IN THE CORONERS COURT
HELD AT AUCKLAND

Decision No 89 /12

IN THE MATTER of the Coroners Act 1988

AND

IN THE MATTER of Inquests into the Deaths of **CHRISTOPHER AREPA KAHUI AND CRU OMEKA KAHUI, INFANTS**

Before: Coroner G L Evans

Dates of Hearing:
4-8 October 2010
11-15 October 2010
1-5 November 2010
8 November 2010
27-30 June 2011

Appearances:
Mr Simon Mount, Counsel for New Zealand Police
Mr Christopher Morris, Counsel Assisting the Court, with him Ms Emma Staples
Mr C Wilkinson-Smith, Counsel for Mr Chris Kahui (October Hearings)
Mrs Michele Wilkinson-Smith, Counsel for Mr Chris Kahui (November 2010 and June 2011 Hearings)
Ms Marie Dyhrberg, Counsel for Ms Macsyna King
Mr Adam Ross, Counsel for Counties-Manakau District Health Board
Ms Anna Adams, with her Ms Claire Campbell, Counsel for Auckland District Health Board
Mr Adam Lewis, Counsel for Dr Jane Vuletic
Mr Harry Waalkens QC, Counsel for Dr Mildenhall
Ms Deborah Mury, Senior Legal Advisor, Ministry of Social Development (October Hearings) and Ms Hayley Bowman
Ms Joanna Holden, Crown Counsel, Counsel for Ministry of Social Development (November Hearings)
Ms Karen Rose, representing Ms Jane Eyres

Date Final Submissions Received: 7 May 2012

Date of Decision: 2 July 2012

RESERVED FINDINGS OF THE CORONER

These Findings comprise two parts. Part I seeks to establish those matters referred to in S15(1)(a) of the Coroners Act 1988. Part II is given over to the phenomenon of child abuse in New Zealand, of which this case is a subset.

PART I

INTRODUCTORY

[1] On the afternoon of Monday, 13 June 2006 Auckland Police received a telephone call from a staff member of Kidz First Children's Hospital, situated adjacent to Middlemore Hospital in Otahuhu, advising that hospital staff were treating two seriously injured twin infants ("the twins"). Their names were Christopher Arepa Kahui and Cru Omeka Kahui. Police went immediately to the hospital to investigate the causes and circumstances of the twins' injuries. That evening, the twins were admitted to the Paediatric Intensive Care Unit at Starship Hospital. There, the true nature and extent of their injuries became known. On Sunday 18 June 2006, following the withdrawal of life-support intervention, the twins died as a result of the injuries they had received.

[2] The twins' deaths were reported to Auckland Coroner Sarn Herdson, who directed that they be made the subject of post-mortem examination. Autopsies were carried out by Dr J Vuletic, forensic pathologist, who reported to the Coroner the results of her examination. Dr Vuletic reported that the cause of death in each case was traumatic brain injury.

POST-MORTEM REPORTS

Christopher Kahui

[3] Dr Vuletic reported that the body of Christopher Kahui appeared consistent with the stated age of three months. A 2.6 x 1.1 cm triangular red bruise was present in the posterior scalp in the occipital area of the midline. A blood-filled blister was present in the skin of the right flank, measuring 1.8 x 0.6 cm. The cardiovascular and respiratory systems were found to be normal, excepting that there were healing fractures of the right 5th, 6th and 7th ribs and the left 3rd, 4th and 5th ribs. The gastrointestinal, genitourinary, haemopoitic and endocrine systems were normal. Examination of the musculoskeletal system showed a fresh fracture present in the mid-shaft of the right femur, which showed complete displacement and no evidence of healing. Examination of the central nervous system showed, in addition to the bruising of the posterior scalp already mentioned, an abnormality in the occipital area involving a suture between the occipital bone and left parietal bone, resulting in a step-like deformity. There was no evidence of skull fracture. The brain was examined. There was no severe generalised swelling and no bulging of the fontanelle membrane. The "tonsils" of the small cerebellar hemispheres were not lengthened. There were a few tiny red shiny blood clots in the subdural space deep to the skull over the surfaces of the large or cerebral brain hemisphere. Two veins running across the surface of the left cerebral hemisphere were enlarged and filled with ante-mortem blood clots. There was no rust-coloured staining of either the dural membrane lining the skull or of the brain surfaces. There had been some haemorrhaging into the brain. There was an area of red subarachnoid blood measuring about

55 x 30 millimetres on the inferior lobule of the left parietal brain lobe. Within the white tissue regions of the left inferior parietal and temporal lobes was a shiny red blood clot measuring about 60 millimetres in maximum width. The clot lay outside the deep-line basal ganglia and thalamus. Smaller red subarachnoid haemorrhages were seen on the under-surfaces of both frontal brain lobes. There were irregular haemorrhages in white tissue deep to these, the largest being about 10 millimetres in depth. Tiny subarachnoid haemorrhages were seen in the back edge or pole of the right occipital brain lobe. Scattered small red haemorrhages were seen in white tissue of this occipital lobe. Small blood clots were seen in the deep cerebrospinal fluid-containing cavities of the brain. There were a few small collections of pinpoint haemorrhages in the surface grey tissue of the right parietal brain lobe close to the midline, in the parasagittal zone. Microscopic sections of the left temporal lobe, orbital surface, right medial parietal and right occipital regions, where haemorrhages were found, were examined. The characteristics of the lesions found were in keeping with haemorrhages having occurred into the so-called contusional tears, a variant of brain bruising seen in young infants. The appearances were compatible with an age of 5 – 7 days. The bruises and focal nerve fibre injuries seen in the mid-brain and pons were of a similar age. There were older foci of subarachnoid haemorrhages in the frontal and orbital region which were probably a few weeks of age at least and are of uncertain significance. Dr Vuletic comments that the findings indicate traumatic brain injury in which the impact rather than the shaking component of the "shaken-impact" syndrome has been important. Secondary changes, or complications, included bleeding into the brain, bruises and nerve cell death from a poor blood flow to the brain. Histology sections of the left 4th and right 5th ribs showed healing fractures of not less than 14 days of age. In addition, next to the epiphysis in each rib there were recent fractures consistent with an age of a few days. Histology sections of the right femur showed fibroblast proliferation at the periosteum associated with fibrin and acute inflammatory cells, consistent with an age of a few days. Dr Vuletic goes on to show:

> "*Summary of findings*
>
> 1. *Bruise on head*
> 2. *Traumatic brain injury*
> 3. *Fracture of right femur*
> 4. *Healing and fresh bilateral rib fractures*
>
> *Comment*
>
> *Post-mortem examination established the cause of death as brain injury secondary to trauma which occurred 5 – 7 days prior to death (based on histological appearances). The bruise on the back of the head is consistent with blunt force trauma. The fracture of the right femur is recent and is consistent with having occurred 5 – 7 days prior to death. The rib fractures are somewhat older and based on histological appearances are consistent with an age of no less than 14 days. There is also evidence of fresh fractures in the ribs adjacent to the older fractures.*

Cru Kahui

[4] In the case of Cru Kahui, Dr Vuletic said a blood-filled blister was present in the left axilla, measuring 0.8 x 0.5 cm. The cardiovascular, genitourinary and haemopoitic systems were normal. Healing fractures were present in the thoracic cage involving the left 3rd to 8th

ribs and the right 1st and 3rd to 6th ribs. The fractures were located several centimetres adjacent to the costochondral junctions anteriorally. No other abnormalities were found in the respiratory system. The gastrointestinal system was normal excepting for the presence of 10ml of clear yellow fluid in the peritoneal cavity. Focal areas of fibrin deposition were present in the right upper quadrant around the appendix and in the area surrounding the ascending colon. No localised area of injury was identified, but the peritoneal lining overlying this area appeared congested. A small area of haemorrhage was present in the right adrenal gland. The endocrine system was otherwise normal. The skull was free of injury, with normal thickness. The brain did not show severe generalised swelling. The fontanelle was not bulging. There were some small red shiny subdural blood clots lying deep to the skull and over the surfaces of the large cerebral brain hemispheres. No rusty-coloured staining was seen in the dural membrane lining the skull or in the membranes covering the brain's surface. Small patches of red subarachnoid blood were seen on the under-surfaces of the frontal brain lobes, with pinpoint haemorrhages also seen in the underlying brain tissues. Some small clefts were found in sub cortical tissues of the orbital or under-surfaces of both frontal brain lobes. Other small red subarachnoid haemorrhages were seen on the under-surfaces of the temporal and occipital brain lobes, but there were no haemorrhages in the underlying brain. There were no haemorrhages in the callosal bridge spanning the large cerebral hemispheres or in the brain stem or cervical spinal cord in the neck. Reddening, swelling and patchy tissue death with fragmentation was found in the parasagittal zone of the frontal brain lobe. In the parietal and occipital brain lobes these changes spread progressively to involve much of the cortex and sub cortical white matter, chiefly in regions supplied by the anterior and middle cerebral artery. The deep-lying basal ganglia, the brain stem and the small cerebellar hemispheres were unremarkable. Microscope sections of the brain showed a few tiny granules of haemosiderin in the small haemorrhages in the wall of the clefts in frontal lobe white matter. There were other microscopic foci of haemorrhage and glial reaction in frontal white matter without clefting. The appearances were consistent with contusional tears or brain bruises of a form that may be seen in young infants as a result of trauma. The tissue appearances were compatible with contusional tears of about 5 – 7 days of age. There was necrosis of cortex and superficial white matter in parts of the occipital cortex with vascular reaction and established macrophage formation. Selective neuronal necrosis was seen in many neurons in the sensitive sector of the hippocampus and in microscopic foci in the caudate nucleus, putamen, thalamus, basal pons and in the depths of some cerebellar cortical culci. The mid-brain, medulla and spinal cord were spared ischaemic damage. These findings were consistent with severe global hypoxia/ischaemia in which hypotension probably played a major role. The appearances were compatible with an age of about 5 – 6 days. Dr Vuletic comments that the finding of contusional tears in the brain is consistent with traumatic brain injury. She says such tears indicate that the impact rather than the shaking component of the "shaken impact" syndrome has been important in brain trauma causation. The secondary changes, consisting of extensive nerve cell death, is likely a complication due to poor blood flow to parts of the brain due to low blood pressure. Dr Vuletic concludes her report thus:

"*Summary of findings*

1. *Traumatic brain injury*
2. *Focal acute colitis and peritonitis*
3. *Healing rib fractures*

Comment

Post-mortem examination established cause of death as brain injury secondary to trauma. Appearances were consistent with the injury occurring 5 – 7 days prior to death. There is also evidence of colitis and focal peritonitis, the cause of which was not evident at post-mortem examination. Healing rib fractures are present which are consistent with occurring not less than 14 days prior to death."

TWINS' FATHER CHARGED AND ACQUITTED OF THEIR MURDER

[5] Following the completion of Police enquiries into the causes of the twins' deaths, their father, Mr Chris Kahui, was charged with their murder. Following a trial that commenced in the Auckland High Court on 14 April 2008, Mr Kahui was found on 22 May of that year to be not guilty of their murder.

THE INQUESTS

[6] Inquests into the twins' deaths were opened by Coroner Herdson. The orders for disposal of the twins' bodies, made by the Coroner on 19 June 2006, state in each case that an inquest will be held.

[7] The statute in force at the time of the twins' deaths, governing inquiry into the causes and circumstances of their deaths, was the Coroners Act 1988 (the Act). Although that statute has since been the subject of repeal, its provisions continue to govern this proceeding through the transitional provisions contained in its successor, the Coroners Act 2006.

[8] S28(1) of the Act provides, materially, that a Coroner to whom a death has been reported may adjourn an inquest opened into the death if the Coroner has been informed that some person has been charged with a criminal offence relating to the death and is satisfied that to proceed with the inquest might prejudice the person, in which case the Coroner shall not proceed with the inquest until criminal proceedings have been finally concluded.

[9] The Coroner's files in respect of the twins' deaths show that Coroner Herdson was early informed by Police that a prosecution would follow. The inquests opened into the twins' deaths were effectively adjourned, in terms of S28(1) of the Act, upon receipt of that advice, and no further action was taken until the prosecution had been completed and time within which to appeal had expired.

[10] S28(6) of the Act provides that a Coroner may decide not to resume an inquest that has been adjourned if satisfied that the matters specified in S15(1)(a) of the Act have been established in respect of the death concerned in the course of the criminal proceedings.

[11] S15(1)(a) of the Act provides that a Coroner holds an inquest for the purposes of establishing, so far as is possible, that a person has died; the identity of that person; when and where the person died; the causes of the person's death; and the circumstances of the death. The Coroner is charged with making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred which may, if drawn

to public attention, reduce the chances of the occurrence of other deaths in such circumstances.

[12] Coroner Herdson resigned her office as Coroner in November 2007. Subsequently the Chief Coroner, His Honour Judge Neil MacLean, designated in writing the present Coroner, who was warranted under the Act, to conduct an inquiry into each death.

[13] It was decided by the present Coroner that because he could not be satisfied that all the matters specified in S15(1)(a) of the Act had been established so far as is possible, and because the further inquiries falling to be made to establish the circumstances of the twins' deaths were likely to give rise to the making of recommendations in terms of S15(1)(b) of the Act, with preventative effect, the inquests must be resumed. The criminal trial and its outcome excited considerable public interest and concern, drawing calls from all sections of society for an inquiry as to how the twins came to fall into harm's way and whether existing State systems of care were adequate to protect vulnerable infants from harm and to make them safe.

[14] On any reasonable consideration of the matters set out in paras (a) – (e) of S20 of the Act, a Coroner could not but conclude that inquests must be held. In the case of each infant the causes of death appeared to be unnatural and violent. Each death appeared to be due to actions and/or inactions on the part of another or other persons. There existed allegations, rumours, suspicions and public concern (which increased over time) about the deaths; and it might reasonably be concluded that "the drawing of attention to the circumstances of the death[s] might be likely to reduce the chances of the occurrence of other deaths in similar circumstances".

[15] The Court is satisfied on the evidence before it that Christopher Arepa Kahui and Cru Omeka Kahui died at Starship Hospital, Auckland, on 18 June 2006 and that the medical cause of each death was traumatic brain injury. It remains for the Court to establish on the evidence before it the causes (in the wider sense of that word) and the circumstances of the twins' deaths.

[16] It is apposite at this point to note that the noun *cause* is defined by the New Shorter Oxford Dictionary (1993) as "that which produces an effect or consequence: an antecedent or antecedents followed by a certain phenomenon. M E. b. A person or other agent who occasions something with or without intent".

THE LAW

[17] It is well-settled law that the Coroner must set the bounds of his or her inquiry: *R v HM Coroner for North Humberside and Scunthorpe ex p Jamieson* [1995] QB 1 at 26 (CA). See also *Abbott v Coroners Court of New Plymouth and others* (HC, New Plymouth civ 2004 - 443-660, 20 April 2005, Randerson J). As famously stated by Lord Lane C J in *R v South London Coroner, Ex P Thompson (1982) 126 S J 625,* emphasising the inquisitorial nature of the inquest process:

> "Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial ... The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires."

[18] The functions of the High Court, sitting in its criminal jurisdiction, are obviously different to those of this Court. It was the function of the jury in Mr Kahui's criminal trial to hear out the evidence presented by the Crown and, assisted by the directions of the presiding Judge, to determine whether the charges of murder preferred against him had been made out according to the standard of proof applicable to the criminal law. The function of this Court is to establish, so far as is possible, the causes and circumstances of the twins' deaths. How did they come to fall into harm's way? What were the circumstances in which they suffered their traumatic brain injuries? If the injuries suffered by them were non-accidental in nature, does the evidence admit of knowledge as to the identity of the perpetrator(s) of such injuries? The principles and authorities relating to the standard of proof applicable to inquests such as this will be discussed *post*.

[19] In *R v HM Coroner for North Humberside and Scunthorpe, ex p* Jamieson *(supra)*, the Court of Appeal laid down at p26 the nature of the duty of a coroner investigating a death that has occurred in custody in this way:

> "It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry."

Whilst the deaths that occurred in these cases are not of the kind specifically addressed by the Court of Appeal in *Jamieson*, they are deaths of infants that occurred whilst they were in parental custody and care, and have excited (as stated in para [13] hereof) considerable public interest and concern. It is the Court's view that the statement by the Court of Appeal of the nature of the duty incumbent upon Coroners investigating deaths in custody is of equal application in these kinds of cases.

[20] The Court will trace the sequence of events having relevance to this inquiry, beginning with the twins' births and ending with their deaths. Such narrative will incorporate the Court's findings of fact and will be accompanied by the kinds of explanatory statements and comments that accompany all judicial decisions, in addition to comments falling to be made under S15(1)(b) and (2) of the Act.

PHENOMENON OF CHILD ABUSE

[21] The Court is concerned with the phenomenon of child abuse in New Zealand, of which these deaths form a tragic sub-set. Following completion of the exercise set out in para [18] above, the Court will go on in Part II to examine the larger issues referred to.

CORONER'S DISCRETION AS TO MODE OF ADMISSION OF EVIDENCE

[22] S26(5) of the Act provides that, subject to sub-section (6), a Coroner may admit at an inquest any evidence that the Coroner thinks fit, whether or not it would be admissible in a court of law. Sub-section (6) provides that a Coroner shall not admit any evidence at an inquest unless satisfied that its admission is necessary or desirable for the purpose of establishing any matter specified in S15(1)(a) of the Act.

[23] The provisions of S26(5) of the Act were the subject of consideration by the High Court in *Abbott v Coroners Court of New Zealand (supra).* The Court held that the Coroner is vested with a discretion to decide whether it is appropriate to examine any of the witnesses who gave evidence at the criminal trial (para [44]). The Coroner, it held, is entitled to admit as evidence the transcript of evidence and exhibits from the criminal trial without calling the witnesses for examination at the inquest (para [45]).

[24] It was determined by the Coroner that he should hear the evidence of Mr Chris Kahui and of a number of the witnesses who gave evidence at the criminal trial, namely:

Detective Sergeant Christopher Barry
Ms Macsyna King
Mr Stuart King
Ms Mona Kahui
Ms Emily King
Mr William (Banjo) Kahui
Ms April Saunders
Mr Shane Saunders (also known as Shane Mohr)

The Court will draw upon the transcript of evidence and exhibits from the criminal trial whenever it is satisfied that the admission of such evidence is necessary or desirable for the purpose of establishing the causes and circumstances of the infants' deaths.

[25] The evidence of the witnesses named in the preceding paragraph was heard during the periods 4 – 8 and 11 – 15 October 2010. The Court subsequently sat on 1 – 5 and 8 November 2010, when it heard evidence from:

Mr Pou Hepi
Mr Paul Curry, CEO, Families Commission
Dr John Angus, Children's Commissioner
Ms Rachael Smith, Policy Advisory, SHINE
Detective Superintendent Winston Van der Velde, National Crime Manager, New Zealand Police
Mr William (Banjo) Kahui

Ms Nadine Ingham
Ms April Saunders (now Martin)
Mr C Davidson
Ms Kathryn Stent (nee Greenwood)
Ms Jane Eyres
Mr Shane Harris
Ms M R Poto
Ms Dianne Rainey
Mr Raymond Smith (then) Deputy Chief Executive Officer, Child and Young Persons Service, Ministry of Social Development
Dr Gopi Nayar, GP
Dr Jane Zuccollo, Perinatal Pathologist
Dr Jane Vuletic, Forensic Pathologist
Dr Lindsay Mildenhall, Neonatologist
Dr Patrick Kelly, Paediatrician.

[26] During the period 27 - 30 June 2011 the Court heard evidence from a panel of medical experts, namely Dr Patrick Kelly, Professor Roger Byard, Dr Terence Donald and Dr Carole Jenny. It also heard evidence from Ms Mona Kahui and Mr E Tuari.

PRELIMINARY EVIDENCE – PROVEN FACTS

[27] Christopher Arepa Kahui and Cru Omeka Kahui were born at National Women's Hospital, Auckland, on 20 March 2006. They were subsequently transferred to the Neonatal Unit of Middlemore Hospital. Their mother was Macsyna Pono King, then aged 29 years. Their father, Ms King's partner, was Christopher Sonny Te Aroha Kahui, then aged 21 years. There was an earlier child of their relationship, Shane Kahui, then aged 13 months.

[28] The intimate relationship formed between Ms King and Mr Kahui was informal in nature and brief in duration, and led to the birth of three children within a year or so. There is a history of abuse and/or neglect of both parents when they were children. The pregnancy giving rise to the birth of the twins was unplanned, unexpected and unwanted. A question subsequently arose as to paternity. At the time Macsyna King became pregnant with Shane, her partner was only 19 years old.

[29] The twins were born at 29 weeks gestation. They were born some 8 weeks prematurely. They were delivered by emergency caesarean section. Their respective birth weights, head circumferences and lengths were clinically satisfactory. Their lungs were in good condition at birth. The only form of respiratory support needing to be provided was continuous positive airways pressure, discontinued after seven days. The twins' eyes were examined prior to their discharge on 7 May and were found to be normal. The twins received the usual immunisations. A detailed neuro-developmental examination was undertaken prior to discharge from hospital, which showed that their development was in keeping with their gestational age of 36 weeks. Discharge weights were satisfactory. *There was no evidence of apnoea of prematurity.* The nursing notes over the period of 30 days down to the twins' discharge show that their mother, or both parents, attended on only 11 of those days, that their visits were often fleeting and that the activities that staff members would encourage parents to engage in, such as changing nappies and assisting with feeding, often were not undertaken.

[30] On 4 May 2006 a social worker, Ms Nadine Ingham, met with Ms King at Middlemore Hospital because of concern about "lack of visiting from both parents." Ms King explained the reasons for such poor visiting history as being moving house, no family car, caring for Shane and the twins having the best possible care.

[31] However, Ms King roomed in with the twins for three nights and four days (described as minimal) under staff supervision, and the supervising paediatrician commented that she did very well. Ms King is shown to have managed the nappies and the feeding quite adequately. The twins' weight gain after those four days was adequate, on the evidence of Dr Mildenhall, Neonatologist, for staff to permit the twins to go home. The twins continued to flourish following their return home, causing Dr Mildenhall to say "so that somebody was doing a very good job". Dr Mildenhall said that after discharge the twins were "very uncomplicated babies to look after". He described them as "very robust". He said the twins did not require home apnoea monitoring because they behaved so well. He said that in many ways they behaved beyond their corrected gestational age. He described them as "quite mature". The Court accepts and adopts the evidence of Dr Mildenhall.

