or campsites.

[47] The NZ Mountain Safety Council has a clear focus on preventing further outdoor recreation fatalities. They also reference the matters referred to in the previous paragraph, expand on them, and suggest the following recommendations that may prevent further deaths in similar circumstances. The NZ Land Safety Code provides five essential steps for staying safe in the outdoors. They are:

1. **Choose the right trip for you** - Learn about the route and make sure you have the skills for it. It's important to choose a trip that suits you and everyone in

your group. When you are looking at the options, make sure you think about everyone's fitness levels and experience in the outdoors.

2. **Understand the weather** - It can change fast. Check the forecast and change your plans if needed. Weather can make or break a trip. It's one of the most important things to consider when going into the outdoors. No matter what the weather is, it will impact your trip. Bad weather such as strong wind, rain and cold temperatures can be very dangerous. The weather changes fast in New Zealand and you should be prepared for any weather. It can be sunny, rainy and windy all in one day. Before any trip, check the weather using New Zealand's public weather forecasting service, metservice.com. If there is bad weather forecast, think carefully about whether your trip will be safe and consider changing or cancelling your plans. Pay careful attention to weather watches or warnings in the area you are planning on visiting.

3. **Pack warm clothes and extra food** - Prepare for bad weather and an unexpected night out. Any trip, even if it is short or easy, needs preparation. Packing the right things makes trips safer and more enjoyable.

4. **Share your plans and take ways to get help** - Telling a trusted person your trip details and taking a distress beacon can save your life. Any time you are going into the outdoors you should:

- Share your plans with someone you trust. Tell them where you are going and when you will be back. If they don't hear from you by an agreed time, they should call 111 and ask for the police. There are lots of ways to share your plans. You can write down the information on paper for your trusted person, email them, text them, or use www.PlanMyWalk.nz;

- Think about how you would call for help if you needed to. Cell phone reception can be patchy or non-existent outside towns and cities, so consider taking a distress beacon.

- If you visit a Department of Conservation hut (even if you aren't staying the night), fill in the Intentions Book.

5. **Take care of yourself and each other** - Eat, drink and rest, stick with your group and make decisions together. The best way to enjoy your experience in the outdoors and make it home safely is to look out for one another. Stop regularly to eat, drink and rest. Discuss how everyone is feeling. If someone is struggling, don't keep going – have a break and consider changing plans. Make decisions together. It's important that all group members agree to changes in the planned route or transport arrangements. You should also stop and wait at every track junction/bridge to ensure you're still all together. Don't just walk on ahead and leave them to meet you at the end of the trip. Decisions to separate should only be made in an emergency situation, and even then, the risks should be evaluated and mitigated. The most vulnerable people in the group should never be left alone.

[48] Of these, Ms Li and her group had adequately addressed step 3 - Pack warm clothes and extra food, and step 4 - Share your plans and take ways to get help, however, steps 1, 2 and 5 were not followed.

[49] Pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendations:

[50] A personal locator beacon, is a type of distress beacon. It is a small, lightweight device that is easy to operate. When activated, it transmits a signal via satellite to tell rescuers you need assistance. A distress beacon allows a person to instantly signal for help. They work almost anywhere in the world. The beacon shows rescuers your approximate location and assists search and rescue. The sooner rescuers can help you, the more likely you are to survive. I recommend that, when hiking alone (particularly outside the hiking season), personal locator beacons are considered an essential piece of equipment, and that they are described as such in publications intended to educate hikers. They can be readily bought or hired.[6] Had Ms Li been in possession of a personal locator beacon and activated it, she may be alive today.

[6] At https://beacons.org.nz/get-a-beacon/hiring-a-beacon/.

[51] Sudden changes to agreed hiking arrangements in unfamiliar environments, with limited or no planning, should be avoided. The present case included a change from the relatively safety of hiking in a group to hiking solo. The originally planned route was reversed due to an early error. If it becomes apparent the majority of a hiking party cannot or chooses not to continue, serious consideration must be given to whether the remainder of the party should continue, particularly if that remainder is a single individual.

[52] For those unfamiliar with a hiking circuit, who may be inexperienced, or who may not have optimal fitness levels, I recommend hiking the Great Walks during the summer season, when additional facilities and assistance are available.

[53] I understand from the NZMSC report that the navigation error made early on by Ms Li's hiking party is an easy one to make. That is, missing the Mangatepopo/Lower Taranaki Falls Track turn-off. I recommend that improvements are made to the signage at this turn-off to ensure it is easily identified.

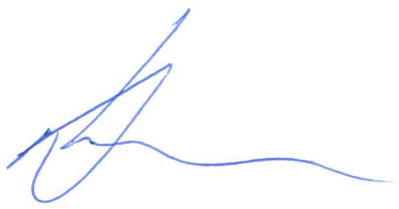
[54] I recommend that improvements to signage are considered to include greater use of widely spoken foreign languages.

Restrictions on publication

[55] Pursuant to section 74 of the Coroners Act 2006, I am satisfied it is in the interests of decency and personal privacy to prohibit the publication of photographs of Ms Li taken during the investigation into her death. I am satisfied that such interests outweigh the public interest in the publication of that evidence.

Condolences

[56] I take this opportunity to extend my condolences to Ms Li's family and friends.



Coroner Matthew Bates