KAHUI AND KING FAMILY MEMBERS

[32] Reference will be made, as these findings develop, to other Kahui and King family members. Those family members include Stuart King, brother of Macsyna King, and Mona Kahui, sister of Chris Kahui. They were partners, having a child named Cyene Kahui. Macsyna King, and her brother Stuart King, had five other siblings: Emily King, Denise King, Fiona King, Robert King and Alan King. Emily King and her partner, Pouata Hepi, had a child named Ellen. Chris Kahui and his sister, Mona Kahui, had six other siblings (or half siblings): Charlene Kahui, Elvis Kahui, Eva Kahui, Frank Kahui, Tracy Stihl, Herman Stihl, William (Chantelle) Kahui and Tania Kahui. Charlene, Frank and Tania had different mothers; Tracy and Herman had different fathers. The parents of the Kahui siblings referred to (with the exceptions above noted) were Gwendeline Hetaraka and William (Bill/Banjo) Kahui.

[33] Following the twins' discharge from the Neonatal Unit of Middlemore Hospital on 7 May 2006, they were taken to their parents' home at 22 Courtenay Crescent, Mangere East. Also living in that house with Chris Kahui, Macsyna King and their son Shane, were Stuart King and Mona Kahui, with their baby daughter Cyene.

[34] Following their discharge from hospital, the twins were seen by health professionals on at least seven occasions. Their parents (especially their mother) were also seen on occasions. The reports from those health professionals were positive. Ms Amanda Retter, homecare nurse, reported that the babies were thriving, putting on weight and were being fed and looked after well. Ms King was described by Ms Retter as very open, wanting to talk and not evasive in any way. Ms King was stated to be "picking [the twins] up, kissing them, cuddling them." Ms Retter was happy with how she was interacting with them. Neither Ms King nor Mr Kahui ever mentioned any incidents of apnoea.

[35] The twins were re-admitted to Middlemore Hospital on 13 May 2006 with mild lower respiratory tract infections, presenting with a clinical picture of bronchiolitis. They were hospitalised for 48 hours. Dr Mildenhall said the twins were monitored for signs of apnoea during their hospital stay. *There was no evidence of apnoea.* The twins were seen on a

number of occasions by members of the medical and nursing staff. No injuries or other concerns were noted.

[36] Ms Jane Eyres, another homecare nurse, visited 22 Courtenay Crescent on 3 occasions (18, 26 and 31 May 2006). She recorded that the twins were "both doing nicely"; that the nursery was very well set up; that the twins had put on weight and were in very good condition; and that "there'd never been any mention of problems with apnoea or things like that". In evidence, Ms Eyres said the twins were beautiful babies and they were growing appropriately. On 26 May she observed Mr Chris Kahui feeding one of the twins.

[37] On 2 June 2006 Ms Dianne Rainey, a social worker with the hospital's Maori Health Unit visited 22 Courtenay Crescent. She recorded the twins as being "wrapped up like little sausages". She visited again on 9 June, when she recorded that the twins were "exactly like before". On each occasion the bedroom is described as tidy and warm and the twins' mother is recorded as respectful and helpful. No concerns were expressed in apnoeic terms.

[38] On 18 May 2006 Chris Kahui's mother, Gwen Hetaraka, was admitted to Middlemore Hospital. She was admitted to the Intensive Care Unit, where she remained until 8 June, suffering from pneumonia. She was then discharged to a medical ward. During this time Chris Kahui and Macsyna King, the twins and Shane, Mona Kahui, Stuart King and Cyene (then aged four months) were living at 22 Courtenay Crescent, which was Mrs Hetaraka's home. There were four adults and four children under 13 months living in a three-bedroomed house.

[39] Chris Kahui was concerned about his mother's health and spent considerable time at Middlemore Hospital with her. On occasions he stayed in hospital with her overnight.

NARRATIVE OF EVENTS, FINDINGS AND COMMENTS

[40] At about 1:00 pm on Sunday 11 June 2006 Macsyna King left 22 Courtenay Crescent with Shane, telling her partner that she needed some "time out". An argument ensued as Chris Kahui did not want her to leave the house. Macsyna King went to her sister Emily's house in Rollerson Street, Papakura, where she spent the afternoon. She then went to the house of her partner's father, William (Banjo) Kahui, at 101 Maplesden Drive, Clevedon, where she fell asleep. She had earlier left 22 Courtenay Crescent and stayed out overnight on Saturday 3 June, leaving her partner to care for the twins. On that occasion she had gone to her partner's cousin's house in Mangere Bridge, where she and two others had smoked methamphetamine. She returned home in the early hours of the following morning.

[41] Macsyna King not having returned home in the evening of Sunday 11 June, her partner went out looking for her. He found her, some time after 11:00 pm, sleeping at his father's house. He became very angry. He told her to "get [her] ass up and get [her] ass home".[1] In a written statement made by her on 13 October 2006 Macsyna King said her partner:

> "..... said he was stressing out and tired and struggling to make the boys' bottles and feed them all on his own. He wanted me to go home and help

[1] Trial Notes of Evidence (TNOE) p78/18-20

him because there was so much work for him to do on his own."

[42] Macsyna King refused to return home. She told her partner to go back home and that he needed to start helping to look after the children. She told him to get "his ass home so that he can look after our boys."[2] Chris Kahui then returned to 22 Courtenay Crescent to look after the twins, whom he had left with Mona Kahui and Stuart King. He was a "bit angry" his partner would not come home.[3]

[43] At about 4:15 am on Monday 12 June Macsyna King took Shane, whom she had with her, to Kidz First Hospital to have him checked over because he was "chesty". He was discharged from hospital at about 10:15 that day. Macsyna King returned to 22 Courtenay Crescent with Shane at about 10:30 am. Earlier, on 7 June, Macsyna King had taken Cru to Dr Gopi Nayar for a check-up. Antibiotic medication was prescribed. Dr Nayar did not observe any bruising or other injuries.

[44] When Macsyna King returned to 22 Courtenay Crescent on the morning of 12 June she fed and bathed the twins.[4] Her partner helped her feed the twins at about 11:00 am.[5] Chris Kahui was at home during the period of 90 minutes or so that his partner was home. He did not see or hear any violence during that time.[6]

[45] Macsyna King left 22 Courtenay Crescent sometime near midday on 12 June. Before she left an argument broke out between her and her partner after she told him she wanted to go and spend some time with her sister, Emily King. She told her partner that she was going to stay the night. He did not want her to go; he told her that she would just "get on the piss" and that he was tired. Macsyna King told him to "go and get fucked."[7] The exchange between the pair was acrimonious. In the statement produced by Chris Kahui at the inquest hearing he said he expected his partner back that evening.[8]

[46] The twins were normal and well when Macsyna King left.[9] In his first Police interview (13 June 2006, CK1), Chris Kahui said at p5 that "everything had been okay" the previous morning (12 June). He was asked:

> "Q The boys were fine? They weren't crying?
> A No.
> Q They weren't unhappy?
> A No, they were okay. They were feeding well and ah sleeping quietly and then ..... that night that episode happened with mm Cru stopped, how he stopped breathing, yeah."

[47] Macsyna King did not return to Courtenay Crescent until approximately 9:30 am the following morning (Tuesday, 13 June).

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[2] TNOE p78/18-20.
[3] Chris Kahui Third Police Interview, p11
[4] TNOE pp81-82
[5] Inquest Notes of Evidence (INOE), p528; Chris Kahui Second Police Interview on 21 June 2006 (CK2), pp23-24.
[6] INOE p529.
[7] INOE p411. See also TNOE, p235 (Stuart King)
[8] Chris Kahui Inquest Statement, p2.
[9] Chris Kahui Second Police Interview (CK2) p23; Chris Kahui Third Police Interview (CK3) p54

[48] It should be interposed at this point that in para 139 of her written submissions dated 29 July 2011, Counsel for Chris Kahui advances three propositions in support of a submission that the evidence before this Court does not establish to the required standard of proof (as discussed and defined in para [183] hereof *post*) the person(s) responsible for the twins' deaths. The propositions advanced by her are that the twins' fatal injuries were:

(i) inflicted by Macsyna King on Tuesday morning 13 June 2006
alternatively
(ii) inflicted by Macsyna King about 7:00 pm on Monday 12 June while Chris Kahui was absent from 22 Courtenay Crescent dropping his sister Mona off at Middlemore Hospital
alternatively
(iii) inflicted by Stuart King.

Mrs Wilkinson-Smith submits that the possibility that the twins' fatal injuries were inflicted in one of the ways suggested by her "cannot be excluded".

[49] For reasons set out *post*, the Court does not find any of the possibilities advanced to be evidentially tenable. Accordingly, each falls to be rejected.

[50] The Court returns to the narrative. Following Macsyna King's departure from 22 Courtenay Crescent on Monday 12 June, her partner's cousin, April Saunders, her partner Shane Saunders and his father, William Kahui, arrived. They arrived about midday.

[51] Evidence was heard from Ms Saunders. A summary of her evidence in relation to her observations of the twins and of her feeding of Cru is contained in the written submissions of Mr Mount, dated 29 July 2011. The Court draws upon that summary for convenience. Ms Saunders' evidence shows:

- When she arrived the twins were in their cots
- She could hear that one of them was awake[10]
- She went into the bedroom and saw that the baby awake was Cru, as that was the name above his head[11]
- There was a half-full bottle of milk on the cot next to Cru. Chris Kahui told her that he had just fed Cru and that he would want to finish off the bottle[12]
- Cru was making a normal hungry cry[13]
- She picked Cru up and gave him the rest of the bottle in the kitchen in front of everyone[14]. Cru drank between 50ml and 100ml, or perhaps an inch of milk.[15] The feed took 5-10 minutes.[16]
- Cru was thirsty.[17]

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[10] April Saunders, Statement 20 June 2006, pp3-4
[11] April Saunders, Statement 20 June 2006, p4.
[12] April Saunders, Statement 20 June 2006, p4
[13] April Saunders, Statement 20 June 2006, p4
[14] April Saunders, Statement 20 June 2006, p4
[15] April Saunders, Statement 21 September 2006, p2. See also TNOE p434/24; Depositions p220/10; TNOE p445/16; TNOE 451/10; INOE 8 November 2010, p2355/9
[16] INOE 8 November 2010, p2376/11; TNOE 434/34 and 446/25-34
[17] INOE 8 November 2010, p2373/6. April Saunders Statement 21 September 2006, p2

- He was drinking the milk, sucking strongly at the teat[18], with a firm suck.[19] There was no milk spillage.[20] There was no vomiting.[21]
- During the feed she was looking at Cru.[22] He did not show any unusual facial expressions[23] and was not making any unusual noises.[24]
- There was nothing wrong with Cru's eyes; they looked up[25] and were not rolling back or anything like that.[26]
- Cru's eyes looked tired perhaps because he was thirsty.[27] His eyelids were not droopy.[28]
- She had no concerns for Cru during his feed.[29] She was happy with the way he was feeding.[30] He had a burp afterwards and then fell back to sleep.[31]
- She carried Cru around for about half an hour.[32] Whilst she held him she did not notice anything unusual about him.[33] He was not twitching or anything like that.[34] He was not unusually floppy.[35] His temperature was good.[36] His skin tone was normal.[37] There was nothing wrong with his breathing.[38]
- Cru's nappy was checked after his feed. Nothing unusual was noticed.[39] His nappy was not wet.[40]
- He was fine, so he was wrapped up again "and he was asleep, he just settled down."[41]

[52] A major power cut occurred in Auckland on Monday, 12 June 2006. Power was cut to 22 Courtenay Crescent at about 8:31 am. It was restored about 1:15 pm. Ms Saunders said the power came on after she had fed Cru.[42] It is unclear as to what time April and Shane Saunders left 22 Courtenay Crescent. At trial she said she thought they had left about 10 minutes after the power came on, but in her statement she said they left about half an hour after the power came on "around 2.00 pm".

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[18] INOE 8 November 2010, p2374/5, April Saunders Statement 21 September 2006, p2
[19] TNOE p434/29
[20] INOE 8 November 2010, p2375/6-16
[21] INOE 8 November 2010, p2374/14, April Saunders Statement 21 September 2006, p2
[22] April Saunders, TNOE p451/11
[23] April Saunders, signed depositions brief, p9; statement of 22 September 2006, p1
[24] April Saunders, statement of 22 September 2006, p1
[25] INOE 8 November 2010, p2383/27
[26] April Saunders, signed depositions brief p9; statement of 22 September 2006, p1; TNOE p434/11. In cross-examination at trial she agreed his eyes looked tired: TNOE p447/16; INOE 8 November 2010, p2383/17, 2383/32
[27] INOE 8 November 2010, p2357/11
[28] INOE 8 November 2010, p2357/16
[29] April Saunders, TNOE p435/1
[30] April Saunders, statement of 21 September 2006 p2
[31] April Saunders, statement of 21 September 2006 p2. April Saunders, signed depositions brief, p10
[32] INOE 8 November 2010, p2378/30; April Saunders, statement of 20 June 2006 p4
[33] April Saunders, Statement of 21 September 2006 p3
[34] INOE 8 November 2010, p2379/10; April Saunders, statement of 21 September 2006 p3
[35] INOE 8 November 2010, p2379/32; April Saunders, signed depositions brief, p9; statement of 22 September 2006, p1
[36] INOE 8 November 2010, p2380/20; April Saunders, statement of 21 September 2006 p3
[37] INOE 8 November 2010, p2385/23
[38] INOE 8 November 2010, p2384/6; April Saunders, NOE p434/17
[39] April Saunders, TNOE p435/16
[40] April Saunders, statement of 20 June 2006, p4
[41] April Saunders, TNOE p435/17
[42] TNOE p226

[53] Chris Kahui said in evidence at the inquest hearing that he was present during the whole period that Ms Saunders fed Cru. He said he saw her feeding him and carrying him around. He said he saw her feed Cru about 50-100mls of milk.[43] He said Cru was responding to people in the house in his normal way. There was nothing unusual about Cru at that time. He was "as normal as can be".[44] In particular, there was nothing wrong with Cru's eyes or with his breathing.[45] He said that April Saunders arrived at about 12:00 pm on 12 June, that Cru was making a normal hungry cry, that he had a firm suck, drank between 50-100mls of milk, that the feed took 5-15 minutes, that Cru was not twitching and that he seemed well. His arms and legs were not unusually floppy.[46] At his third Police interview on 3 October 2006 Chris Kahui said the twins had fed well at the lunch time feed. He said April had fed Cru and he had fed Chris. Chris drank his full bottle (150 mls) and Cru drank 100mls.[47]

TWINS NORMAL AND WELL AT 1.00 PM MONDAY 12 JUNE

[54] The Court finds on the combined evidence of April Saunders and Chris Kahui that the twins were in every respect normal and well during the morning of Monday 12 June, down until the time April and Shane Saunders left the house. Putting it another way, there is nothing in the evidence before the Court that would show, hint or suggest any change in their clearly documented good state of health. Ms Saunders was well experienced in the care and nurturing of infants and babies and the evidence she gave was given with the authority of such experience. The twins were not, on the evidence, showing symptoms from the older, healing rib fractures found at autopsy or, in the case of Chris, from the sub-dural haemorrhage thought to be 2 – 3 weeks old (see paras [130] – [133] *post*). They had not then sustained the serious brain injuries that led to their deaths.

WERE THE TWINS FED AGAIN?

[55] The Court turns now to the question of whether the twins were fed again after April and Shane Saunders left 22 Courtenay Crescent and, if so, when and by whom. Different stories have been given by Chris Kahui on different occasions to different persons concerning the subsequent feeding, or non-feeding of the twins. The Court found his evidence seriously conflicting in nature, lacking in credibility and not to be relied upon. Indeed, the Coroner felt moved to say to him while he was giving his evidence that he did not know what to believe, whether what he had told the Police was correct or what he was then saying in the statement produced to the Court (INOE p741).

POLICE INTERVIEWS

[56] Mr Kahui was interviewed by Police on three occasions: 13 June, 21 June and 3 October 2006. He did not give evidence at his criminal trial. He appeared under summons to give evidence at this inquest.

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[43] INOE 7 October 2010 pp600-601
[44] INOE 7 October 2010 p607/10
[45] INOE 7 October 2010 p603/16
[46] INOE 7 October 2010 p602/9
[47] Chris Kahui Third Police Interview, p55

[57] At each of his three Police interviews Mr Kahui stated that he fed the twins after April and Shane Saunders had left the house.

[58] In his first interview on 13 June 2006 Mr Kahui said:

- He fed both twins a full 150ml bottle at about 5:00 pm on Monday 12 June[48]
- The twins drank the entire bottles[49]
- They were normal, as they usually are[50]
- He changed each of the twins' nappies, put them to bed at about 6:00 pm, and they went to sleep.[51]

[59] In his second Police interview Mr Kahui confirms that the twins were fed about 6:00 pm and said he thought he had given them this feed himself.[52]

[60] In his third Police interview, Mr Kahui said the twins received a feed after the top-up feed with April Saunders which "went good", "just like normal". He said he did not know what time it was but he thought it was about six hours after April's feed.[53] In one of his replies to questions he said he thought the feed was at about 1:00 pm but he was not clear on this timing. He said he and Mona changed the twins' nappies (the Court comments that there is no evidence that would support this statement). He said everything was okay and he could not see any injuries. He said this was the twins' last feed. [54]

DEPOSITION PRODUCED AT INQUEST

[61] A written statement of evidence was produced by Mr Kahui at the inquest hearing. In that statement he says he has read the transcripts of his Police interviews. He says "there are some matters which I wish to add". He then says he left Macsyna to do everything for the twins. He says she was alone in the house with them and Shane almost every day. The Court comments that the evidence shows, in fact, that Chris Kahui materially assisted his partner from time to time in caring for the twins. It is stated so in his Police statements. Chris Kahui goes on to say that about a week before the twins went into hospital Macsyna was talking about being really stressed and needing time out. He says a family meeting was held about Macsyna needing help. He says that looking back, Macsyna did not get much help. He says that on Sunday 11 June she "took off" and didn't come home that night. He says she came home on the Monday morning of the power cut. He says she wanted to go out again to see her sister Emily. He says "we argued about that and she was pretty angry that morning because I wanted her to stay but in the end I was OK about her going". He says the arrangement was that Macsyna was supposed to be home before the boys were due to be fed again at about 6:00 pm. He expected her back that evening. He says the boys were fed before Macsyna left at about lunch time on Monday. He says he can't now remember whether he helped with that feed or whether she did it. He says "I know now that it is really important to know exactly when they last fed normally and seemed well". He says:

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[48] Chris Kahui 1st Police interview pp 5-6
[49] Chris Kahui 1st Police interview pp 6-7
[50] Chris Kahui 1st Police interview, p6
[51] Chris Kahui 1st Police interview, p6
[52] Chris Kahui 2nd Police interview, pp32, 34, 65
[53] Chris Kahui 3rd Police Interview, pp62-63
[54] Chris Kahui 3rd Police Interview, p64

> "When I first spoke to the Police I didn't realise that it mattered that much when they were fed. I didn't want the Police to think I was a bad father and over the 2 nights Macsyna was away I had pretty much tried to keep to their feeding routine which was every 6 hours."

He goes on to say:

> "But looking back the boys didn't feed when they usually would have after Macsyna left on the day of the power cut.
>
> I can't now remember exactly when they fed but I think what I said in my last Police interview must be correct. That is the babies were fed before Macsyna left around lunchtime. I was expecting Macsyna back for the next feed.
>
> I don't think baby Chris cried or fed at all after Macsyna left."

[62] Chris Kahui says in his inquest statement that baby Cru did cry and that is when April Saunders gave him the rest of the feed he hadn't finished. He says the babies didn't wake up or cry during the afternoon, adding "*if they had everyone in the house would have heard them. It wasn't a big house.*" It should be recorded at this point that, significantly, none of the family members who gave evidence deposed to hearing the babies cry on any occasion from the time Macsyna left the house until they were taken to see Dr Nayar at about midday the following day. Nor, it should be added, did any family member who was in the house on the afternoon/evening of 12 June and the morning of 13 June depose to having personally seen Chris Kahui on any occasion feeding the twins, bathing or changing them or of having done so themselves.

[63] Chris Kahui says in his inquest statement that the twins just seemed to sleep during the afternoon of Monday 12 June. This did not worry him as he "wasn't expecting them to need a feed. They were only feeding every 6 hours." He says he took his sister Mona to the hospital to see their mother about 7:00 o'clock on the Monday evening. He says he was gone for about 20 minutes. The twins were asleep when he got home. He says:

> "I sort of knew they must need a feed and I was expecting them to wake up. I thought Macsyna would have been home before I got back from the hospital.
>
> Eventually I decided I better make some bottles and feed the twins as Macsyna hadn't come back. I made the bottles and went into feed them. The bedroom door was open. I picked up baby Chris and was just about to wake him up and give him a bottle when Mona came in and picked up Cru. That is when Cru stopped breathing."

[64] Chris Kahui says in his statement that when he was first spoken to by Police he thought it was about 11:00 pm when Cru stopped breathing, adding "that's why I thought I must have fed them earlier. I now know that it was around 8:00 pm so that must have been their evening feed which was late because they hadn't woken up crying for it as they usually would." He goes on to say that "in all the panic I don't think either of the twins had a feed". Nor were they fed during the night or the following morning.

[65] The evidence given by Mr Kahui at the inquest hearing, including that contained in his inquest statement, was significantly different to the evidence he gave to the Police, contained in the transcripts of his three Police interviews. It was not suggested by him or his counsel that there were errors in transcription. His evidence at inquest constituted, as Mr Mount puts it in his written submissions at para 4.31, "a significant change in his position". When asked for an explanation for such significant change in evidence, Mr Kahui said his lawyers had prepared his written statement without his having told them what to put in it.[55] The Court comments that if his inquest statement contained errors he or his counsel could have corrected them. There was no attempt to do so. Nor did his experienced counsel seek an adjournment to discuss matters with his client, or offer an explanation or comment on what was said by his client. In the circumstances the Court can only conclude that the evidence contained in Mr Kahui's statement was in accordance with his instructions following briefing by counsel and had been read through by him, as he conceded. Mr Kahui was asked for an explanation for his change of testimony. He had no explanation. It was not suggested that Mr Kahui had a problem with his memory. The evidence given by him was conflicted:

(i) At p2 of his inquest statement Mr Kahui says, contrary to the evidence contained in his three Police statements, that Chris did not cry or feed after Macsyna King left the house. At p2 of his inquest statement, he says that Cru fed with April Saunders, but did not wake or cry during the afternoon;

(ii) During the inquest hearing Mr Kahui variously said:

- He did not think Chris had fed again between the time he was fed by Macsyna King on Monday morning and his visit to Dr Nayar the next day.[56] This is in conflict with the evidence in his Police interview statements that the twins were fed again by him after April and Shane Saunders had left the house.
- It "could be true" that he fed the twins around 5:00 pm, but he was not certain if he had done so.[57] He said he could not remember doing so,[58] but accepted that his memory would have been better at the time of the first Police interview.[59] At pp619-20, INOE 7 October 2010 he is recorded as saying that he was trying to keep the six hourly cycle going and would not have wanted to miss the feed. He said he tried to ensure that the babies were fed every six hours. No explanation is given for the extended and dramatic break in the cycle.
- He "might have" fed the twins again about six hours after the earlier feed before Macsyna King left.[60] He could not "be sure".
- If the twins had not fed around 6.00 pm he would have told the Police.[61] That would have been unusual.

[55] INOE 7 October 2010 pp573-574
[56] INOE 7 October 2010 p464-5
[57] INOE 7 October 2010 p618/9
[58] INOE 7 October 2010 p618/31
[59] INOE 7 October 2010 p619/6
[60] INOE 7 October 2010 p621/9
[61] INOE 7 October 2010 p624/4

(iii) Later in the inquest hearing, however, Mr Kahui accepted that there *had been* another feed after April Saunders had left the house,[62] but he was unsure of the time.

(iv) Still later, he said he did not think Chris cried or fed from when Macsyna King left.[63]

(v) Later still, he said he did not think he had fed either twin after Macsyna King had left the house on Monday.[64]

[66] The evidence given by Mr Kahui at inquest as to feeding was in contradiction of the evidence contained in his three Police statements that the twins had been fed by him subsequent to the departure of April and Shane Saunders. What was said by him to Police in relation to feeding after April and Shane Saunders left may be tabulated in this way:

CHRIS KAHUI STATEMENTS RE FEEDING

	FIRST INTERVIEW	**SECOND INTERVIEW**	**THIRD INTERVIEW**
11.00am – 12.00pm		Thinks Macsyna helped him feed twins before she left (p23) April helped feed Cru and accused fed Chris at lunchtime feed after Macsyna had left (p26)	Twins fed well. April feeds Cru and accused fees Chris (p55) Chris drank all bottle (150mls) and Cru (100mls) (p61)
5.00pm-6.00pm	Fed about 5.00pm (p5) Drank entire bottles (p6 and p7) Changed them and they went to sleep	Thinks he did this feed himself (p32; 34; 65)	Fed them himself in their cot (thought it was about 1.00pm)(p62) Chris and Mona changed them (p64) It was their last feed (p64)
11.00pm-Midnight	They were feeding okay and Cru stopped breathing for a little bit Sleeping well and sleeping quietly until Cru stopped breathing (p5) Started to give Chris (incorrectly refers to twin as Cru but corrects himself on pa) his bottle and that's when Cru stops breathing	Sitting on couch; started to give Chris his bottle when Mona says Cru isn't breathing (p37) Wanted to see if Cru would feed normally after CPR. Drank normally. Had 100mls and then finished the rest (p45; 67) Chris fed normally (p67)	Didn't feed them after Cru stopped breathing (p63)

[62] INOE 7 October 2010 p626/32
[63] INOE 7 October 2010 p739
[64] INOE 7 October 2010 pp753,756

	Mona came in when feeing Chris (p9) Drank all his bottle (150mls)(p8) After Cru came right he drank 100mls but left 50mls (9 & p11)	Thinks Mona fed Chris while he fed Cru (p68)	
6.00am-7.00am	At 6.00 Chris drank the whole lot (150mls)(p13) Cru also drank whole lot (150mls)(p13)	Ran out of milk because used it in last feed and had to go and buy some more (p47,48) Macsyna returns and he thinks they both fed boys (p50; 51) Drank all their bottles; everything normal, changed them (p51)	Didn't feed them because he'd run out of formula (p63)

[67] The picture presented by Mr Kahui to Police in his first two interviews was one of uninterrupted normal feedings at six hourly intervals from midday on Monday 12 June through to 6.00 am-7.00 am the following day. The evidence contained in the statement presented by him at inquest (although modified to a degree under cross-examination) directly contradicts what he had earlier said. If the evidence given by Chris Kahui at inquest is correct, the twins were either never fed again after their midday feeds and Cru's 'top-up' feed on Monday 12 June, or they might have had one further feed at about 5.00-6.00 pm that day. It follows that, as at midday on Tuesday 13 June they had not been fed for a period approaching either 24 or 18 hours, depending upon which version of Chris Kahui's evidence is correct.

PERIOD PRECEDING CRU'S APNOEIC EPISODE AND THAT EVENT

[68] Shortly before 7.00 pm on Monday 12 June Chris Kahui left 22 Courtenay Crescent to drop off his sister, Mona Kahui, at Middlemore Hospital to visit their mother, Mrs Hetaraka. Stuart King estimated that Mr Kahui was away from the house for 10-15 minutes.[65] As recorded in para [63] hereof, Mr Kahui said he was gone for about 20 minutes. Mr King remained in the house. Evidence was heard from Detective Sergeant Barry that a test drive by Police of the route taken by Mr Kahui took approximately 17 minutes,[66] which time included a stop for petrol. As recorded in para [48] *ante*, Mr Kahui contends it is possible that Macsyna King returned to the house during the time he was absent and inflicted the injuries that brought about the twins' deaths.

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[65] Stuart King TNOE p242/2

[66] Supplementary brief of Detective Sergeant Barry 7 October 2010

[69] At about 8.25 the same evening Mona Kahui and William Kahui returned to the house after visiting Mrs Hetaraka at Middlemore Hospital with baby Cyene. They were intending to drop off Cyene. Mona Kahui was then going to return to the hospital to stay the night with her mother.

[70] The evidence shows that, as April Saunders put it, the 'vibes' in the house, after Macsyna King had left, were not good.[67] When William Kahui arrived he spoke to his son about Macsyna King's absence from the house and "kind of blew him up really to see why she's not there".[68] Chris Kahui told his father to shut up, saying it was not his relationship.[69] He asked Mona to tell their father to shut up.[70] Chris Kahui acknowledged that his father was "going on and on about it", but denied being annoyed.[71]

[71] About 8.40 pm Chris Kahui, his father, Mona Kahui and Stuart King went outside onto the front doorstep of the house for a smoke.[72] Chris Kahui seemed "a bit angry, down, a bit pissed off that he couldn't go to the hospital ... cos he had the twins and Shane to look after".[73]

[72] While the family members were outside, Shane came to the glassed front door. He was crying. He began to bang on the door, calling out "Dadda".[74] Chris Kahui then went into the house.[75]

[73] Chris Kahui went into the twins' bedroom. He was alone in the room for a period of time. His evidence as to events whilst he was in the twins' rooms is conflicted. At his third Police interview he said, initially, that he was alone in the room for about ten minutes prior to the 'CPR incident'.[76] Later in the interview he said he was in the room "for three minutes or round about that".[77] He said he was 'just picking things up, rubbish and stuff." He said his father was in the lounge, Stuart King was in the kitchen and Mona Kahui was in her room.[78] At the inquest hearing he said he had been alone in the room for at least three minutes.[79] He said he was "still annoyed" but not angry at that time.[80] When interviewed by Police on 13 June 2006 Chris Kahui repeatedly stated that he was in the nursery feeding Chris when Mona came into the room.[81] At the inquest hearing he denied feeding Chris at this time.[82] He confirmed at inquest that he was alone with the twins in the nursery for at least three minutes between the time he was smoking with other family members and when Cru stopped

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[67] April Saunders TNOE 427
[68] William Kahui's words, William Kahui TNOE p375/2
[69] Monda Kahui TNOE pp318/22 and 356/33
[70] Mona Kahui TNOE p357/1
[71] Chris Kahui Third Police Interview p19
[72] Stuart King TNOE 245/2. Mona Kahui INOE 327-328
[73] Stuart King TNOE p245/18
[74] Mona Kahui TNOE p320/18; INOE p328
[75] Chris Kahui Third Police Interview p25-26
[76] Chris Kahui Third Police Interview p26
[77] Chris Kahui Third Police Interview p29
[78] Chris Kahui Third Police Interview p30; INOE p799
[79] INOE 7 October 2010 p558/28
[80] INOE 7 October 2010 p558/32; 559/25
[81] Chris Kahui First Police Interview pp4, 7, 8 and 9
[82] INOE 464-465

breathing.[83] His father said Chris Kahui was alone in the nursery with the twins and that he could have been alone with them for three minutes.[84]

[74] At the inquest hearing Mona Kahui said that she went into the twins' room some ten minutes after finishing her smoke on the doorstep. She said Chris Kahui was in the room by himself, cuddling Chris. *She said there were no feeding bottles in sight. She said Chris Kahui was not feeding Chris.*[85] He asked her to pick up Cru and give him a cuddle before she left to return to the hospital. She then saw that Cru's face was starting to turn pale; his eyes started to roll back and his lips started to go purple.[86] She said Chris Kahui said "he gets like that when he's tired".[87] She realised that Cru had stopped breathing.[88] She passed Cru to Chris Kahui and, scared by what she had seen, ran out of the room to get Stuart King. The Court comments that Mona Kahui's actions in running out of the room to get help underline the seriousness of what to her was a frightening event.

[75] Stuart King then came into the nursery. He took Cru off Chris Kahui. The serious nature of the event that had overtaken Cru was well described by him in evidence at the criminal trial. He said Cru's lips:

> "were like a dark purple. They kept getting darker and darker and darker. His body was so flimsy and so limp you could tell [it] wasn't normal."

Mr King went on to say that Cru was not breathing "for about five to ten minutes, he was just lying in my arms lifeless". He said Cru then started to breathe "in short bursts like he was trying to suck in the air ..... like sucking a drink through a straw." He said there were 40 second gaps between bursts of breathing. Every time Cru tried to open his eyes they would just roll back. Cru was making "a queasy sound" and his hands were shaking every time he tried to take a breath.[89] Mr King said he thought Cru's stopping breathing was a really serious incident and at one stage he thought he had died.[90]

[76] In his first Police interview Chris Kahui gave a version of events in the nursery, which is at variance with the evidence before the Court. He is recorded as saying:

> "..... last night when I was with them they were okay. They were feeding okay and ..... Cru stopped breathing for a little bit there. I asked ..... I asked my sister Mona if she could um ..... cos I was holding Chris at the time, feeding Chris and I asked my sister if she could hold him, hold ..... hold Cru and .....and she said that he was a bit blue around the lips and ..... and then I put my ear to his mouth and yeah he ..... he wasn't breathing so I gave him like a bit a CPR and put his head up and an five ..... five breaths and one pump and yeah he come right. He started breathing again and yeah that was a bit of a shock cos um the brother-in-law, Stuart and Mona and my Dad was ..... also in the room and we were all freaking out and then yeah it was a bit freaky ..... ".[91]

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[83] INOE p558
[84] INOE p2257-2258
[85] INOE p329-330
[86] Mona Kahui TNOE p324-328
[87] INOE pp328-331
[88] Mona Kahui TNOE p326
[89] Stuart King, TNOE pp249-251
[90] INOE p1054
[91] Chris Kahui First Police Interview p4

[77] At inquest, Chris Kahui said he had to perform CPR and that Cru "came normal after that" (INOE p467). At a later point in his evidence he said he went to perform CPR but Cru had already "come right" (INOE p560). Still later, he said he had had to do five chest compressions (INOE p653).

[78] During cross-examination, Chris Kahui said he "was freaking out" and "really frightened ..... really afraid". He thought Cru was dying.[92] He accepted that he was in charge of the twins, that it was his decision not to call an ambulance[93] and that instead of getting medical help he sent Mona and his father to try and find Macsyna King.[94] He was unable to offer any explanation for not taking Cru to hospital.[95] He said, however, that if a puppy in his care had stopped breathing he would have taken it to a vet.

[79] The evidence shows that Stuart King, Chris Kahui's father and Mona were in agreement that Cru should be taken to hospital or that an ambulance should be called.[96] At inquest, Stuart King said all the adults wanted to take Cru to hospital or call an ambulance except for Chris Kahui.[97] Mr King said "Banj [William Banjo Kahui] wanted to ring an ambulance ..... Chris wanted Macs back".[98] Mona Kahui said she would have taken her child to hospital and confirmed that Chris Kahui did not want the twins to go to hospital at that time.[99] The Court accepts the evidence of Stuart King and Mona Kahui as to what they saw and heard in the nursery.

[80] At his first Police interview Chris Kahui said that when the others in the house said it would be a good idea to take Cru to hospital or call an ambulance, he had said "nah he's breathing again, he should be fine now".[100] He said this was "the same as my dad", subsequently adding he "came right". If Chris Kahui really did believe that Cru "should be fine now", why did he send Mona and his father to try and find his partner? When Macsyna King arrived at the house the next morning and yelled at her partner, demanding to know how Chris had got bruising about his face, he is reported by her as having said words to the effect:

> "well, then you should have been here. Why the hell, then you should have been here taking care of the kids."[101]

The reasonable inference to be drawn from these words, which the Court accepts were spoken by Chris Kahui, is that something had happened to the twins whilst Macsyna King was away, and that had she not left her partner alone with them (and Shane), what happened to them would not have happened. Responsibility or a sharing of responsibility for what had happened was being imputed to her. Significantly, Mr Kahui was saying that *what had happened to the twins had occurred in Macsyna King's absence.*

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[92] INOE 11 October 2010 pp733-734
[93] INOE 11 October 2010 p667/12-20
[94] INOE 11 October 2010 p677/23
[95] INOE 11 October 2010 pp668-669; 682/14-24
[96] Chris Kahui Third Police Interview p34
[97] INOE 13 October 2010 pp1053/23 and 1054/21
[98] TNOE 252
[99] INOE 29 June 2011 p333/9
[100] Chris Kahui Third Police Interview p34. See also First Police Interview p12
[101] Macsyna King TNOE p90/9

[81] Chris Kahui was, in fact, still worried about Cru after his breathing had restarted. He said that he wanted to sleep in the twins' room in case Cru stopped breathing again.[102] Chris Kahui must have had other reasons for holding out against the suggestions of the other family members that medical assistance be sought or an ambulance called. What might these reasons have been? Clearly, he wanted Macsyna brought back as soon as possible. Equally clearly, she could not stand in the place of a health professional in medical advisory terms. The evidence would strongly suggest that Chris Kahui wanted Macsyna back to see what should be done about the twins in the condition in which they then lay and for her to face what he saw as her responsibility for what had happened to them in her absence. It is implicit in the view just stated, formed on the evidence before the Court, that by then the twins had suffered the head injuries that led to their deaths.

[82] It should be added that at trial Chris Kahui's father, William Kahui, said that he went into the nursery when he heard Mona screaming. He saw his son carrying out CPR. He said he thought his son "didn't know how to do it so I was actually going to give the young fellow compressions ..... [I] probably just given him one and he was back to his jovial self".[103] Such latter statement does not accord with the evidence before the Court and is rejected. When first questioned by Police as to the events concerning the twins, William Kahui omitted all reference to the apnoeic event because he "did not want to incriminate [his] son" (INOE p2238). He admitted during cross-examination that he had lied to protect his son. In an undated statement made to Police by Mr Stuart King (the second of five statements made by him), he says that after about 10 minutes Cru appeared to be breathing properly by himself again, but that he did not properly recover, saying "he wasn't fully there". (p15-17 of such statement) It is clear that neither twin returned to normality and, on the medical evidence, could not do so. The Court finds that neither ever fed or cried again.

[83] After Cru had resumed breathing, William Kahui and Mona Kahui left the house and went to look for Macsyna King. They went to William Kahui's house at Maplesden Drive, Clendon and then to Emily King's house at 12 Rollerson Street, Papakura. They did not find Macsyna, who was with her sister Emily visiting a friend in New Lynn named Ginta Gaile. William Kahui dropped Mona Kahui off at Middlemore Hospital to stay overnight with her mother and returned to 22 Courtenay Crescent where he looked after Shane overnight. As stated, Chris Kahui slept in the twins' bedroom that night to make sure Cru was "still breathing".[104]

[84] The next morning, Tuesday 13 June, Chris Kahui got up and checked on the twins. He said that during the morning he noticed bruising on Chris' face.[105] He left the house at about 9.00 am, purchased petrol, withdrew money from an ATM and bought baby formula.

MACSYNA KING RETURNS HOME

[85] Macsyna King arrived home at about 9.35 am. Chris Kahui was still out. She spoke to Stuart King and went into the nursery to check the twins. She said both were breathing and appeared to be sleeping.[106] She asked Stuart King what had happened the night before. Chris

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[102] Chris Kahui Third Police Interview p36
[103] TNOE pp384-385
[104] Chris Kahui Third Police Interview p36
[105] Chris Kahui, First Police Interview p15; Third Police Interview p37
[106] Macsyna King TNOE p88/31

Kahui then arrived home to be confronted by Macsyna who said words to the effect "what the fuck was happening while I was gone away and how the hell did our boy get that new bruise on his face and what the hell happened?"[107]

[86] Chris Kahui said, in effect, that he had left the door to the nursery open and that Shane had crawled into the room, climbed up on the couch and had run along the top of it.[108] Macsyna then yelled at Chris Kahui and he replied, as already stated, with words to the effect "well then you should have been here. Why the hell, then you should have been here taking care of the kids."[109] It should be added that, as recorded at pp81-83 TNOE, Macsyna King said she had noticed a fading bruise on the face of one of the boys on the Monday morning when she thought she had bathed, fed and changed the twins. She said she spoke to Chris Kahui about the bruise and he told her "that he'd gone out of the room to take their bottles to the kitchen and while he'd done that he didn't completely close the door that led into the nursery and Shane had gotten into the nursery, crawled in there, climbed on top of the couch and got at the boys". The fact that fading bruising was seen by Macsyna King on the face of one of the twins on the day before a fresh bruise was seen on Chris' face, and that Chris Kahui should attempt to explain the cause of the bruising on each day by recourse to the same invention, is disturbing.

[87] In his third Police interview (pp 48-49) Chris Kahui said he had put the twins on the couch and that Shane was standing on them. He said he had put Shane on the couch. He said no-one else saw this happen. He had not mentioned this incident to anyone else. At inquest, Chris Kahui denied seeing Shane standing on the twins and said that he had "got that wrong", adding "yeah, I think [Shane] was on the floor crawling."[110] It should be recorded that at his first Police interview, when asked about the bruising on Chris' face, he said (p17) "Shane might have gone in there .... and whacked him or something." He repeated this at his third Police interview (p48). The evidence shows that there was no possible basis for such suggestion.

[88] In her written submissions dated 30 July 2011 Ms Dyhrberg submits, in para 90, that Chris Kahui "has clearly lied about baby Shane being responsible for the injuries to the twins". She says he told Macsyna King on three occasions, when asked what had happened to the twins, that baby Shane had caused the injuries.[111] Ms Dyhrberg reminds the Court that Mrs Stent, an early childhood educator, gave evidence that Shane would not have been able to pull himself up on a couch or to crawl across it. Ms Dyhrberg submits that Chris Kahui's evidence in this respect gives the impression that he seeks to apportion blame or to deflect inquiry as to his actions.

[89] Chris Kahui's response to the expression of his partner's concerns is not what one might expect from a father whose attention has been drawn to bruising on the face of one of his sons. His response was to explain away Chris' facial bruising by recourse to an invention. It is likely that a father who bore no responsibility for the injury that had led to bruising would be very concerned, would want to know how his son had got such an injury and would join his partner in enquiring into what had gone on.

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[107] Macsyna King TNOE p89/7
[108] Macsyna King TNOE p89/12
[109] Macsyna King TNOE p90/4
[110] INOE 5 October 2010 pp731-733
[111] See INO 5 October 2010, pp171-172

[90] In his first Police interview Chris Kahui stated (p14) that he had fed, burped and changed the twins on Tuesday morning at 6.00am. He said (p18) that he had discussed the bruising referred to with his partner and had asked whether they should take the boys to the doctor. Macsyna said "yep". He said they had got the twins ready and had taken them to Dr Nayar. In his second interview (p79), Chris Kahui said that when Macsyna returned on Tuesday morning "I was just like ..... we'll take them to the doctor's to get them checked or to the hospital. She was like ..... let's go and we were just getting ready and then shot off". In his third interview Chris Kahui was asked whether it was Macsyna who wanted to take Cru to the hospital. He answered "No ..... it was me" (p43). The Court finds on the evidence that each of the statements by Chris Kahui referred to above was untrue. Mr Kahui is recorded as having given no answer to the question as to why he did not take Cru to the doctor or the hospital when he first woke up on Tuesday morning (p43). It was put to him that he had seen the bruise on Chris' face and that Cru had stopped breathing the night before.

[91] It should be recorded that in his first Police interview Chris Kahui said he did not notice Chris' facial bruising on Tuesday morning at the claimed 6.00am feed (p14 of first statement) and that the twins were feeding normally (p21). He said (p15) he saw bruising on Chris' cheek coming up a couple of hours after feeding (10.00-10.30 am). This is said to be before Macsyna returned home (p16). In the second Police interview he said he first saw bruising just before he went to shop for formula (p72). At p51 he says he started to see bruising on Chris' face when/after feeding the twins with Macsyna. It should be recorded that the evidence shows Macsyna returned to 22 Courtenay Crescent at *9.35am* on Tuesday 13 June. Chris Kahui was then out purchasing formula.

[92] As recorded, the twins were not fed on Tuesday 13 June. They were last fed the day before. The evidence given by Chris Kahui in each of his first two Police interviews that they were fed on Tuesday morning was untrue and, the Court finds, untrue to his knowledge as his evidence at inquest shows. The evidence shows that it was Macsyna who made arrangements to take the twins to Dr Nayar to be checked. They were, in fact due for a general check-up at that time. When Macsyna King arrived at the house she saw two bottles of formula on the kitchen bench that looked "pretty much full".[112] The bottles looked untouched.[113] Chris Kahui told his partner that the twins "didn't want their feed", that they were not hungry and didn't take the bottles.[114] The twins were "asleep" when Macsyna King arrived home. In other words, they were unconscious. In her written statement to Police dated 13 October 2006, Ms King says (p13) that "looking back", the twins "were in a different condition when I got home on Tuesday although I didn't immediately realise that they were hurt or how seriously they had been hurt".

[93] Significantly, Chris Kahui did not tell his partner that the twins had not fed since the day before. Nor did he tell anyone else in the house, as already stated. He did not tell Dr Nayar this either. This was vitally important information which he kept to himself.

[94] The Court finds that Macsyna King was materially misled by Chris Kahui as to the health of the twins. The evidence shows that he was well aware that they had recently been changed from a four-hourly to a six-hourly feeding cycle. They had to be fed six-hourly. Indeed, Dr Jenny thought they should still have been feeding four-hourly. It is clear on the evidence that neither twin ever fed again after Cru's apnoeic episode and are unlikely to have

[112] TNOE p92/2
[113] TNOE p92/18
[114] TNOE p91/30

been fed again after 1.00 pm on Monday 12 June. The Court has difficulty on the evidence in determining the level of interaction between Macsyna King and the twins upon her return to the house. The evidence is unclear as to whether the twins were bathed by her that day. There is no clear evidence that she did bath them. She may have changed their clothes. She was given to understand by Chris Kahui that the twins were being fed. It was she who decided that the twins should be taken to a doctor.

[95] Chris Kahui's behaviour in not disclosing to anyone else in the house the fact that the twins were not feeding, in not disclosing that fact to Macsyna King when she arrived on Tuesday morning, in making no enquiries of anyone as to what should be done in what were deeply worrying circumstances and in failing to get urgent medical help for the twins speaks eloquently of his desire to keep this fact secret from everyone else. The twins were not waking for food. They were not crying to be fed. They were not being fed. Chris Kahui's behaviour in keeping these facts from others is incompatible with the behaviour one would reasonably expect from a normal father who had nothing to hide concerning his children's condition.

[96] Chris and Macsyna Kahui and Stuart King, with Cyene, the twins and Ellen (Emily's baby daughter) travelled in two cars to McDonalds Restaurant on Massey Road at about 12.00 pm on Tuesday. They then went on to Dr Nayar's surgery, arriving shortly after 1.00 pm.

VISIT TO DR NAYAR

[97] Dr Nayar observed a "large" and "obvious" bruise on Chris' cheek. He asked the twins' parents what their concerns were. Chris Kahui referred to the apnoeic episode the night before but did not tell Dr Nayar that neither infant had fed since early the previous evening. Chris was examined by Dr Nayar. "Straight away" he knew that that baby was neurologically very unwell.[115] He asked the parents if the babies had been dropped on their heads. He telephoned a referral to Middlemore Hospital at about 1.15 pm. It would have been prudent of Dr Nayar, certainly in retrospect, to have called for an ambulance.

[98] Dr Nayar told Macsyna King and Chris Kahui that the twins needed to be taken to Middlemore Hospital straight away. He said "and they seemed to agree. They understood my instruction." He told them that the babies "were very sick and needed to be seen at the hospital immediately". [116] The Court accepts this evidence, which is based upon Dr Nayar's clinical notes.

EVENTS AFTER VISIT TO DR NAYAR

[99] Following the consultation Chris Kahui and Macsyna King returned to their car with the twins. Chris Kahui drove off. They were supposed to go to the hospital. Chris Kahui said he did not want to go to the hospital. He drove past the Middlemore Hospital turn-off. He told his partner that he did not want to, and was not going to go to the hospital.[117]

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[115] Dr Nayar TNOE p489/16
[116] Dr Nayar TNOE p495/5
[117] Macsyna King TNOE p105/5

[100] Macsyna King then asked Chris Kahui to stop the car on Massey Road so that she could buy nappies and other baby supplies. She visited Countdown Supermarket and Hunt's Pharmacy. The two returned to 22 Courtenay Crescent at about 2.00 pm. Macsyna collected the twins' "Well Child" books and medicine.

[101] Chris Kahui described himself as "amped" and angry when he arrived home.[118] Stuart King described the situation when Chris Kahui and Macsyna King got home as "I just heard Macsyna swearing, going off her face .... she was upset, crying, swearing".[119]

[102] The Court finds that Chris Kahui knew the twins needed to be taken to hospital straight away. Having refused to turn off to the hospital on the way there, he drove home and then walked out of the house, leaving his partner to cope alone with two very sick babies. At the inquest he said he knew Macsyna wanted him to go with her to the hospital, but that he was furious.[120] Again, the behaviour of Chris Kahui in turning his back on the pressing needs of his sons for medical attention "straight away" is incompatible with that of a normal father whose only concerns are his children's welfare.

[103] Mona Kahui said her brother explained his reason for going for a walk as being because "he had been picked on because he had my sister [Tracey Stihl] nagging about the house being untidy and my dad [William Kahui] nagging about his relationship and Macs was also in his ear about what had happened with the twins.[121]

[104] It should be recorded at this point that William Kahui accepted at inquest that a conversation had taken place between him and his son after the twins' deaths in terms such as these:

> "Chris Kahui: You see, fuck, if we never went to the hospital that time we went to the doctor's, fucken they probably never would've found out."
> William Kahui: Who?
> Chris Kahui: The Police, when they ain't even you know, if we never had checked up on anything then we still probably, you know, the boys, you know."[122]

Chris Kahui said he did not remember that conversation.[123] The conversation was recorded by Police pursuant to a High Court warrant authorising the interception of private conversations at 22 Courtenay Crescent, Mangere, issued under S312CA of the Crimes Act 1961. Whilst this evidence is admissible, the Court accords it no weight in its deliberations as it lacks a complete transcript of the recorded conversations. The conversation cannot be contextualised. It should be added that at inquest Mr Kahui accepted that there was evidence he had spoken to people about handing himself in on at least five occasions (INOE 7 October 2010 p500/5) and that his reasons for turning himself in would only make sense if he was the person responsible for hurting the twins (INOE 7 October 2010 p500/18). As with the former evidence referred to in this paragraph, the Court accords this latter evidence no weight, it not

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[118] Chris Kahui Third Police Interview p44-46
[119] Stuart King INOE p260/6
[120] INOE pp711-712
[121] Mona Kahui TNOE p338/12
[122] William Kahui INOE p2241
[123] Chris Kahui INOE p671

being satisfied that Mr Kahui's statements that he should turn himself in are clearly denotive of an admission by him that he was solely responsible for the twins' deaths.

[105] At approximately 1.55pm on Tuesday afternoon Macsyna King rang Tracey Stihl and told her "Chris has fucked off, the boys need to go to the hospital, can you call him on his fucking phone and tell him to get his ass home and help me".[124]

MACSYNA KING ARRIVES AT MIDDLEMORE HOSPITAL WITH THE TWINS

[106] Macsyna King arrived at the Emergency Department triage desk at Middlemore Hospital at 2.37 pm. She was seen by Charge Nurse Fleur Paulson, who noticed a bruise on Chris' face. She asked about that bruise. She said Macsyna King said "she'd been told that another child in the home had done it".[125] The twins were assigned triage category 3.

[107] The twins were then seen by Staff Nurse Claire Dillon, who noticed fresh bruising on the faces of each.[126] She undressed Chris but did not notice the femoral fracture found at autopsy.[127] Nurse Dillon asked Macsyna King what had happened. Macsyna said her one year old put his hands through the cot and hit their heads together.[128] Nurse Dillon heard no sounds from Cru. She heard only one small high-pitched cry from Chris when he was placed on the heat table.[129]

[108] The twins were then taken to the resuscitation room. Chris was fitting. The attending clinician, Dr Ang, recorded an altered level of consciousness on the part of Chris; eyes not focussing; unequal pupils; limb posturing; an unusual breathing pattern; bruises on both cheeks; and leg fracture.[130]

[109] At about 2.55 pm Dr Wendy Walker was called to the resuscitation room to assist with baby Cru who was having convulsions.[131] She noticed a small bruise on Cru's left cheek. Dr Walker spoke to Macsyna King about 3.25 pm.[132] Macsyna King said she had been out the night before, had come home and had been concerned the boys did not look well. So she had taken them to the doctor. Dr Walker told her she thought the twins had been injured. Macsyna King's answer to that "was that her young child, a toddler, had climbed up onto some furniture and pulled the twins along through the cot, up against the bars of the cot".[133] Dr Walker told Macsyna King that the twins would need to have CT scans.

[110] As recorded, at his first Police interview Chris Kahui said that when his partner asked him about the bruising on Chris' face, after he came home on Tuesday morning from buying formula, he suggested "Shane might have gone in there ..... and whacked him or something".[134] At the second interview he agreed that Shane could not be responsible for the

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[124] Macsyna King TNOE p109/8
[125] TNOE p468/1 Effectively she was relaying the explanation given to her by Chris Kahui
[126] TNOE p454
[127] TNOE p455/12
[128] TNOE p455/24
[129] TNOE p457/5
[130] TNOE pp517-520
[131] TNOE p525
[132] TNOE 527
[133] TNOE p527/7
[134] Chris Kahui First Police Interview p17

twins' injuries[135] At the third Police interview he said that when he had put the twins on the couch, Shane was standing on them and could have whacked the twins in the face.[136] At inquest Chris Kahui said that what he had told Police at his third interview about seeing Shane *on* the twins was wrong,[137] underlining again the unreliability of his evidence and his capacity for invention.

[111] At approximately 3.40 pm Macsyna King called Stuart King's mobile phone. She asked to speak to her partner. Stuart King described her tone as "upset, pissed off, angry". By then, Chris Kahui had returned from his walk and was at home playing on a PlayStation gaming console with Stuart King. Stuart King said he recalled Chris Kahui saying "whatever" on the phone, that he seemed a bit upset about the phone call but,

> "well it was his turn on the game, so he played again."[138]

[112] Macsyna King called Stuart King's mobile phone twice again at about 4.07 pm but was not connected. She was connected for 2-5 minutes when she rang again at about 5.02 pm. The call appears to have been disconnected and was continued at 5.06 pm for a further 3-5 minutes.

[113] Stuart King described a second call from Macsyna King when "Macs rang me again ..... pretty much in the same mood ..... wanted to talk to Chris again.[139] The phone was handed to Chris Kahui who left the room to talk to Macsyna King.[140]

[114] Mona Kahui said she saw Chris Kahui take a call from Macsyna King and hold the phone away from his ear because she was shouting.[141] After hanging up the phone Chris Kahui told Mona Kahui "that Macs was in the ICU with the twins and they found that Chris had a broken leg and they had fractured ribs and brain damage."[142]

[115] The twins were transferred to Starship Hospital by ambulances between 6.10 pm and 6.30 pm.

[116] Cru Kahui died on Sunday 18 June at 4.55 am.

[117] Later that day, at 6.45 pm, Chris Kahui died.

[118] Macsyna King said at inquest that she rang Chris Kahui and spoke to him at least three times whilst she was at Middlemore Hospital.[143]

[119] Chris Kahui accepted that he spoke to his partner twice on Stuart King's phone and maybe more than twice.[144]

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[135] Chris Kahui Second Police Interview p75
[136] Chris Kahui Third Police Interview pp47-49
[137] INOE p733
[138] Stuart King TNOE p266/10
[139] Stuart King TNOE p267/16
[140] Stuart King TNOE p267/25
[141] Mona Kahui TNOE p340/9
[142] Mona Kahui TNOE p340/14-25
[143] INOE p390
[144] INOE pp846-847

[120] Poignantly, Macsyna King said that she rang her brother Stuart "to see if Chris had come home yet and to tell him that we were in hospital and that the boys were in really critical danger, and I wanted him with me, and if he could get him to come to us".[145]

[121] At inquest, Macsyna said the first time she rang Chris Kahui she screamed at him and told him that the boys were in a critical, critical condition. She told him that the boys were hurt "and it is really bad". She said he hung up on her.[146] The Court accepts the evidence of Macsyna King in relation to the events that took place during this period of time.

[122] At inquest, Chris Kahui confirmed that on the first occasion he spoke to his partner on the phone she asked him to come to the hospital to be with her and the twins.[147]

[123] Instead, he returned to playing PlayStation with Stuart King.

[124] Chris Kahui accepted at inquest that he knew of the twins' serious injuries when his partner rang him, before there was any mention of the Police coming round to his home.[148] He said he did not go to the hospital as he did not want to walk.[149] In his Police interviews he incorrectly claimed not to have known how serious the twins' injuries were during the early phone calls.

[125] Macsyna King was told by Dr Walker at about 4.00 pm "that both boys were severely critically ill" and that she would be notifying the Police.[150]

[126] Chris Kahui had returned home about an hour (or an hour and a half) after he had walked off, leaving Macsyna King to take the twins to hospital by herself. He could have gone to the hospital on his return. Emily King's Subaru was at the house and Mona Kahui and Stuart King were also there. He could easily have walked to the hospital which was close by. He chose not to do so.

[127] Chris Kahui accepted at inquest that Dr Nayar told his partner and him to take the twins straight to Middlemore Hospital.[151] He later agreed, as his actions showed, that he did not want to go straight to the hospital after seeing Dr Nayar. He admitted that Macsyna wished to go straight there.[152] Immediately before that admission, however, he claimed that it was Macsyna King who had wanted to go home before going on to the hospital. As recorded, upon arrival at home he walked off leaving Macsyna King on her own. Upon his return to the house, he was, according to Mona Kahui, in a "relieved mood". Chris Kahui told her that he went for a walk to "cool off" after arguing with Macsyna King.[153] Stuart King described Chris Kahui as "upset" when he arrived home from the doctor. He said that after returning home from the walk he was "still upset but a lot more calm".[154]

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[145] TNOE p50/9
[146] INOE p167
[147] INOE p864-866
[148] INOE pp709 and 713
[149] INOE p865
[150] TNOE p528/5
[151] INOE p691
[152] INOE p718
[153] TNOE 337
[154] TNOE 261

[128] The actions of Chris Kahui in avoiding going to the hospital with the twins, whom he knew (on the advice of Dr Nayar) were very sick, in subsequently walking away from home and leaving his partner to make her way to the hospital with the twins on her own, and in avoiding going to hospital on his return from his walk, is congruent with his earlier behaviour in not disclosing to other family members in the house, his partner and Dr Nayar the fact that the twins had not fed or cried for food since (on his inquest statement) 1.00 pm the previous day and in offering Macsyna King a specious explanation for Chris' noticeable facial bruise. His behaviour is consistent with a wish to avoid the hospital authorities.

MEDICAL EVIDENCE

[129] The Court turns now to a consideration of the medical evidence, including that heard from the panel of four medical specialists (the panel) in the week beginning 27 June 2011. The latter evidence was not available to the jury at the criminal trial.

[130] As recorded in para [3] hereof, under *Summary of Findings* and *Comment*, Dr Vuletic attributed the cause of Chris' death to brain injury secondary to trauma which occurred 5-7 days prior to death. She said the bruise on the back of Chris' head was consistent with blunt force trauma. The right femoral fracture was recent and consistent with having occurred 5-7 days prior to death. The rib fractures (right 5th, 6th and 7th, and left 3rd, 4th and 5th) were somewhat older, their histological appearances being consistent with an age of not less than 14 days. However, next to the epiphysis in each of the left 4th and right 5th ribs there were recent fractures consistent with an age of a few days.

[131] As recorded in para [4] hereof, under *Summary of Findings* and *Comment*, Dr Vuletic attributed the cause of Cru's death to brain injury secondary to trauma. As with Chris, she said the appearances were consistent with such injury having occurred 5-7 days prior to death. She said healing rib fractures were present (the left 3rd to 8th and the right 1st and 3rd to 6th ribs), the appearances of which were consistent with having occurred not less than 14 days prior to death.

HOUSEHOLD ENVIRONMENT UNSAFE

[132] The fact that there was an admixture of both old and fresh injuries affecting the twins is deeply disturbing and shows that the household environment in which they were being brought up was unsafe.

[133] The Coroner is not clothed with jurisdiction, in terms of S15 of the Act, to make findings in respect of those injuries suffered by the twins at an earlier point in time, such injuries not being on the evidence causal of, or materially contributory to, death. Such earlier injuries include the twins' older rib fractures; the subdural haemorrhage suffered by Chris (which was thought to be 2-3 weeks old);[155] and possible fractures in the case of Cru of both femoral and tibial bones at the knee (not examined histologically *post-mortem)*. In any event, the evidence does not admit of the identity of the person(s) responsible for the earlier injuries suffered by the twins.

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[155] INOE 27 June 2011 p59/11-13; p93/27-8; INOE 27 June 2011 p94/2

[134] The Court is satisfied that the injuries suffered by the twins that led to their deaths (the fatal injuries) were non-accidental in nature. All the medical specialists whose evidence was heard in this Court so agreed.[156] It has not been argued by Counsel that this is not so.

[135] It follows that the Court is satisfied that the fatal injuries resulted from the application of external force at the hands of another or others.

TWINS LIKELY INJURED TOGETHER AT SAME TIME BY SAME PERSON

[136] The Court is satisfied that, more likely than not, the twins' fatal injuries were inflicted within the same period of time.[157] This is the view of Dr Jane Zuccollo, a perinatal pathologist of considerable experience. The twins' fatal injuries and their symptomatic effects bear an awful symmetry. The twins ceased to cry or to take food within the same time period.

[137] The Court is also satisfied on the evidence before it that the physical mechanisms of injury are likely to have been the same in each case and that, more likely than not, the twins were injured at the hands of the same person. The twins slept together and were cared for together. Dr Zuccollo said the injuries were so similar that she regarded them as one (TNOE p841/3).

[138] The Court finds on the evidence that the right femoral fracture suffered by Chris likely occurred at the time he received his fatal injuries, along with his more recent rib injuries.

[139] Before the Court may seek to establish the circumstances in which the twins suffered their fatal injuries it needs to establish the time when those injuries were likely inflicted and the kind(s) of physical force they were likely subjected to.

LIKELY NATURE OF INJURIES TO TWINS

[140] As to the latter, the panel members were in general agreement as to the kind of physical action or force necessary to cause the injuries inflicted. Mr Mount accurately summarises panel members' views at para 3.3 of his written submissions as follows:

> "The experts' views were that the twins' brain injuries had been caused by severe impact forces to the head[158] and rapid acceleration and deceleration of the head[159], either from direct blows or being hit or thrown against a firm surface[160], or from being slammed against a firm surface.[161] Dr Byard elaborated that:[162]

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[156] See Dr Kelly's report, 15 April 2011, p6; Dr Byard's report, 5 June 2011; p11; Dr Donald's report, 6 June 2011, p14

[157] Dr Jane Zuccollo TNOE pp845, 846/18. See also Dr Kelly's report 20 April 2011 [8.1]; Dr Byard's report 23 December 2010 p11; Dr Donald's report 23 October 2010 p13; Report attached to Coroner's Minute dated 23 June 2011 at [6]-[7]

[158] Dr Kelly's report dated 20 April 2011 – p5, [9.5]; Dr Jenny's report dated 14 February 2011, p1; Dr Byard's report dated 5 June 2011 – p4; Dr Donald's report dated 23 December 2010 – p13 [9]

[159] Dr Kelly's report dated 20 April 2011 – p5 [9.5]; Dr Donald's report dated 23 December 2010 – p13 [9]

[160] Dr Byard's report dated 5 June 2011 – p11 [9]

[161] Dr Kelly's report dated 20 April 2011 – p5 [9.5]

> "it could be all sorts of surfaces, if it's a hard surface like this [Court] Bench with sufficient force you could cause it, if it's a mattress it's not hard but it's still firm enough to stop the head quickly, it can cause that. So really it's any surface is going to rapidly decelerate the brain."

The possibility of violent shaking as one of the causes of the injuries also could not be excluded.[163]

These views were supported by the nature of the injuries sustained to the infants' heads. Both twins had diffuse multi-layered retinal haemorrhages (most likely caused by violent rotational deceleration of the head, associated with shaking and/or impact of the head),[164] subdural bleeding (caused when the bridging subdural veins were torn by acceleration and deceleration of the head, especially where the movement is rotational),[165] contusional tears to the brain (caused by the same traumatic shearing forces that tear the subdural veins and which is associated with impact forces on the head),[166] inward displacement of the lambdoid sutures (caused by significant impact to the head)[167] and intraventricular bleeding (associated with blunt force impact of considerable magnitude).[168]

In addition to the above head injuries, baby Chris also had a parietal skull fracture[169] and bruising to the occiput (both of which were caused by significant impact to the head).[170]"

WHEN WERE THE FATAL INJURIES LIKELY INFLICTED?

[141] When were the fatal injuries likely inflicted? At inquest the four panel members unanimously accepted that:[171]

(a) The contusional tears in Cru's brain were indicative of a serious primary injury which was the cause of death
(b) The primary injury must have occurred after the last normal feed
(c) If the evidence of April Saunders (Martin) is accepted by the Court, the primary injury occurred after that feed

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[162] INOE (June 2011) p117/4
[163] Dr Kelly's report dated 20 April 2011 – p5, [9.6]; Dr Byard's report dated 5 June 2011 – p11 [9]; p8-9; Dr Donald's report dated 23 December 2010 – p14 [9]
[164] Dr Kelly's report dated 20 April 2011 – p5, [9.4]; Dr Kelly's report on Chris Kahui dated 24 November 2006 p5; Dr Kelly's report on Cru Kahui dated 24 November 2006 p5
[165] Dr Kelly's report dated 20 April 2011 p5, [9.1]
[166] Dr Kelly's report dated 20 April 2011 – p5, [9.3]; Dr Kelly's report on Chris Kahui dated 24 November 2006, p6; Dr Kelly's report on Cru Kahui dated 24 November 2006, p6.
[167] Dr Kelly's report dated 20 April 2011, p5 [9.5]
[168] Dr Kelly's report on Chris Kahui dated 24 November 2006, p6; Dr Kelly's report on Cru Kahui dated 24 November 2006, p6
[169] Dr Kelly's report dated 20 April 2011, p5 [9.5]
[170] Dr Kelly's report dated 20 April 2011, p5 [9.5]
[171] INOE 27 June 2011 pp41, 47-49

(d) If the Court accepts there was a normal feed around 5.00 or 6.00pm then, equally, the primary injury occurred after that time
(e) If Cru had been taken to hospital immediately after the apnoeic episode suffered by him on the evening of 12 June he could well have been saved
(f) If Chris' fatal injury was received at the same time as Cru's injury, the sooner he received care (as with Cru) the better the outcome would have been.

[142] The panel members were of the view that *the effects of the twins' fatal injuries would have been immediate and obvious*, with some alteration in their levels of consciousness, or loss thereof; and that *they would have remained abnormal from that point onwards.*[172]

[143] The Court adopts and applies the evidence referred to. It pays particular attention to the evidence of Dr Jenny, who has an internationally established reputation in the area of child abuse paediatrics. Dr Jenny reviewed the evidence in this case with fresh eyes, she having had no earlier involvement. In her report to the Court, Dr Jenny describes the twins' fatal injuries as devastating and extensive. She says *infants with injuries as extensive as these would have been profoundly symptomatic afterwards.*[173] She says Chris and Cru would not have been able to accomplish effective feeds after they sustained their injuries. She says the descriptions given (by April Saunders) of Cru's feeding on the afternoon of 12 June are incompatible with a gravely injured infant with an extensive head injury. At pp2-3 of her report she gives further reasons for her view.

[144] The Court repeats its finding (recorded in para [54] hereof) that the twins were in every respect normal and well at the time they were fed together about midday on Monday 12 June and at the time Cru received the rest of his bottle from April Saunders a little time later.

[145] Justice Venning, who presided at the criminal trial, is recorded in para [115] of the notes of his Summing Up as saying:

> "The defence say that Macsyna King could have inflicted the fatal injuries either before she left on the Monday morning [12 June] or at some stage when the accused was up at the hospital dropping Mona off at about 7 pm that night."

[146] It is patent that the former of the two propositions put to the jury by Chris Kahui's counsel, apportioning blame for the twins' deaths upon Macsyna King, cannot lie in the light of the medical and other evidence heard in this Court. Significantly, Counsel for Mr Kahui no longer advances the proposition that the twins' fatal injuries were inflicted by Macsyna King before she left the house on the Monday morning. The propositions relied upon by Mrs Wilkinson-Smith are set out in para [48] hereof.

[147] When did the twins receive their fatal injuries? Mr Mount submits that the Court should conclude the injuries occurred after 5.00 pm on 12 June. He submits, in the alternative, "it is established at a minimum that the fatal injuries to both twins occurred after midday on 12 June 2006." He says that "at its widest ..... the critical period for both twins therefore starts at the time just after the midday feed, that is approximately 1.00 pm."

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[172] INOE 27 June 2011, Dr Kelly pp2/17-21 and p73; Dr Kelly pp2/17-21; Dr Jenny p21/5-6 and p74/9; Dr Byard p74/13; and Dr Donald p74/22. See also Dr Kelly's report 20 April 2011 p8 [13]; Dr Jenny's report p4; Dr Byard's report 23 December 2010 p11; Dr Donald's report 23 October 2010; Report attached to Coroner's Minute dated 23 June 2011 at [6]-[7]

[173] The other panel members are recorded in INOE at p74 as being in agreement with such statement

[148] Ms Dyhrberg submits (para 55 of her submissions) that whilst a wide view could encapsulate a critical time period between 12.00pm and 9.00pm on 12 June, it is likely that the injuries were inflicted between 5.00pm and 9.00pm. She says this is due to Chris Kahui's evidence in his first two Police statements that he fed the twins between 5.00-6.00pm on 12 June. She points out that in cross-examination Chris Kahui told the Coroner that what he told the Police in his first two interviews as to feeding (that he had fed the twins between 5.00-6.00pm on 12 June "would have been what [he] remembered" and that his memory of events would have been better then than what it was at the time of the inquest hearing.[174]

[149] Mrs Wilkinson-Smith says (para 61 of her submissions) that there can be little doubt that Chris Kahui overstated the feeds in the first interview of 13 June. She says the only questions are the degree to which he overstated the feeds and his reason for doing so. She asks why did Chris Kahui say he had fed the twins after their midday/1.00pm feeds if he did not? She concedes one possibility is that he had hurt the twins and was trying to cover it up. She says the "other explanation" is that, "having failed to be overly concerned by the twins' lack of feeding, he realised, when speaking to the Police, that he should have been concerned and did not want to appear as a bad father so he told the Police that he had stuck to the 6 hr feeding routine". Mrs Wilkinson-Smith submits that it is not beyond the realms of possibility that a 21 year old father with a low IQ could simply allow babies to sleep rather than disturb them provided they appeared to be breathing and otherwise sleeping normally.

[150] The Court rejects Mrs Wilkinson-Smith's "other explanation". Given the Court's finding that the twins were normal and well when Chris Kahui took charge of them after 1.00 pm on Monday, the dramatic changes that took place in their states of health and behaviour could only have resulted from something that had happened to them whilst they were in the sole custody and care of their father during the afternoon/early evening of 12 June. That event was, of course, the infliction of the injuries that led to their deaths.

[151] The Court rejects the proposition that Chris Kahui might simply have allowed the twins to sleep rather than disturb them had they "appeared to be breathing and otherwise sleeping normally". They were neither crying to be fed nor feeding. Mr Kahui had no difficulty in assessing the twins' state of health at lunchtime on 12 June.[175] Detailed evidence was given by him as to normality[176]. Dr Kelly said the key significance, as he saw it, in terms of Chris Kahui's ability to judge the normality of the twins

> "is that he was clearly able to judge their normality. He'd feed them regularly, he changed them, he knew their normal behaviour and a basic principle of clinical paediatrics is that you always listen to the parent or caregiver who knows the baby."[177]

Dr Kelly said Chris Kahui was a parent who had the ability to know whether his baby was normal. He said if Mr Kahui stated that Cru was normal to his observation during the feeding by April Saunders then he would regard that as a reliable observation.[178] The Court comments that it has to be kept in mind that the twins' disordered states continued through

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[174] INOE 12 October 2010 pp882-883
[175] Chris Kahui First Police Interview 2006, p5
[176] INOE 7 October 2010 pp606-609. See also para [53] ante
[177] INOE 27 June 2011 p23/22-34
[178] INOE 27 June 2011 p23/34. See also INOE 27 June 2011 p24/8, 11 (Dr Jenny) and INOE 27 June 2011, p24/14 (Dr Donald)

the night of 12 June until they were taken to see Dr Nayar at midday the next day. Mr Kahui was experienced, as already stated, in caring for the twins (and Shane).

[152] As already recorded (paras [142] – [143]), the effects of the twins' fatal injuries would have been immediate and obvious, with loss or alteration in level of consciousness. The twins would have been profoundly symptomatic afterwards and would not have fed again. The Court finds that the effects of the infliction of the twins' fatal injuries whilst they were in their father's care and control would have been immediate and obvious to him, certainly as time went on, in the respects already spelt out.

[153] Of relevance, the following passage appears at INOE pp680-681:

> "CORONER: Did Cru appear to you to be well when he stopped breathing and showed those signs that we have been discussing, that is he went limp, he was ..... blue and so on? Did he appear to you to be well?
>
> MR KAHUI: Not fully well, sir, but he – yes, he did look like he was not fully himself.
>
> CORONER: Well, he was unwell, was he not?
>
> MR KAHUI: Yes, sir.
>
> CORONER: Do you know the meaning of unwell?
>
> MR KAHUI: Yes.
>
> CORONER: You were worried about him, were you not?
>
> MR KAHUI: Yes.
>
> CORONER: You wanted Macsyna to come and help you to tell you about his breathing.
>
> MR KAHUI: Yes. Yes, sir.
>
> CORONER: You could not get her, could you?
>
> MR KAHUI: No, I could not.
>
> CORONER: You were not able to feed Cru, were you?
>
> MR KAHUI: No.
>
> CORONER: He was not taking any food.
>
> MR KAHUI: No, he was not.
>
> CORONER: And he was not crying, was he?

MR KAHUI: No.

CORONER: And he was just sleeping, was he not?

MR KAHUI: Yes.

CORONER: That was out of keeping with Cru, a normal healthy baby, was it not?

MR KAHUI: Yes, it was.

CORONER: My question to you is knowing that that was out of keeping with his normal behaviour and knowing that he was unwell, and you were not able to get Macsyna, why did you not take him to the doctor, as everyone else in the house said you should? Now, you can take as long as you like. What is the explanation for that?

MR KAHUI: I do not really have an answer for that."

The Court finds that Chris Kahui knew that the twins had ceased to cry out to be fed (he said Chris did not cry or feed after Macsyna King left the house on Monday 12 June), that they had stopped feeding and that they were obviously very unwell. For reasons of his own he neglected to summon the medical help they urgently needed. It should be recorded that Mr Kahui was asked at Inquest why he wanted Macsyna King to return to the house. He said, as recorded at INOE p677:

> "Because Macsyna had – we had some discussions and that Cru stopped breathing sometimes. She had told me this, days before. And I thought ... that she would of known what to do."

Later, Mr Kahui was cross-examined by Ms Dyhrberg. At p722 of INOE the following interchange is recorded:

"MS DYHRBERG: Yes, thank you, Mr Kahui. I just I think mentioned about a topic that I am going to go into and that is in terms of the "breathing" in terms of the twins, and it is in relation to whether there were any prior incidents of non-breathing, all right?

MR KAHUI: Yes.

MS DYHRBERG: So that is not to do with the actual stopping of the breathing by Cru that night.

Now before this incident, that we have been talking about on the Monday evening, as far as you are concerned there had been no earlier incidents, had there, of either baby stopping breathing?

MR KAHUI: No.

MS DYHRBERG: And this business about Macsyna shaking the babies if they stop breathing that is just something that Mona said to you, is that right?

MR KAHUI: Yes.

MS DYHRBERG: So that is not something that you and Macsyna had ever discussed or talking about, is it?

MR KAHUI: No.

MS DYHRBERG: I just want to give you the opportunity of being clear in your evidence on this matter, Mr Kahui."

Why was a search made for Macsyna King? If Cru had, in Mr Kahui's words, "come right", if there had been no earlier incidents of either baby having stopped breathing as stated by Mr Kahui (excluding the report to Macsyna King and him of an incident at the hospital), and, if indeed there was no need to summon medical help, why was there a need for family members to go out into the night looking for Macsyna King? The evidence shows, in fact, that Mr Kahui remained worried about Cru. He said he wanted to sleep in the twins' room in case Cru stopped breathing again. See para [81] *ante*. That being so, why was Macsyna King sought instead of a doctor? His behaviour is consistent with not wanting the twins to be seen by a doctor. The evidence shows that he wanted to see Macsyna King to face her with what had happened to the twins in her absence.

REPORT OF DR NUTH

[154] Lying before the Court is a report from Dr Jon Nuth, clinical psychologist, who was asked by the Court to interview Chris Kahui and to carry out a neuropsychological assessment. At no time has Mr Kahui's competence to instruct solicitors or to give evidence been raised with the Court. There is no evidence that he is other than competent.[179] Dr Nuth reported that Mr Kahui is a person of low IQ who would find it easier to answer simple, short questions rather than long, complicated questions.[180] Mr Kahui was represented throughout by experienced counsel. He was given adequate time to answer the questions put to him, which were phrased in simple English. Dr Jenny commented that Mr Kahui "clearly ..... understands the King's English".[181] The Court is satisfied that Mr Kahui fully understood the evidence he gave and the questions put to him by way of cross-examination.

MRS WILKINSON-SMITH'S SUBMISSIONS

[155] It is appropriate at this point to deal with the submissions made by Mrs Wilkinson-Smith (set out in para [48] hereof) that the evidence does not establish to the required standard of proof (as discussed and defined in para [183] hereof, *post*) the person(s) responsible for the twins' deaths. As recorded, it is postulated by her that the fatal injuries might have been :

(i) inflicted by Macsyna King on Tuesday morning 13 June
alternatively

[179] INOE 13 October 2010 p1021/14-19; 1021/30
[180] Dr Nuth's report pp 12-13
[181] INOE 27 June 2011 pp28/31, 29/1-2

(ii) inflicted by Macsyna King about 7.00 pm on Monday 12 June while Chris Kahui was absent from 22 Courtenay Crescent dropping Mona off at Middlemore Hospital
alternatively
(iii) inflicted by Stuart King.

[156] In his Submissions in Reply, Mr Mount submits that none of these "scenarios" is supported by the evidence and each is directly contradicted by the evidence in significant respects. He submits that the only conclusion reasonably available on the evidence is that Chris Kahui inflicted the fatal injuries at 22 Courtenay Crescent on Monday 12 June.

FIRST THEORY

[157] The proposition that Macsyna King fatally injured the twins on the morning of 13 June is rejected. It is expressly contradicted by the evidence. As stated by Mr Mount, it is a 'novel' theory, never previously advanced on behalf of Mr Kahui. In order that such a theory might lie, the Court would need to find that the apnoeic episode on the evening of 12 June, followed by changes in or loss of consciousness, and an inability to cry or feed, were not the symptomatic expression of the fatal injuries inflicted on Cru but the sequel to an earlier non-fatal assault on the twins at the hands of Macsyna King before she left the house on Monday morning.

[158] The theory lies entirely without evidential support and flies in the face of the expert and other evidence:

(i) The evidence shows that the fatal injuries *preceded* and gave rise to the apnoeic episode. Dr Jenny said "it is very clear that the apnoeia occurred *after* the severe head injury." [182]

(ii) Dr Kelly said:
"an episode of stopping breathing is a very typical manifestation of an acute head injury in a baby of this age and in my view it is the best guide to the timing of Cru's head injury, that I suspect his head injury occurred immediately prior to that apnoea. I can't be entirely certain about that, his head injury may have occurred earlier that afternoon and the apnoea may have been a delayed consequence of it".[183]

The evidence shows that the apnoeia was the symptomatic expression of the fatal injury that had been inflicted upon Cru's brain tissue. There is no specialist medical support for Mrs Wilkinson-Smith's first theory.

(iii) Dr Zuccollo was of the same view as Drs Jenny and Kelly at trial, stating that she thought the apnoeic episode was likely to have been very close to the injury. [184]

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[182] INOE June 2011 p22/3
[183] INOE June 2011 p3/11
[184] TNOE p877/33

(iv) Chris Kahui said at inquest that the twins were completely normal before the apnoeic episode and that they had been doing all the things that he would expect them to do. [185]

[159] The Court is satisfied on the evidence before it, to the required standard of proof,[186] that Cru's fatal injury preceded the apnoeic episode and that, more likely than not, Chris was fatally injured at about the same time. It is significant that at trial, when Mona Kahui was asked whether there was any talk about ambulances or hospitals after the apnoeic event, she said (TNOE p331):

> "Yes, we were going to call the ambulance but then Chris said because he had the car, that it might be faster *if he just puts them in their car seats and takes them* 'cause the hospital was only five minutes away from us". (Italics added)

She was then asked:

> "What did Chris want to have happen?"

To which she replied:

> "Chris asked me and my dad if we would go and look for Macs and let her know that *the boys had stopped breathing* but that *they were okay.*" (Italics added)

Later in cross-examination Ms Kahui was asked whether she had called for an ambulance. She answered that she had not. She was asked if there was a reason why she did not do so. She answered (TNOE p362-363):

> "Because we had a vehicle at the house and I thought it would be faster *if we just took the babies in the car."* (Italics added)

[160] As pointed out by Mr Mount in his Reply Submissions (para 2.3(b)), the evidence of Dr Jenny relied upon by Mrs Wilkinson-Smith for her "earlier assault" theory (followed by fatal assault on the morning of 13 June) is not authority for her submission. The twins did not fall into the accumulating mass of blood category,[187] relied upon by Mrs Wilkinson-Smith, in which an infant may be able to feed before the more serious effects are made manifest The injuries received by the twins were in the nature of a severe primary brain injury.[188] As also pointed out by Mr Mount, when the "earlier assault" theory was put to the panel, Dr Jenny described it as "totally speculative"[189] and Dr Kelly said it invited "speculation on speculation".[190] While Dr Donald expressed concern that the twins might have experienced more than one episode of head injury, none of the panel members said the apnoeic episode might have been the result of a non-fatal assault before Macsyna King left the house at about midday on 12 June.

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[185] INOE p636
[186] As discussed and defined in para [183] hereof, *post.*
[187] INOE June 2011 p8/34
[188] INOE June 2011 p9/2
[189] INOE June 2011 p109/9
[190] INOE June 2011 p112/4

[161] There is not a scintilla of evidence to support the proposition that the twins' fatal injuries were inflicted not during the afternoon/evening of 12 June but at the hands of Macsyna King on Tuesday morning. Ms King arrived at 22 Courtenay Crescent at about 9.25 am. Stuart King was present[191] and Chris Kahui arrived home shortly (perhaps 20 minutes) afterwards.[192] Neither Chris Kahui nor Stuart King has ever suggested that Macsyna King assaulted the twins that morning. Nor, until Mrs Wilkinson-Smith advanced her theory, had anyone else suggested it. The signs and symptoms of the twins' fatal injuries were fully established at the time Macsyna King arrived at the house on Tuesday morning.

THIRD THEORY

[162] Before examining the third of Mrs Wilkinson-Smith's theories, the Court will deal with the second, namely, that the twins' fatal injuries were inflicted by Stuart King. Not only is there not a scintilla of evidence to support this allegation, Mrs Wilkinson-Smith acknowledges in para 193 of her submissions that "there is no evidence to support it". She also acknowledges that Chris Kahui "has never regarded Stuart King as someone who would hurt his babies", adding "nevertheless Stuart King had opportunity and cannot be rejected". The doubt raised by Mrs Wilkinson-Smith is an unreasonable doubt and is rejected. Mr King's evidence both at trial and (TNOE pp271-272) inquest (INOE p1073) that he did not harm the twins was never challenged by Chris Kahui's counsel. Mr King acknowledged at trial that he had a conviction for assault on a child in 2002, the circumstances of which he described.

MRS WILKINSON-SMITH'S SECOND THEORY

[163] The Court now turns to the second theory. Mrs Wilkinson-Smith submits that "the possibility that Macsyna King driving Emily Hepi's car, returned to Courtenay Crescent about 7.00 pm on the evening of 2006 cannot be excluded." She submits "it is possible Macsyna King became angry at finding Chris Kahui had once again gone to the hospital. She assaulted the twins and left the house, later meeting up with Emily King and spending the rest of the night with Emily King."

[164] A considerable volume of evidence was heard concerning the movements of Macsyna King and Emily King from early afternoon to late evening on 12 June. Evidence was heard relating to the timings of cellphone calls made by various persons and the cellphone sites with which those calls connected. There is no evidence that would show, or from which it might reasonably be inferred, that Macsyna King returned to 22 Courtenay Crescent at any time during the evening of 12 June, let alone that she fatally assaulted the twins. Indeed, Chris Kahui himself stated that his partner did not return to the house that night.[193] Stuart King remained in the house alone while Chris Kahui was taking his sister Mona to the hospital. He said Macsyna King did not return during that time.[194] It is inherently implausible that Mr King would have been unaware of Macsyna King's return to the house had she done so. Having heard Mr King's evidence, the Court is satisfied that there is no possibility of Macsyna King having returned to the house without his having become aware of that fact.

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[191] INOE p87
[192] INOE pp87-88
[193] Chris Kahui, First Police Interview p12. See also INOE p693/13
[194] Stuart King INOE p242/31. See also TNOE pp285-286, 291/28 and 292/5

Emily King said she and Macsyna King had been together throughout the evening of 12 June.[195] The Court is satisfied on the evidence that the two women were together that evening and were travelling in the same vehicle. Emily King denied going to Courtenay Crescent at any time that night to drop off or pick up Macsyna King.[196] Macsyna King denied having returned to Courtenay Crescent at about 7.00 pm on 12 June.[197] Mr Mount and Ms Dyhrberg submit that had Macsyna King returned to 22 Courtenay Crescent at about 7.00 pm, to the knowledge of Emily King, her partner Pou Hepi and Stuart King, their denials that she had done so would amount to a conspiracy to withhold the truth. The Court finds no evidence of this. Nor has it any cause to doubt the truth of the evidence that Macsyna King did not return to 22 Courtenay Crescent during the evening of 12 June.

[165] Mrs Wilkinson-Smith's proposition that Macsyna King might have returned to 22 Courtenay Crescent at about 7.00 pm on 12 June is predicated on a telephone call from Pou Hepi to his partner Emily King at 7.54 pm that evening, which call interfaced with the Mangere cell site. Mr Mount submits that such telephone call was consistent with the evidence given by Emily King at trial,[198] and the evidence given by Macsyna King,[199] Emily King[200] and Pou Hepi[201] at inquest. He says the movements of Macsyna and Emily King are *corroborated* by the cellphone evidence. He says the route taken by them is consistent with the cellphone records and has been consistently described by Emily King since she first gave evidence in the High Court in 2008. The closest to Mangere those records get Emily's car to is the Southwestern Motorway. There is no evidence that her vehicle left that motorway to travel to Mangere and no evidence that it was ever in Mangere.

[166] The evidence shows that Emily and Macsyna King were in Papakura at 6.58 pm on 12 June. Evidence was given by Detective Sergeant Barry at trial that the drive from Emily King's Papakura house to 22 Courtenay Crescent is approximately 23 minutes.[202] Mona Kahui gave evidence that she and Chris Kahui left 22 Courtenay Crescent shortly before 7.00 pm.[203] The evidence shows that Chris Kahui would have returned home by 7.20 pm. The trip to Middlemore Hospital, including one stop for petrol, was timed by Detective Sergeant Barry at 17 minutes.[204] Mr Mount submits, and the Court accepts, that on these timings there is insufficient time for Macsyna King to have travelled from Papakura to Courtenay Crescent, assaulted the twins and then left before Chris Kahui's return at 7.20 pm. The evidence also shows (see para 116, Mrs Wilkinson-Smith's submissions) that at 7:38 pm on 12 June the vehicle in which the two women were travelling was in the Unitec cell site area, which lies in the general Northwestern Motorway area of Auckland. The house which the two women said they were visiting, which is owned by Ms Ginta Gaile, also lies in that general area.

[167] Mr Mount submits, and the Court accepts that, leaving this evidence aside, it is inherently implausible that Macsyna would have interrupted her evening out with her sister to return to Courtenay Crescent, happened to arrive during the 20 minute period when her partner happened to be out, fatally assaulted the twins and then left, devised an alibi that was

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[195] Emily King TNOE p628/1
[196] Emily King TNOE p644/10-26; INOE 6 October 2010 p299/32; INOE 6 October 2010 p350/32
[197] Macsyna King TNOE p191/6
[198] TNOE pp607/32, 608/3 and TNOE pp580-581
[199] INOE 6 October 2010 p275/16-26, inquest statement 10 October 2010, p4
[200] INOE 13 October 2010 pp1102/11; 11/03/15
[201] INOE 14 October 2010, p1398/1-14
[202] TNOE 1040/9
[203] TNOE pp313/24, 314/3
[204] Supplement Inquest Statement of Detective Sergeant Barry dated 7 October 2010

consistent with cellphone records *that she was unaware of* and then successfully persuaded Stuart King, Emily King and Pou Hepi to cover this up. Mr Mount submits that such a "scenario" is incapable of belief. The Court reiterates that there is no evidence Emily King's car left the Southwestern Motorway it was travelling on during the early evening of 12 June to travel to Mangere, that it was ever in Mangere during the evening of 12 June or that Macsyna King went to 22 Courtenay Crescent during the short period of time that her partner was absent from the house. The allegation that she fatally injured her two sons that night is entirely unsupported on the evidence and must be dismissed. The evidence and submissions relating to Macsyna King's cellphone use, and that of others, has been carefully considered by the Court. They do not advance matters, as shown by paras 3.4-3.5 of Mr Mount's Submissions in Reply. It should be recorded that the Court has certain reservations as to the truth of the evidence heard from Macsyna King, Emily King and Pou Hepi relating to their general movements during the evening of 12 June and the explanations provided by them for their lack of recall of events until confronted with cell site and cellphone records. In particular, the Court has reservations as to whether it has been told the truth as to the reasons for the various cellphone calls that were made by and to Mr Hepi. However, on the critical issue of whether Macsyna King returned, or might have returned, to Courtenay Crescent on the evening of 12 June, there is no evidence that she did so and no reasonable possibility that she might have done so, let alone been responsible for causing fatal injuries to the twins. No reasonable explanation is offered as to why Macsyna King, having returned home, might then choose to inflict severe injuries on her own children. The Court is satisfied that the telephone calls and the whereabouts of Macsyna King, Emily King and Pou Hepi during the evening had nothing to do with the deaths of the twins.

EVIDENCE OF MR TUARI

[168] Evidence was heard in June this year from Mr Eru Tuari. Mr Tuari gave evidence for Chris Kahui at the trial. He said he had met Macsyna King about November or December 2006. He visited her on one occasion at Emily King's Papakura home. He went into her bedroom. He was intending to take a photograph of her. He said she was "freaking out". There was conversation between them. He said that at one point the conversation was as follows:[205]

> "[Macsyna said] Chris didn't do it – I did it.
> And I said, "Did what?"
> She goes "I did it"
> And I said "Did what?"
> She said "Oh fuck this". That's what she said.
> "Never mind, fuck this" sorry. She said "never mind, fuck this."

[169] Mr Tuari claimed he had recorded this conversation on a cellphone, although he no longer had the cellphone or the recording. He said that "almost straight away" at the start of the conversation he had closed the phone and thrown it on the bed.[206] He accepted that the phone would have stopped recording when it was closed.[207] The phone was located. There was no evidence of any recorded conversation with Ms King.[208]

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[205] Eru Tuari TNOE p1069/14
[206] Eru Tuari TNOE p1089/24
[207] Eru Tuari TNOE p1091/28
[208] Eru Tuari TNOE p1084/9

[170] At inquest Mr Tuari clearly acknowledged that Macsyna King had never told him that she had killed the twins.[209] He further acknowledged that he was "a little bit vague" on exactly how Macsyna King had said "Chris didn't do it, I did", and when she had said this.[210] Significantly, when asked if he actually remembered Macsyna King saying that phrase, he replied:

> "sort of ..... not really".[211]

Mr Tuari admitted that at the time he first told the Police about the alleged conversation he had not been completely sure of the words Macsyna King had used,[212] and that he had never been sure of them.[213] He said he had committed to having heard Macsyna King say the words and had to keep repeating them.[214]

[171] Mr Tuari has, among other convictions, 41 convictions for dishonesty. He is currently in prison. When asked how careful he was with the truth, he said "not very good to be honest".[215] The Court found his evidence to be unreliable. It found him not to be a credible witness. It can form no idea of what was actually said by Ms King, if anything, in relation to the deaths of the twins. It is unable to know the context in which such words were allegedly spoken. On his own admission, Mr Tuari is not "really" sure of what she said. Both at inquest and at trial Macsyna King denied having spoken to Mr Tuari in the terms stated by him (TNOE pp125/12, 181/22-26; INOE 6 October 2010 p316/16, 22, 27-31). The Court rejects Mr Tuari's evidence as unreliable and unhelpful.

MACSYNA KING'S CHARACTER

[172] Much was made by Chris Kahui's counsel during the inquest of those aspects of Macsyna King's character which do not show her in a good light. Some of the criticisms levelled at her by Chris Kahui's counsel are set out in paras 5.28-5.32 of Mr Mount's submissions. As Mr Mount says, such criticisms are of little or no relevance to this Court's inquiry and do not ultimately shed any light on the principal issue of how the twins came to die.

BLACK POWER

[173] As noted by Mr Mount (para 5.33 of his submissions), it was suggested at inquest that the Black Power gang were exerting influence on witnesses on behalf of Macsyna King to ensure their silence.[216] Mr Wilkinson-Smith, who appeared as Counsel during the October 2010 hearings, stated that Mr Tuari had given evidence to this effect at the trial[217] and that threats had been made to Stuart King that he would "get a bullet" if he talked about the

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[209] INOE 30 June 2011 p366/4-11; p370/15
[210] INOE 30 June 2011 p375/31
[211] INOE 30 June 2011 p378/4,6
[212] INOE 30 June 2011 p379/9,11
[213] INOE 30 JUNE 2011 P379/13,15
[214] INOE 30 June 2011 p378/7-20
[215] INOE 30 June 2011 p364/12
[216] INOE 4 October 2010 p38/15-17
[217] INOE 5 October 2010 p118/24-26

homicide.[218] At the trial Stuart King denied that he had been threatened,[219] and his partner Mona Kahui denied that he had been the subject of threats.[220] At inquest Stuart King said he could not remember if any comment denoting a threat had been made to him and that, in any event, his evidence was unaffected by any such threat and given freely to Police and the Courts.[221] Mr Mount submits there is no credible evidence that Black Power influenced witnesses on behalf of Macsyna King or that the evidence heard by the Court was affected by its influence. There is no evidence before the Court to suggest this and no issue is now made of this matter by Mrs Wilkinson-Smith in her submissions.

PRINCIPAL FINDINGS OF FACT

[174] The principal findings of the Court may now be summarised as follows:

1. The twins' primary caregivers were their parents, Chris Kahui and Macsyna King.
2. Macsyna King left 22 Courtenay Crescent at about midday on Monday, 12 June and did not return until about 9.30 am the following day.
3. The twins were fed by Chris Kahui and Macsyna King before she left the house, and were bathed and changed by her.
4. Cru was fed some milk that remained in his bottle by April Saunders before she left the house, some time after 1.00 pm on 12 June.
5. The twins were in every respect normal and well at 1.00pm on 12 June.
6. Following the departures of Macsyna King and April Saunders, Chris Kahui became the twins' sole caregiver.
7. Chris Kahui was experienced in the care of the twins and was able to know when they were well and when they were unwell.
8. In addition to the twins, Chris Kahui had his son Shane to care for on his own.
9. The twins were being fed on a 6-hourly feeding cycle. Their next feed would have been due around about 6.00 pm.
10. Feeding, changing and bathing the twins was difficult for Chris Kahui to carry out on his own, in addition to caring for Shane.
11. Chris Kahui was resentful of the fact that for the second night in succession he had been left by his partner to care for the twins on his own. He was angered by her absence from the home and was expecting her to return to care for the twins at 6.00 pm. She did not do so. His father, William Kahui, described himself as being in a rage, and Chris Kahui as "absolutely furious that Macsyna King was not at home looking after the twins" (INOE p2240).
12. After the twins' deaths, Chris Kahui stated to Police that he had continued to feed the twins in accordance with their feeding cycle after the departure of his partner and April Saunders.
13. There is no evidence that he did so.
14. There is no evidence that Chris Kahui was seen by any of the other adults in the house feeding the twins during the afternoon/evening of 12 June through to the following midday.

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[218] INOE 5 october 2010 p120/5-6
[219] TNOE p287/22
[220] TNOE p343/26
[221] INOE 12 October 2010 pp996/1-2; 996/32; 1004/17-25

15. There is no evidence that the twins were ever fed during the period stated in sub-para 14 by anyone in the house.
16. There is no evidence that the twins were changed or bathed by Chris Kahui on any occasion after 1.00 pm on 12 June.
17. There is no evidence that the twins were changed or bathed by anyone else in the house during the period from 1.00 pm on 12 June until the arrival of Macsyna King at about 9.30 am the following day.
18. In this Court Chris Kahui sought to retract the evidence contained in his Police statements that he had continued to feed the twins after his partner and April Saunders had left the house on 12 June.
19. The statements made by him to Police that he had continued to feed the twins after the departures of his partner and April Saunders were untrue and untrue to his knowledge.
20. The statement made by Chris Kahui in this Court that baby Chris never cried or fed after Macsyna King left the house at about midday on 12 June was true.
21. There is no evidence that Cru ever cried or fed again after his last feed about 1.00 pm on 12 June.
22. The statement made in this Court by Chris Kahui that Cru never fed or cried again after the apnoeic episode was true. Neither Chris nor Cru was being fed by Chris Kahui at the time Cru became apnoeic.
23. Had the twins remained normal and well during the afternoon/evening of 12 June and morning of 13 June they would have made their hunger known by crying.
24. Had the twins cried out for food during the afternoon/evening of 12 June or the morning of 13 June they would have been heard by the other adults in the house, which was small. The twins were not heard by any of those adults to cry out for food at any time.
25. The twins being on a six-hourly feeding cycle, they should have roused to the stimulus of hunger approximately six hours after their last feed (INOE 27 June 2011p57/5 (Dr Jenny); p57/10 (Dr Donald). See also p54/24 and 55/1.
26. The fact that the twins had ceased to feed and to cry out for food was known to Chris Kahui, who also knew that they were very unwell and in need of urgent medical help.
27. At no time during the late afternoon/evening of 12 June and morning of 13 June did Chris Kahui initiate or arrange for medical help for the twins.
28. Chris Kahui hid from his partner Macsyna King and others his knowledge of the fact that the twins were not crying or eating and were very unwell. He represented to Ms King that the twins had been feeding but had not been hungry for their feed on the morning of Tuesday 13 June when she returned home.
29. Following the apnoeic episode during the evening of 12 June Chris Kahui resisted the views of the other adults in the house that an ambulance should be called or that the twins should be taken to the hospital.
30. Had the twins been taken to hospital after the apnoeic event their lives might have been saved.
31. After having been told by Dr Nayar on 13 June that the twins were very unwell (which he already knew) and should be taken to hospital straight away, Chris Kahui drove on past the hospital and, having done so, refused subsequently to accompany his partner to the hospital with the twins. He left her on her own

with the twins at the family home and went for a walk. On his return, he refused to join his partner at the hospital and played a video game instead.

32. The fatal injuries that led to the twins' deaths were inflicted whilst they were in Chris Kahui's sole custody and care during the afternoon or early evening of 12 June, prior to the time that Cru became apnoeic.
33. The effects of such injuries would have been obvious and immediate, the twins would have remained abnormal from then onwards and they would not have fed thereafter.
34. The twins were injured in the same manner, at the same time and at the hands of the same person.
35. The account given by Chris Kahui to his partner as to the cause of Chris' facial bruising was an invention.
36. When he and his partner took the twins to see Dr Nayar, Chris Kahui did not disclose to the doctor the fact that the twins had neither cried nor fed for a period approaching 24 hours.
37. The behaviour of Chris Kahui throughout the period afternoon/evening 12 June – morning 13 June was incompatible with what might reasonably be expected of a caring father who had nothing to hide in respect of his care of his children.
38. For his own reasons Chris Kahui hid from the other adults in the house the fact that the twins were very unwell and were neither feeding nor crying for their food.
39. The allegation that Macsyna King was responsible for the infliction of the twins' fatal injuries lies unsupported by the evidence and is without substance in fact. The allegation that Stuart King might have brought about the twins' deaths is also unsupported by the evidence and is without substance in fact.

[175] The evidence given by Chris Kahui was unreliable, conflicting and, on many occasions, untrue. The Court formed a poor view of his credibility. Different versions of events have been given by him on different occasions to different people.

THE LAW

[176] It is desirable that before the Court draws its conclusions on the evidence it should state the law it understands to be applicable to this kind of case.

[177] Ordinarily, the standard of proof to be applied by the Coroner in an inquest or inquiry is the civil standard of the balance of probabilities.[222] In this case, it is alleged by Police that the cause of the twins' deaths was the infliction of injury at the hands of Chris Kahui. This is a serious allegation, requiring proof that must be clear, cogent and exact, and, when considering such proof, weight must be given to the presumption of innocence:*Anderson v Blashki* [1993] 2VR 89 at 95, per Gobbo J (applying *Briginshaw v Briginshaw* (1938) 60 CLR 336); *Secretary, Department of Health and Community Services v Gurich* [1995] 2 VR 69 at 73 per Southwell J; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at 19 per Hedigan J; *Khawaja v Secretary of State for Home Department* [1983] 1 A11ER 765. The required standard of proof is discussed and defined in para [183] hereof *post*.

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[222] Denning J (as he then was) defined the standard in *Miller v Minister of Pensions* [1947] 2 A11ER 372, 373-374

FINDING

[178] The Court is satisfied, on all the evidence before it, to the required standard of proof, that the traumatic brain injuries suffered by Chris and Cru Kahui were incurred by them during the afternoon/early evening of 12 June 2006, whilst they were in the sole custody, care and control of their father at 22 Courtenay Crescent, Mangere, Auckland.

COMMENT

[179] The Court has found that Chris Kahui's statements to Police that he continued to feed the twins after his partner and April Saunders had left the house were untrue and untrue to his knowledge. That evidence, which imposed upon a scene of violence an illusion of normality, was antithetical to the theory advanced by his counsel both at the trial and the inquest that Macsyna King had fatally injured the twins before she left the house on the afternoon of Monday, 12 June. Had she done so, the twins would not have continued to feed normally as Mr Kahui said they did. The fundamental change effected in Mr Kahui's evidence at inquest, namely, that the twins did not cry or feed again after their midday feed (although under cross-examination he said there might have been one last feed between 5.00-6.00pm) was synchronous with the evidence of the expert panel members that the twins would not have been able to feed again after the infliction of their fatal injuries. In his inquest statement Mr Kahui says he now knows it is "really important to know exactly when [the twins] last fed normally and seemed well". He says that when he first spoke to Police he "didn't realise that it mattered that much when they were fed". He says he didn't want the Police to think he was a bad father "and over the 2 nights Macsyna was away I had pretty much tried to keep to their feeding routine which was every 6 hours".

[180] The Court rejects Mr Kahui's statement that when he first spoke to the Police he didn't realise that it mattered that much when the twins were fed. He knew that the question of whether the twins continued to be fed after midday on Monday was a matter of real importance both to Police and to him. This matter was discussed with him by Police at formal interview not once but three times. In his inquest statement he conflates the condition of the twins during the night of 12 June with the night before, saying he "had pretty much tried to keep to their feeding routine which was every 6 hours".

[181] The twins had not kept to their 6-hourly feeding routine on the night of 12 June and Mr Kahui knew that. The Court finds that he falsely represented to Police that the twins had fed during the evening of 12 June 6 hourly, as they had the night before. The Court rejects Mr Kahui's explanation for his misrepresentations of fact as being that he did not want the Police to think he was a bad father. The quality of his caregiving was not in issue and he knew that. What was in issue was how the twins received the injuries that caused their deaths, at what time those injuries were inflicted and at whose hands. The Court finds it likely that the false account given by Mr Kahui was to protect himself by representing that the twins remained well whilst in his hands.

[182] The theory that Macsyna King fatally injured the twins before she left the family home at midday on 12 June was required to be abandoned, and does not appear in Mrs Wilkinson-Smith's final submissions, because the evidence at inquest plainly showed that the twins were in every respect normal and well at 1.00 pm on 12 June (see para [54] hereof). Reliance is now placed on a theory that has not previously been advanced, namely that

Macsyna King fatally injured the twins when she came home on the morning of Tuesday 13 June. In the alternative, Mr Kahui's counsel continues to submit that Macsyna King might have killed the twins by slipping home on Monday night when Chris Kahui was out. The Tuesday morning theory cannot stand in light of the fact that the evidence clearly shows the twins were suffering the baleful effects of the fatal injuries earlier inflicted upon them when Macsyna King arrived home at 9.30 am on 13 June. As to the Monday night theory, there is no evidential support for the proposition that Emily King's motor vehicle left the Southwestern Motorway and was driven to Mangere East at the time Macsyna King would need to have been in that suburb to do what it is alleged she might have done to the twins, namely fatally injured them. Nor is it reasonably possible that Macsyna King might have done these things within the time constraints discussed in paras [163] to [167] hereof. There is not a skerrick of evidence that Ms King was at 22 Courtenay Crescent between 7.00-7.20 pm on 12 June (or, indeed, at any time during that evening), let alone that she had a motive to kill her own children and did so. Apart from being completely without evidential support, the theory is implausible.

STANDARD OF PROOF

[183] In finding that the injuries suffered by the twins were incurred during the afternoon/early evening of 12 June 2006, whilst they were in the sole custody, care and control of their father at 22 Courtenay Crescent, Mangere, Auckland, the Court has had regard to, and has applied, the standard of proof ("the required standard of proof") laid down by the Supreme Court of New Zealand in *Z v Dental Complaints Assessment Committee* [2009] 1 NZLR 1.

At para [26] of that decision, Elias C J said:

> "References to the "standard of proof" concern the quality or degree of persuasion of those required to determine facts in order to make conclusions of legal responsibility. Except where a different standard is required by statute, New Zealand law recognises only two standards of proof. The standard that the trier of fact be sure of the facts in issue is applied in criminal cases. If the trier is left with a reasonable doubt that cannot be excluded, the standard is not reached. In civil cases, and in most non-criminal proceedings unless a different standard is prescribed or applied, the trier of fact must be satisfied on the balance of probabilities. In that case he must be convinced by the evidence that the fact in issue is more likely than not."

Delivering the decision of the majority of the Court in *Z v Dental Complaints Assessment Committee*, at para [112], McGrath J said there is "a single civil standard, the balance of probabilities, which is applied flexibly according to the seriousness of the matters to be proved and the consequences of proving them". He went on to say at para [113], that "on the flexible approach serious allegations must always be proved by evidence having sufficient probative force". Earlier, at para [102], Elias C J said 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.

Reference is made in para [177] of these Findings to *Anderson v Blashki* [1993] 2 VR 89, a decision of the Supreme Court of Victoria. There it was held that an allegation of assault was

required to be proved on the balance of probabilities but that the gravity of the allegation required proof of the act to be clear, cogent and exact and that, when considering such proof, weight must be given to the presumption of innocence.

In making its findings of fact the Court has had regard to and has applied, in flexible manner, the standard of proof laid down in *Z v Dental Complaints Assessment Committee*, and *Anderson v Blashki*, taking into account the seriousness of the matters to be proved, the consequences of proving them, and giving due weight to the presumption of innocence.

If the Court is wrong in applying the principle laid down in *Z v Dental Complaints Assessment Committee* in relation to the required standard of proof, it records that it is satisfied to the point of being sure that the injuries suffered by the twins were incurred during the afternoon/early evening of 12 June 2006, whilst they were in the sole custody, care and control of their father at 22 Courtenay Crescent, Mangere, Auckland.

COURT CONCERNED ONLY WITH QUESTIONS OF FACT

[184] This Court is concerned only with questions of fact. Questions relating to criminal responsibility have already been tried out and disposed of in the High Court. Chris Kahui was found not guilty of the murder of the twins. The question of how the twins came to meet their deaths[223] is quite different to the question of whether Chris Kahui bears any

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[223] See *Peere v Chivell* [2000] SASC 279 for the Australian approach towards the kind of finding made in this case. In that case the Coroner had found that a letter bomb sent to a Police officer, who died as a result, had been sent by a named person (Domenic Perre). Nyland J said at para 55 that the Coroner had simply recorded his findings as to the sequence of events which culminated in Sergeant Bowen's death. He went on to say:

> "For example, in an inquest concerned with the death of a pedestrian struck by a motor vehicle, such matters as the identity of the driver of the car, his/her level of intoxication by reason of alcohol or drugs, and the position of the car on the road, would all be relevant matters upon which the coroner could make findings of fact. A finding by the coroner that the driver of a car was affected by alcohol or drugs, or his/her motor vehicle was on the wrong side of the road, might lead to a subsequent determination of criminal or civil liability, but that consequence does not preclude the coroner from making the particular finding of fact.
>
> In other words, the factual findings of themselves cannot be said to be findings of criminal or civil liability. A finding of criminal or civil liability requires the application of the relevant law to the facts in order to determine whether the essential elements of a given crime or civil obligation have been made out. It is not the coroner's role to undertake this process, it is the role of the courts, and this is what s26(3) was enacted to ensure."

See also *Berryman v Solicitor-General* [2008] 2 NZLR 772 where at [2] Mallon J said:

> "The purpose [of an inquest] is not to determine fault, although in identifying the cause and circumstances of the death, and making comments or recommendations so that lessons may be learnt, it is sometimes inevitable that fault is attributed to a party. This is not fault in the legal sense that legal consequences will follow – the findings at an inquest are not conclusive and may be traversed in other proceedings."

At para [58] Mallon J distinguishes between "blameworthiness", which may be determined by a Coroner as a matter of fact, as opposed to "legal fault", which may not. Also see *Re Hendrie* HC Christchurch CP 445/87 12 January 1988Hardie Boys J at p11 and *Death Investigation and the Coroner's Inquest* (Ian Freckelton and David Ranson) OUP 2006, pp649-650

responsibility in terms of the criminal law for their deaths. He has been found to bear no such responsibility.

[185] The Court wishes to sincerely thank Mr Mount, Mrs Wilkinson-Smith and Ms Dyhrberg for their assistance in this inquest and for the thoroughness of their written submissions. It thanks Mr Christopher Morris, Counsel Assisting, and Ms Staples also for their invaluable assistance.

[186] Pursuant to S25 of the Coroners Act an order was made prohibiting publication of Mr Tuari's name and of any evidence that may serve to identify him.

C O D A

1. On 22 July 2011 the Court received a memorandum from Counsel Assisting (Mr Morris) relating to emails he had received from Mr Ian Wishart, an investigative journalist. The principal emails, dated 19 and 21 July (first and second emails respectively), relate to a breathing incident at Middlemore Hospital, spoken of by Macsyna King to Mr Wishart. A letter from Mr Morris to the Coroner followed, attaching all the emails from Mr Wishart.

2. In his first email Mr Wishart asserts that information relayed to him by Ms King "directly contradicts the sworn testimony of a medical witness". That witness was Dr Lindsay Mildenhall, Consultant Neonatologist and Clinical Leader of Newborn Services at Middlemore Hospital. Mr Wishart says he has reason to believe, upon the basis of the information relayed to him, "that some of the medical evidence provided to the Inquest is materially wrong in fact". He says there is a "possibility, however remote, that someone in Middlemore may have intentionally chosen to erase any record of this incident from their file prior to the witness who testified before the inquiry seeing the file".

3. In his second email Mr Wishart states that the incident referred to by him was "the apnoea incident in the hospital shortly before the twins were discharged". He says the incident is referred to in the transcript of the evidence given by Mr Chris Kahui. He says Ms King "has told [him] of an almost identical story ... alarms going off, friend alerting her. Macsyna says she got a briefing from the nurse who resuscitated Cru, who described it as 'apnoea' ". He says "this places both Chris and Macsyna on a collision course with Dr Mildenhall, who assured the Coroner on oath that there were no apnoea or breathing incidents involving the twins." He adds that Ms King told him Cru required CPR "which Middlemore denies took place".

4. The Court has before it an affirmation from Ms King, made at Gisborne on 23 September 2011. Ms King says that at about two weeks into the babies' stay at Middlemore she received a texted message from a woman she had met in the neonatal unit, named Losa. The text read something like "Hi Max, I just wanted you to know that Cru had a breathing episode, the alarms went off and I think you should come". Ms King says that she and Mr Kahui left their house and went to the hospital. She met Losa and another woman, who told her "that the alarms went off". Ms King says "they pointed out the nurse who was first on the scene to attend Cru. They said the nurse hit the panic button, the doctor came in and the nurse had resuscitated Cru until he started breathing." Ms King says "the way they explained it to me was that the cover was taken off the crib and the doctor or the nurse manually worked on Cru's chest".

5. Ms King says the women's babies "were in the corridor across from [her] babies", but they could see through the glass windows of the doctors' and nurses' station that was in the middle of both nurseries. The nurse was said by the two women to be crying after the incident and "was really upset". Ms King says a third woman, whose baby was in a crib directly over from Chris's crib told her that there was "a major panic around Cru's crib" and that she was "freaked out".

6. Ms King says she and her partner went to check on Cru when they got to the hospital. He was sleeping peacefully. She says "if I hadn't have been told then I would never have thought anything had happened to him". She spoke with the nurse "who had resuscitated Cru". The nurse had been pointed out to her by the two women already referred to. The nurse said Cru was "OK now". Ms King says the nurse told her Cru had "a breathing episode where he went slightly blue and held his breath". Ms King says she was told by the nurse that "one of the possibilities was it was an apnoea attack".

7. Ms King says the doctor came to talk to her. He "basically repeated what the nurse had told [her]". Asked by Ms King if there were any issues she should be aware of, such as breathing aids for Cru later on, the doctor said "right now he just needs you to be beside him and to keep breastfeeding". Ms King says that when she asked the doctor why she wasn't called, the doctor said that the first priority was to stabilise her son "and that is what we did". The doctor told Ms King that she "just needed to spend more time with the babies". Ms King says she felt that the doctor was really disrespectful to her.

8. The doctor's latter comment needs to be viewed in the context of the concern of hospital staff members of the "lack of visiting from both parents (see para [29] of these Findings). Ms King accepts in her affirmation "that the story [the episode referred to involving Cru] had come to [her] second and third-hand. The accounts given to Ms King from the two women first referred to were based on what they saw from the other side of the corridor and their apprehension of what was going on. The account given by the woman whose baby lay in a crib "directly over from Chris's crib" was, similarly, based on her apprehension of events. There is no evidence that the event was apnoeic in nature. The nurse described it as a "breathing episode". An apnoeic attack was said by the nurse to be "one of the possibilities" for the breathing episode. The doctor did not say that the incident was apnoeic in nature. There is no evidence that Cru required to be resuscitated. In a written statement made to Police on 13 October 2006 Ms King said at p13:

> "From the time that the twins were discharged from Middlemore Hospital there has never been an incident of them stopping breathing. This may have happened when they were first born and were in hospital but not after they came home."

Clearly, Ms King did not regard the hospital "breathing episode" as important at the time she made her Police statement. Neither she nor Mr Kahui ascribed to such episode any significance in the evidence they gave to this Court. Mr Kahui's account of this episode is set out in INOE pp 867-871. No mention of such incident was made by Ms King in oral evidence and she was not questioned about it.

9. Mr Ross, Counsel for Dr Mildenhall, made a supplementary statement from his client available to the Court after circulation of Ms King's affirmation to Counsel. In that

statement, Dr Mildenhall says he has received the twins' medical records at Middlemore Hospital. He says there are references to "apnoea" and "apnoea alarms" in the clinical notes towards the end of the twins' stay in the Neonatal Unit, but that such incidents are not unusual for any baby in the Unit. He says "they are not considered to be significant clinical events in the absence of other clinical signs suggesting deterioration". He says they are usually obstructive events from mucous plugging of the nasal passages. They can also be related to feeding, as was the case with one of the twins, or simply the medical monitoring not picking up signals properly because of the baby moving excessively.

10. Dr Mildenhall says "the occasional events the Kahui twins displayed" are quite different from the developmental condition known as "apnoea of prematurity", which he says is a phenomenon of pre-term babies where a baby will stop breathing without any provocation. Dr Mildenhall says this is a brain maturational feature and is unusual beyond 35-36 weeks post-conceptual age.

11. Dr Mildenhall says neither twin displayed symptoms suggestive of apnoea of prematurity. This is the evidence he gave at inquest (see INOE pp 2152-2153). He gave similar evidence at trial (see TNOE pp 199-201). He says neither Chris nor Cru received CPR during their post-natal care at Middlemore. He says CPR is a serious medical intervention and would require significant documentation in the medical records had it been administered. Any baby who had had CPR performed on it would be quite unwell for some hours after the event and would require readmission to an intensive care area. Dr Mildenhall says "no such clinical events are documented in the notes because neither twin was subjected to CPR." Dr Mildenhall is a specialist medical practitioner of integrity. The Court accepts the truth of the evidence contained in his supplementary statement. The assertions made by Mr Wishart in his first email lie without evidential support and are dismissed.

12. Mr Wishart raised several other issues, relating to telephone call tracing, the possibility of an alternative cause of death and the discharge of the twins after "only" two days treatment for bronchiolitis. The evidence shows there is no prospect of retrieving the electronic elements of telephone calls made by Ms King; the unanimous view of the medical experts is that the twins' deaths followed the violent infliction of injuries; and the Court is satisfied on the evidence that the twins were medically well-cared for at all times in Middlemore Hospital. The further matters raised by Mr Wishart are also dismissed.

13. On 1 November 2011 the Coroner received a Memorandum from Counsel for Mr Kahui. Mrs Wilkinson-Smith says Mr Kahui recalls an incident when one of the twins had stopped breathing in the neonatal ward. He and Ms King went to Middlemore Hospital; a nurse was crying "and two doctors were present reassuring the nurse that this was quite normal and happens with premature infants. The baby was recovering slowly."

14. Mrs Wilkinson-Smith says in her Memorandum that Mr Kahui has been invited to attend a Family Group Conference in relation to issues arising from the fact that Mr Stuart King "is currently under investigation by CYFS for child abuse". She says Mr Kahui has been advised that Ms Emily King has been charged with offences involving child abuse or neglect. She says given "Mr Kahui's position is that Stuart King cannot be excluded as a perpetrator and that Emily King may have assisted Macsyna King to give a false alibi concerning her movements, Mr Kahui asked that the Coroner be advised of the situation so that [he] can decide whether to seek further details from CYFS or the Police".

15. By Memorandum dated 4 November 2011 the Coroner despatched to all Counsel copies of all relevant email correspondence between Ms Hayley Bowman, Ministry of Social Development, and Mr Morris relating to the CYFS matters referred to by Mrs Wilkinson-Smith. That email correspondence relates to the welfare of several of the children of adult members of the King and Kahui families and has been made available to Mr Morris and other Counsel on a confidential basis.

16. Submissions were received from Counsel as to the relevance of both the incident in the Neonatal Unit and the CYFS matters raised by Mrs Wilkinson-Smith.

17. By Memorandum dated 7 November, Mr Morris notes that there is no reference to the Neonatal Unit incident in the hospital notes. He notes that the observations passed on to Ms King "are from persons who were not in the same room as the medical staff attending to Cru". He points out that neither the nurse nor the doctor to whom Ms King spoke are noted by Ms King as raising any suggestion of there being CPR. Mr Morris says any further inquiry of the hospital would seem pointless in terms of establishing the cause and circumstances of the twins' deaths. He says the cause of death was not an apnoea-related incident "but rather a deliberate assault of the twins sufficient to cause death".

18. With regard to the CYFS matters, Mr Morris says the information provided on a counsel-to-counsel basis by CYFS is of limited relevance to the issue of cause of death. He says the new CYFS information is in the nature of an allegation only "and limited to the Police forming a view that sufficient evidence exists to prosecute Emily King and Pou Hepi for assault". He says no further allegations of a criminal nature have been made. The Court has since been informed that Macsyna King recently appeared in the Gisborne District Court charged with assault upon a child. An order was made suppressing publication of her name. That order presently remains in force. An order is made by this Court pursuant to S25 of the Coroners Act 1988 prohibiting publication of the names of Emily King and Pou Hepi and of any evidence that may serve to identify them, they not having presently been charged with any offence.

19. Mr Morris submits that the CYFS allegations are different in nature and degree to the actions that are likely to have caused the deaths of the twins. He says that even if the allegations are proven in respect of Emily King and Pou Hepi, there is no similarity between their alleged conduct with respect to children in their care and what is known to have occurred in respect of the twins. He goes on to say:

> "1.5 Given the above, it is submitted the material received by [the Coroner] from CYF is of no significance. It would be dangerous to conclude because somebody was charged with unrelated and dis-similar allegations of child abuse they could therefore be involved in actions which resulted in the death of two children.
>
> 1.6 The memorandum from counsel for Mr Kahui dated the 11th of November 2011 notes ("inter alia") Mr Kahui's position now is:
>
> > "Stuart King cannot be excluded as perpetrator and that Emily King may have assisted Macsyna King to give a false alibi concerning her movements."

1.7 Mr King has not been charged by the Police with any offences arising from their investigation. Again by reference to the material from CYF the allegations of child abuse against him, even if accepted, bear no relation to the types of actions that caused the extensive injuries and ultimately the death of the Kahui twins.

1.8 It is submitted in respect of Emily King, again even if one accepts the nature of the allegations made, such does not provide any probative evidence to establish she has any type of propensity to assist someone (namely Macsyna King) to give a false alibi.

1.9 Accordingly, it is submitted there is nothing to be gained by seeking any further investigation by either the Police or CYF. The investigations from the material available have been on-going and lengthy and it is difficult to envisage what further inquiries could be conducted in any event."

20. By Memorandum dated 8 November, Mrs Wilkinson-Smith submits (without any reference to the relevant provisions of The Evidence Act 2006) that the CYFS information raises issues of propensity by Emily King, Pou Hepi, Stuart King and Macsyna King to behave inappropriately towards children in their care. She says that whilst the allegations have not (yet) been proven in a criminal court "they have been found to be substantiated by CYF so they are more than "allegation only" in that respect". Mrs Wilkinson-Smith submits that, "in a case which relies entirely on circumstantial evidence, propensity evidence should make the Court cautious about simply dismissing alternative explanations for how the twins received their injuries and when". She reiterates her earlier submission that Stuart King cannot be excluded as the perpetrator of the twins' fatal injuries, saying he was the only other person alone with the twins in the timeframe which the Police content is relevant. She asks "on what basis can he simply be disregarded as a potential perpetrator", adding that he has a history of inappropriate behaviour towards children both before and after the twins' deaths. The answer to Mrs Wilkinson-Smith's question is to be found in para [162] of these Findings.

21. With regard to Emily King, Mrs Wilkinson-Smith says her apparent propensity to violence towards children is relevant to how seriously she regards violence towards children and how forgiving she might be of Macsyna King's actions. She says that, on the other hand, Mr Kahui has been monitored closely since the birth of his daughter without evidence of any problems. Mrs Wilkinson-Smith says the CYF information is propensity evidence and is relevant to issues of credibility and to the issue of who injured the twins.

22. Mrs Wilkinson-Smith says the hospital breathing incident raised by Mr Wishart is of some relevance to the issue of why Mr Kahui did not take Cru to hospital when he stopped breathing. She says Mr Kahui heard doctors reassuring a nurse who was upset that the incident was quite normal and that the baby was fine. She says "this may be relevant to Mr Kahui's credibility when he says effectively that he did not think Cru necessarily needed to go to hospital as he seemed to recover from the breathing episode". The failure on the part of Mr Kahui to obtain medical help is the subject of careful and detailed consideration in these Findings and does not, in the Court's view, require to be re-visited in the light of Mrs Wilkinson-Smith's further comments. In his evidence, Mr Kahui did not point to, or rely upon, the hospital incident to justify his opposition to the suggestions by other family members that medical advice should be sought after Cru's apnoeic event.

23. Mrs Wilkinson-Smith goes on to refer to a recently-published book on Macsyna King, written by Mr Wishart (unread by the Coroner), and to comments made by Emily King in a *New Zealand Herald* article. The Court sees no good reason to make further comment on the matters raised by Mrs Wilkinson-Smith, arising from the *New Zealand Herald* article.

24. By Memorandum dated 9 November Mr Mount submits that in light of Dr Mildenhall's supplementary statement there is no matter arising from the material provided by Mr Wishart that warrants further investigation. Ms Dyhrberg is of the same view (see *post)*. Mr Mount says, and the Court accepts, that the most reliable source of information of the twins' state in hospital is the medical records. He says Dr Mildenhall's evidence confirms that neither twin showed signs of apnoea of prematurity during his stay in hospital and neither twin received CPR in hospital. This evidence is accepted by the Court.

25. Mr Mount submits that there is no basis for a submission that the twins' experience in hospital could have led either parent to believe that stopping breathing was a normal or expected phenomenon. As stated, Mr Kahui did not in his evidence rely upon the hospital incident for his decision not to seek medical help for Cru following the apnoeic incident.

26. With regard to the CYFS information, Mr Mount supports the submissions made by Mr Morris. He says, in short, that the material made available by CYFS following the investigations referred to is not relevant to the question of who fatally injured the twins.

27. As Mr Mount says, the material provided by the Ministry of Social Development in relation to the five children evidentially interviewed presents, if true, a concerning picture. He says Police note the allegations by 10 years old Tyson King that he was kicked on the ground by Macsyna King and the allegations of inappropriate discipline by Stuart King. Mr Mount notes there are allegations of physical assaults by Emily King and Pou Hepi.

28. Mr Mount submits that there is nothing in this material that bears on the issue of who fatally injured the Kahui twins. The allegations are, as he says, unproven. He submits that the allegations do not cross the evidential threshold of cogency required to make them relevant to the issue of who killed the twins in 2006. He joins with Mr Morris in submitting that the allegations are different in nature and degree from the allegations from the actions that resulted in the twins' deaths. Such submission is soundly based. Mr Mount says the identity of the person who fatally injured the twins is established by the evidence as to the timing of the injuries, and the surrounding evidence of the actions of those caring for them on 12 and 13 June 2006. He says that evidence is not altered by these later allegations. Mr Mount correctly summates the evidential position and his submission reflects the view of the Court on a careful re-examination of the evidence.

29. Mr Mount says:

(a) Stuart King's position has been given careful consideration from the early stages of the investigation and that Police submit there is no basis to conclude he was responsible for injuring the twins.

(b) Mrs Wilkinson-Smith's submission that the present allegations against Emily King make it more likely that she covered up fatal assaults by Macsyna King "stretches logic to breaking point". Police submit there is

no basis to submit that the present allegations make it more likely that Emily King or Pou Hepi committed the kind of repeated perjury required to cover up fatal assaults by Macsyna King. The Court accepts such submission.

(c) The 2008 newspaper story relied upon by Mrs Wilkinson-Smith to show that Macsyna King's position, as expressed in Mr Wishart's book, has changed, is based entirely on a recorded conversation with Emily King and may not therefore be relied upon as expressive of inconsistency or contradiction on the part of Macsyna King's attitude towards Chris Kahui.

30. By Memorandum dated 11 November, Ms Dyhrberg submits that in order to admit the allegations contained in the CYFS correspondence the Court would need first to assess their truth. She submits that the truth of such allegations cannot be assessed and, accordingly, they should not be admitted as propensity evidence. She further submits that it would be outside the scope of the inquest to take into account such allegations as propensity evidence, "especially so when one considers that the allegations are of a different nature and are unrelated to the inquest at hand". She says that the duty of the Coroner is to determine who caused the twins' fatal injuries. This centres on who was caring for the twins on 12 and 13 June and evidence of the timing of the injuries. Ms Dyhrberg submits that the allegations put forward by CYFS do not aid in the determination of these fundamental issues, that the allegations are irrelevant and that they should not be admitted as propensity evidence in this inquest.

31. S40(2) of The Evidence Act provides that a party may offer propensity evidence in a civil or criminal proceeding about any person. S40(1)(a) of the Act defines propensity evidence as meaning "evidence that tends to show a person's propensity to act in a particular way or to have a particular state of mind, being evidence of acts, omissions, events or circumstances with which a person is alleged to have been involved ....." The matters to be considered by a Judge in assessing the probative value of evidence admitted as showing propensity are set out, in a criminal proceedings context, in S40(3) of the Act.

32. As submitted by Messrs Morris and Mount and Ms Dyhrberg, the CYFS allegations are *allegations* only; they are different in nature and degree to the actions likely to have caused the death of the twins. Even if proven, there is no factual similarity between the actions alleged on the part of Emily King, Pou Hepi and Macsyna King and the severe and extensive injuries inflicted on the Kahui twins. As Mr Mount puts it, the allegations do not cross the evidential threshold of cogency required to make them relevant to the issue of who killed the twins in 2006 and would not have been admissible for that purpose in the criminal trial. As Mr Morris says with regard to Emily King, even if one were to accept the nature of the allegations made, they are entirely without probative value in attempting to establish she had a propensity to assist someone (Macsyna King) to give a false alibi. Even if the Court were to admit the CYFS allegations as evidence of propensity against the persons referred to, they would be of no probative value, the Court's determinations being based upon careful analysis of the relevant factual evidence before it. For the reasons already stated, the Court declines to admit the CYFS allegations as evidence of propensity, as defined by S40(1)(a) of the Act.

VERDICTS

Christopher Arepa Kahui, an infant, late of 22 Courtenay Crescent, Mangere, Auckland died at Starship Hospital, Auckland, on 18 June 2006, the cause of his death being brain injury secondary to trauma, which injury was incurred by him during the afternoon/early evening of 12 June 2006, whilst he was in the sole custody, care and control of his father, Christopher Kahui, at 22 Courtenay Crescent, Mangere, Auckland.

Cru Omeka Kahui, an infant, late of 22 Courtenay Crescent, Mangere, Auckland died at Starship Hospital, Auckland, on 18 June 2006, the cause of his death being brain injury secondary to trauma, which injury was incurred by him during the afternoon/early evening of 12 June 2006, whilst he was in the sole custody, care and control of his father, Christopher Kahui, at 22 Courtenay Crescent, Mangere, Auckland.

PART II

THE PHENOMENON OF CHILD ABUSE

[187] In an article titled *Reframing child protection: A response to a constant crisis of confidence in child protection*[224] the authors say that confidence in child protection systems across the United States, Australia, the United Kingdom, Canada and New Zealand appears to be continually in a state of crisis. They say the types of crises experienced within these countries are remarkably similar. Criticism stems from the seeming inability of those systems to stop the deaths of children due to maltreatment. At other times, however, child protection systems are criticised for doing too much. The authors say that child protection services have become so 'forensic' and focused on detecting new cases of child maltreatment that capacity to provide adequate services is diminished and demand then overwhelms caring services. They say constant injections of funding and resources, and attempts at reform, have consistently failed to avoid further crises. Not surprisingly, staff morale is low and turnover high. The authors say child protection agencies work in a highly risk-intolerant environment.[225]

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[224] Mansell J et al, Children and Youth Services Review (2011)

[225] The opening words of the editorial *Silent Stand – The Government will need strong arguments if the legal right to silence is to be removed* (New Zealand Listener Vol 230, No 3724 September 24-30 2011) epitomise the public view:

> "The tragic case of infant twins Chris and Cru Kahui, whose father Chris Kahui was found not guilty of their murder or manslaughter, was offensive to the public in almost every way. The acts that claimed the babies' lives were an offence not only in the eyes of the law, but also in the eyes of any caring society."

In his valedictory speech to Parliament on 5 October 2011 the Minister of Justice (the Hon Simon Power) spoke for Everyman when he asked, rhetorically:

> "What the hell is it about the psyche of this country that we feel the need to go home and hit someone, be it a partner, a child or another family member? This is totally unjustifiable, wrong, and an indictment on us as a society. Our legal system needs to protect these people ....." (DominionPost Thursday, October 6, 2011

[188] To those politicians who hope to achieve 'zero tolerance', the authors of the article say "think again". They say calls for mandatory reporting and universal screening fail to take into account what they describe as the wholesale misallocation of resources towards forensic screening ('false positive' investigations) and the harm this does to other children, their families and the community. They say there is no silver bullet or simple answer to child protection problems. They say child protection systems need to be reframed to provide a stronger focus on what vulnerable children really need. They say:

> "Rather than focus solely on questions about screening levels and abuse rates – which at the end of the day do not tell us what to do – there can be a dialogue about what Health, Corrections, Police and NGOs are doing about the mental health, addiction and domestic violence in some of our families."

[189] One of the purposes for which a Coroner holds an inquest (S15 of the Coroners Act 1988) is the making of recommendations or comments on the avoidance of circumstances similar to those in which the death occurred which, if drawn to public attention, may reduce the chances of the occurrence of other deaths in such circumstances.

[190] The factual circumstances in which the Kahui twins' deaths occurred are traced in Part I of these Findings. The evidence showed that the twins were being reared in an unsafe environment, there being evidence at autopsy of injuries that preceded the infliction of the injuries that led to their deaths. But what of the wider circumstances? And what of the wider issues? The Court heard a considerable amount of evidence from persons with special knowledge and experience in the area of child abuse. What did the Court learn, and what might it usefully pass onto Government and the community?

[191] At para 195 of her written submissions, Mrs Wilkinson-Smith sets out what she describes as the wider issues and risk factors in this case:

- A couple in a brief informal relationship which led quickly to the birth of 3 children in under a year
- A mother who had failed to parent three previous children from previous relationships
- A history of abuse and/or neglect pertaining to both parents when they were children themselves
- An unwanted pregnancy resulting in premature twins
- A lack of bonding evidenced by both parents while the twins were in hospital following their birth but most worryingly for medical staff a lack of bonding evidenced by the mother who would usually be the primary caregiver
- An episode in hospital which was not reported where the mother was observed reacting angrily to her partner and being rough with a baby
- Financial stress
- Unstable living arrangements with the family sharing a three bedroom house with another couple and their baby
- A lack of support and assistance for the mother on a day to day basis
- A mother who used methamphetamine while caring for the twins
- A father who was often absent because he was visiting his critically ill mother

to which one might add:

- A mother who walked out on three occasions, staying out all night and leaving her partner to care for three children under thirteen months by himself.

[192] It should be stated immediately that although Macsyna King had children from previous relationships (with Child, Youth and Family Service (CYFS) involvement later on), the outward progress of the twins had been seen as unremarkable and CYFS did not become involved in their care until 13 June 2006 when it was notified by a paediatrician at Starship Hospital that they had been admitted to the hospital with life-threatening injuries that were suspected to be non-accidental in nature. On 16 June interim custody orders under S78 of the Children, Young Persons and their Families Act 1989 were sought and obtained. CYFS had previously been involved with both Macsyna King and Chris Kahui before the twins were born. It should be borne in mind, as Lord Laming stated in a report released by him in the United Kingdom in 2009,[226] that "a child can appear safe one minute and be injured the next. A peaceful scene can be transformed in seconds because of a sudden outburst of uncontrolled anger." It should be noted, as pointed out by Dr Patrick Kelly, Consultant Paediatrician at Starship Children's Hospital, Auckland (from whom evidence was heard), that Lord Laming's report dealt with the deaths of children who had presented repeatedly prior to death with clear manifestations of abuse and neglect.

[193] Whilst in this case there was evidence of earlier injuries, the existence of those earlier injuries remained unknown. The fact that the twins were being nurtured in an unsafe environment and were at risk of further injury also remained unknown to the authorities. The existence of those earlier injuries was known, of course, to the perpetrator, whose identity remains unknown to Police and the Court. This is by no means an uncommon situation.

[194] The physical abuse and neglect of children is a centuries-old problem. The lot of children unprotected by the law is vividly portrayed by Victor Hugo in *Les Miserables*. With the advent of industrialisation in Europe the exploitation of children simply became *regularised.* Dickens, that great social geographer and reformer was sent to work at age 12 in a Blacking Factory. Until 1831 many children in England worked 16 hour days under dreadful conditions. In that year a Royal Commission recommended that children working in the textile industry, aged 11-18 years, be permitted to work a maximum of 12 hours per day. Children 9-11 years were permitted to work 8 hour days. Children under 9 years were no longer permitted to work (prior to this children as young as 3 were put to work). In 1847 the English Parliament limited both adults and children to ten hours of work daily.[227]

[195] The relationship of child to family and wider society continues to be blighted, in the 21st century, by physical (and sexual) assault and neglect. Child abuse and neglect is a complex phenomenon with multiple causes. Understanding the causes is fundamental to addressing the problem. The factors causative of and contributory to child abuse and neglect are well established. So also are those factors that are protective in nature. The world literature on child abuse is considerable in volume, covers every aspect of the topic (types, prevalence, history, causes, effects, prevention and treatment) and is the subject of ongoing development.

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[226] *The Protection of Children in England: A Progress Report,* March 2009, The Lord Laming

[227] See *Child Labor*, David Cody, The Victorian Web www.victorianweb.org/history

[196] Because child abuse, like suicide, is complex and multi-factorial in causative terms, it is obvious that no single strategy will go far in its eradication or reduction. A range of interventional strategies is needed. Today's children and young people are tomorrow's society and a strong State requires healthy, well-adjusted members. It also demands that its children be kept safe and well. This is the obligation of the State in terms of the international *Convention on the Rights of the Child,* to which New Zealand is a party.

[197] In the late 1990s Government instituted the Family Start Programme, said to be "an important initiative under the Government Strengthening of Families Strategy, which guarantees health, education and welfare services for families experiencing difficulties". The programme is a joint Education, Health and Welfare initiative and recognises that "families who show multiple indicators of disadvantage are at risk of poor outcomes for their children", which disadvantages include:

- poor parental educational attainment
- poor housing in poor neighbourhoods
- low income
- long-term unemployment
- solo parenthood
- high residential mobility.

Factors associated with such disadvantages are said to include:

- poor family health (frequent preventable illnesses)
- alcohol and drug dependency
- lower levels of parenting skills
- truancy and low educational achievement
- involvement in criminal behaviour
- young motherhood.

[198] The Family Start Programme recognises that "intense early home-based support can support parents and reduce the risks of poor social and emotional development and subsequent problems with children". The impoverishment of some of our young people in economic, educational, social, moral, mental and emotional health terms cannot be made good overnight. New Zealand has a whole generation of young people who have been reared against a background of social/educational/moral/economic disadvantage/deprivation and we are presently experiencing the results of societal/familial neglect, with second, and even third, generational malaise. There has been an increasing tendency towards the formation of transient, serial personal relationships between men and women, with the children of such relationships suffering as a result.

[199] There will be no early realisable results from the Family Start and similar Programmes. Their fruits are unlikely to be gathered for another decade or two. The Family Start Programme has been strengthened by the present Administration by a stronger focus on prevention of abuse and neglect. Many of the disadvantages referred to above, and the factors associated therewith, are recognisable in members of the King and Kahui families. Chris Kahui and Macsyna King were both receiving social welfare benefits at the time of the twins' deaths. As Dr Kelly points out there was a disengagement on the part of the twins' parents, in relation to their children, to an unusual degree. It should be recorded that extensive work has

been carried out by CYFS in relation to members of both families with a view to securing the safety and welfare of their children. Details of CYFS' interventions should remain unpublished.

[200] In a report to the Coroner dated 31 May 2010 Dr Nick Baker, Chair, Child and Youth Mortality Review Committee says injury is the leading cause of death amongst New Zealand children.[228] Out of 24 OECD countries, New Zealand has the highest rate for deaths from accidents or injuries in children under 19 years.[229] Our rate of death from maltreatment of children under 15 years is the 5th highest out of 26 OECD countries, with the largest proportion occurring in infants less than 1 year of age.[230]

[201] Dr Baker says an important principle noted in the Child and Youth Mortality Review Committee's *Fifth Report* is that there are frequently opportunities missed to identify risk and intervene long before a death occurs. He says that if this principle is applied to child protection, all professionals working with families need to be aware of the profound risks that result from family violence, including child abuse, and should actively seek out warning signs, support families and know how to intervene appropriately.

[202] Such latter comment raises the question of whether there should be mandatory reporting of child abuse, or suspected abuse, by health professionals and the creation of a statutory duty on the part of health and education authorities to protect children.

[203] It should be stressed, however, as Dr Baker points out, that even with the best care some cases of lethal child abuse cannot be anticipated. Lord Laming's remark applies. Dr Kelly said the fact that the Kahui twins were not known to CYFS prior to their admission with fatal injuries is typical of inflicted head injury in New Zealand.

[204] The lethal abuse that occurred in this case *could* have been anticipated, and protective steps taken, *had* the existence of the earlier injuries been known. The Children's Commissioner, Dr John Angus, said pragmatically that it was hard to conceive of a world in which vulnerable infants never die as a result of assaults in the setting in which they are expected to be safe and secure, namely their family households. He said "there is an element of randomness about such extreme acts of violence that defies prediction", adding that "that does not mean that we should not strive for such a world". As Dr Baker puts it, systems to protect children need to be the responsibility of the whole society. Government cannot do its work alone.

[205] Dr Baker said New Zealand statistics when compared to other countries suggest that the present child protection system is not adequate or, at least, could be improved. He suggests the following improvements:

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[228] Child and Youth Mortality Review Committee 2009 *Fifth Report to the Minister of Health: Reporting Mortality 2002-2008.* Wellington: Child and Youth Mortality Review Committee (see page 28 and the appendices)

[229] UNICEF Innocenti Research Centre 2007 *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries.* Florence: UNICEF Innocenti Research Centre. Retrieved from http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf.

[230] UNICEF Innocenti Research Centre 2003 *A League Table of Child Maltreatment Deaths in Rich Nations.* Florence: UNICEF Innocenti Research Centre. Retrieved from http://www.unicef-irc.org/publications/pdf/repcard5e.pdf.

1. Training in child protection for all professionals working with families should be mandatory and coordinated.
2. Effective and appropriately resourced teams to identify and intervene in children-at-risk should be in place around all maternal and antenatal health services.
3. With regard to issues around holistic care, the *Health and Disability Sector Standards Children and Young People Audit Tool Workbook* recommends: *"Staffing levels and skills mix being sufficient to allow a holistic and family centred approach to care (e.g. addressing more than just the problem in hand), supporting family and connected to well child services."* These Standards should be more widely used for quality improvement and service audit than is currently the case.
4. A national alert system to flag individuals at risk of abuse or neglect needs to be developed.
5. There should be training of professionals to impart the skills needed for them to better understand their responsibilities to share information around child protection.
6. Improvements to current systems to facilitate information sharing need to be made within and across agencies and disciplines.
7. The development of systems to protect infants in the first year of life requires effective liaising between organizations that include Maternity Services, Child Youth and Family, Police, Mental Health Services, Neonatal Services, Drug and Alcohol Services, Well Child Providers, Whanau Ora providers, Family Start and Hospital Social Workers. Families do best when they receive active case management from a nominated key worker, as was identified in Chapter 5 of our *Fifth Report*. Effective liaising and trust, with easy exchange of relevant information to ensure protection of children, are needed and occurs best when people work together as teams.
8. Systems need to ensure that services such as Mental Health, Corrections, Police, Work and Income NZ, Drug and Alcohol and Probation Services consider the welfare of the children of their clients as paramount. Specific systems are therefore required to ensure that children become visible within the services that care for adults.
9. Finally, systems to protect children need to be the responsibility of the whole of society. This duty cannot fall solely on organizations or services.

[206] As stated, the Court had the benefit of hearing evidence from Dr Patrick Kelly on the phenomenon of child abuse. Dr Kelly's experience and expertise in forensic paediatrics is recognised internationally. Dr Kelly said:

> (i) That he thought any attempt to identify the factors that led directly to the abuse of the twins was necessarily speculative (the identity of the perpetrator not then having been established). The Court comments that on all the evidence before it, the probabilities are that the twins incurred their fatal injuries in the dreadful suddenness of the kind of event spoken of by Lord Laming. Resentment, anger and frustration on the part of a father that, for the third time, he had been left by the twins' mother to cope on his own, together with a perceived inability to cope, are the kinds of emotion that may lead to momentary loss of control on the part of the caregiver who should not have been left in the position of sole caregiver of three infant children under the age of twelve months (Shane was aged eleven months). Macsyna King should not have left her partner to manage the three infants on his own without first ensuring that suitable assistance was at hand.

(ii) That it was not clear to him that there was any marker in the four week period between hospital discharge and death which, if acted upon, would have led to a different outcome. The Court is in agreement with such observation. It is also in agreement with Dr Kelly's comment that considerable effort was put into ongoing engagement with the family by visiting health professionals and others following discharge home.

(iii) That the policies and procedures of Counties Manukau District Health Board, and documentation in the Clinical Record of the Neonatal Unit, Middlemore Hospital, are consistent with current best practice. The Court has no reason to think otherwise. Dr Kelly says the failure of the whanau support worker, Manaaki Poutu, to document an episode of rough handling of the twins by their mother was non-compliant with the Board's policies and that many hospital staff members (of all professional disciplines) are reluctant to record observations of difficult family behaviour in the clinical record. He says addressing professional reluctance to record observations of this kind is an important aspect of child protection training. In the Court's view, reluctance by health professionals to record incidents of concern (which indicate or may raise a reasonable suspicion of child abuse) falls ultimately to be addressed by a requirement for mandatory reporting by health professionals and/or the creation of a statutory duty on the part of health (and education) authorities to take all necessary measures for the protection of children. Dr Kelly says the Hospital Board's criteria and guidelines for discharge were met when Macsyna King roomed in for several days prior to discharge "and in the arrangements made for follow-up after discharge". Whilst the Court appreciates what the Commissioner for Children had to say on this subject (as to which, see below), it is in agreement with the views of Dr Kelly, who is best-placed to comment on overall care. The Court is in agreement with Dr Kelly that even if the concerns of Ms Pouto and the observations of the community support worker, Dianne Nikora in relation to Macsyna King's care of the twins were passed on to CYFS, it is unlikely that an investigation would have reached a level of concern sufficient to justify removal of the twins from their parents' care. It is important to keep in mind the fact that, in looking back on what went on in the neonatal ward and in forming certain views, we necessarily do so with the benefit of retrospection and in the light of what happened to the twins after discharge. Dr Kelly says difficult and hostile parents are a common feature of paediatric practice, and working with such families requires a delicate balance of negotiation and compromise. He says he is not convinced (nor is the Court) that what the Commissioner described as "a more proactive approach" by the Board would have led to a different outcome in this case. As the evidence show, the twins received regular visits from health

professionals after discharge home and appeared to be thriving and well-cared for on each visit, as documented by Nurse Jane Eyres.

ARE PRESENT STATE SYSTEMS FOR THE CARE AND PROTECTION OF CHILDREN ADEQUATE?

[207] The magnitude of the problem is well illustrated by the fact that care and protection notifications to CYFS during the year 2009-2010 totalled 124,291. In its submissions to the Court, the Ministry of Social Development says "this highlights an increased awareness of the need for the care and protection of children and a growing willingness by communities to contact CYFS where there are concerns for a child's welfare. The increases [in notifications over the last seven years] also reflect Police practice to notify CYFS if children are present when Police attend a family violence incident".

[208] Detective Superintendent Winston Van Der Velde, formerly National Manager of the Criminal Investigations Group at Police National Headquarters, said in evidence that 11.67% of all occurrences reported to Police in 2009 were family violence-related, representing an increase of 10.36% for 2008 and 9.53% in 2007. In the year ending 30 June 2009 Police notified CYFS of 14,430 concerns relating to child safety. Over the last five years (2004-2009) Police have increased their notifications to CYFS by 50% (7,311-14,430).

[209] The Detective Superintendent said that in January 2010, as a result of a national stocktake of child abuse offending, Police identified 7,282 active ongoing child abuse investigations. He said that since October 2008 homicides that are family violence-related become the subject of a family violence death review, in terms of which such incidents are the subject of critical analysis with a highlighting of areas in which improved responses might have assisted to prevent death. Such reviews link into the work of the Family Violence Death Review Committee. *Operation River* was initiated in August 2009 to coordinate all Police activities in response to concerns about the adequacy of investigations into child abuse complaints. Two further operations have been initiated, *Hope* and *Scope*, each of which is designed to address child abuse complaints and delays in dealing with them, including the high number in the Masterton CIB office. Following the release in May 2010 by the Independent Police Complaints Authority of its first report into the practices, policies and procedures of New Zealand Police in respect of child abuse investigations, a new Police Child Protection Policy has been implemented. The new Policy incorporates an improved method of reporting child protection cases between Police and CYFS.

[210] Dr Kelly said he was in agreement with the Children's Commissioner that New Zealand lacks the kind of comprehensive child-centred approach reported to exist in the United Kingdom. He said he also agreed with the comments made by the Commissioner regarding:

- The importance of being able to recognise potential risk to vulnerable infants and children
- Systemic weaknesses in New Zealand information-gathering and sharing processes to assess risk and prevent abuse occurring or worsening
- The need to amend legislation to ensure that health and education authorities have a statutory responsibility for child protection.

[211] Dr Kelly said that in his view health professionals should become involved "as the front line" in child protection in New Zealand. He said most infants and children diagnosed with serious abuse are not known to CYFS at the time their abuse is first recognised. He said:

> "In contrast all children born in New Zealand are known to a health practitioner – if one includes lead maternity carers and all primary healthcare providers. If there is any possibility for early intervention, health practitioners are a key to it.
>
> Child health professionals have the necessary background to assess and interpret child health and behaviour but have minimal training and support in the recognition and management of child abuse and neglect. With such training and support they could become a very competent child protection workforce."

[212] Dr Kelly submits that all District Health Boards should establish dedicated child protection teams. He says the development of such teams within District Health Boards would provide the nucleus from which a much more integrated and systemic local and national programme of training, support intervention, inter-agency collaboration and research could grow.

[213] Dr Kelly said there is also a need for better information-sharing between agencies. As the Ministry of Social Development (the Ministry) puts it in its written submissions to the Court:

"Barriers to information sharing

19. The Ministry recognises that our information sharing objectives must be balanced against privacy interests. Our services involve collecting significant amounts of personal information from clients. It is important that we maintain trust, and do not engage in activities that are harmful to clients or would discourage them from volunteering information in future.

20. The Ministry considers that the Privacy Act 1993 presently does not strike the right balance between these interests. The Ministry believes that the Act creates real barriers to appropriate information-sharing and interagency cooperation.

21. Child, Youth and Family has the ability to collect information directly from other government agencies when investigating whether a child or young person is in need of care or protection, or for care or protection court proceedings (section 66 of the Children, Young Persons, and Their Families Act 1989). This assists in the investigation of notifications but it doesn't provide for the sharing of information with other agencies, or cover non-government agencies.

22. Professionals must be able to identify children in need of timely intervention, promote their well-being, and protect them from harm. The Privacy Act does provide for information sharing in some situations however the 'serious and imminent threat' threshold in Principle 10(d) and Principle 11(f) is an impediment to prudent and professional discussions between professionals regarding vulnerable children.

23. It is also important to improve the understanding of the agencies, practitioners, and the public about when and how they are able to share information. Unfortunately there is some inconsistency in what people and agencies think they are able to share under the present law.

Amendments to the Privacy Act

24. Effective information sharing is one of the key areas where agencies can make a difference to our most vulnerable children. Often it is only *after* information is shared that agencies can see the whole picture for a family, and risks and patterns that reveal serious underlying problems. Each agency alone may have insufficient information to determine whether a client is in need of assistance and support and may be unable to see the seriousness of a situation.

25. The role of the Experts' Forum on Child Abuse [*Ministry's Report to the Coroner,* paragraphs 115-116] was to provide Minister Paula Bennett with a report detailing their key recommendations for the development of a policy response to the issue of child abuse and neglect. The Forum recommended an integrated, graduated and increasingly multi-disciplinary approach to the prevention and treatment of child abuse and neglect.

26. As a result, on 17 March 2010, the Cabinet Social Policy Committee directed the Ministry to work with the Ministry of Justice and other agencies to improve information sharing to protect vulnerable children.

27. The Committee also directed the Ministry to ensure that the Law Commission considers the issue of improving information sharing to protect vulnerable children and options in its review of the Privacy Act 1993 ("the Act").

28. Consequently the Ministry made submissions to the Law Commission proposing changes to the Act to better facilitate information sharing between agencies to protect children and young persons. The Ministry has provided the Coroner with a copy of the Ministry's submission to the Law Commission.

29. The Law Commission recommended a new Part to be added to the Privacy Act to facilitate greater information sharing between agencies. Following on from that work, the Ministry of Justice are working towards introducing the Privacy (Information Sharing) Amendment Bill in August 2011. The Bill will enable agencies to enter into information sharing agreements that can be wider that the sharing currently allowed under the Privacy Act. This has the potential to increase cross agency collaboration around child protection.

30. The Ministry's submission to the Law Commission also points out that the Privacy Act's 'serious and imminent' harm threshold in paragraph (f)(ii) of Privacy Principle 11 means that agencies are forced to wait until a threat escalates to become 'serious and imminent' before they can act.

31. The Ministry proposed the removal of the word 'imminent', and the addition of a 'welfare' criterion. The Privacy (Information Sharing) Amendment Bill will

remove 'and imminent' from the harm threshold in Principles 10 and 11 of the Privacy Act – enabling more use and disclosure of information to prevent harm.

[214] The Bill referred to was introduced to Parliament on 16 August 2011 and awaits its first reading. It represents a marked advance in the ability of agencies such as Police, CYFS, Education, Health and Distinct Health Boards to share information relating, inter alia, to the health, care and welfare of infants. The exceptions to Information Privacy Principles 10(d) and 11(f) of the Privacy Act 1993 are widened to allow the use and disclosure of personal information where there is a serious threat (the qualification "imminent" has been removed) to public health or safety or the life or health of an individual. Information sharing agreements may be implemented by Order in Council to modify or clarify the application of the information privacy principles, and a procedure for the making of such Orders in Council is provided for.

[215] Another Government initiative has been to put on a statutory footing, with criminal sanctions, a duty on the part of parents and caregivers to protect children and infants from assault, neglect, ill-treatment and injury. On 19 September 2011 Parliament enacted the Crimes Amendment Act (No 3), which makes three key changes to the criminal law to ensure that children are adequately protected:

(i) Everyone who is a parent, or is a person in place of a parent, who has care or charge of a child under the age of 18 years, is now under a legal duty to provide that child with the necessaries of life *and* to take reasonable steps to protect that child from injury;

(ii) Everyone is liable to imprisonment for a term not exceeding ten years who, being (inter alia) a person who has charge of a child, is grossly negligent in caring for that child or intentionally engages in conduct that is likely to cause suffering, injury or disability; and

(iii) Everyone is liable to imprisonment for a term not exceeding ten years who, being a member of the same household as a child (or a staff member of an institution in which the child resides), and knowing that child to be at risk of death or grievous bodily harm as a result of an unlawful act by another person or gross negligence in caring for that child, fails to take reasonable steps to protect that child from that risk.

[216] Dr Kelly said there has been a significant international movement to address family violence, noting that Government has focused its efforts to prevent child abuse by tackling the issue of family violence. There is in place a Family Violence Inter-agency Response System (FVIARS), which requires CYFS, Police and Women's Refuge to collaborate on decision-making in respect of cases referred by Police to CYFS where there has been an incident involving domestic violence with children present. A SHINE community social worker now visits the family as soon as possible after Police attend an incident. The social worker will assist the family to make a safety plan, refer the family to services if appropriate and, if necessary, will make a referral to CYFS.

[217] The Ministry says that as part of the Government's vulnerable infant programme CYFS now has a policy requirement for multi-agency safety plans for children admitted to hospital as a result of suspected or substantiated abuse. CYFS is now required to meet with

the Police and health professionals to ensure that there is a clear, safe plan established prior to the child's discharge from hospital. This process also involves an agreement about ongoing monitoring of the child's safety and wellbeing.

[218] The Ministry further says:

(i) Since the twins' deaths, it has enhanced its ongoing campaign to educate the public in an easy and accessible way, about what people can do if they are worried about a child's welfare, and how CYFS will respond by such means as the "Keeping Kids Safe" brochure (a broad document aimed at the public, informing the reader who to contact if they have concerns), the "Never Shake a Baby" campaign and the "It's Not OK" campaign.

(ii) Its care and protection system depends upon those with information about abuse notifying CYFS so that CYFS can assess and investigate whether there are any care and protection concerns. In Chris and Cru's case, there were some concerns among professionals working with the family, but a notification was not made to CYFS until the twins were admitted to hospital with critical injuries on 13 June 2006. If CYFS had received a notification that the twins were at risk of abuse or neglect then a trained social worker would have conducted an investigation to determine whether they were in need of care and protection. If the social worker had considered them at risk of serious harm or neglect, CYFS could have applied to the District Court for a warrant to search the Kahui/King household and may have removed children in the household to the Chief Executive's custody.

(iii) One of the professionals working with the Kahui/King whanau after the twins were born was concerned enough about Macsyna's behaviour to contact a former colleague at Child, Youth and Family. The two former colleagues discussed Macsyna and the twins as a hypothetical scenario where a mother was not bonding with her premature twins. No names were used in this conversation; therefore the CYFS employee could not conduct a search of CYFS records to reveal CYFS' previous involvement with Macsyna King. It was decided at the conclusion of this conversation that the grounds for a notification to CYFS had not been met. The Court heard evidence at the Inquest that certain concerns of hospital professionals working with the twins after their birth were not documented, and those professionals did not discuss their concerns with their colleagues. CYFS now has hospital-based CYFS social workers to work with hospital professionals in the assessment of risk, bringing relevant CYFS held information to support that work. The Court comments that this is an important innovation.

(iv) Information sharing between agencies relies upon various professionals sharing information with one another to obtain a complete 'picture' of a child or youth's particular situation. In Chris and Cru's situation, no one reported to the authorities that they were at risk and consequently, none of the professionals in their life had any notice that they were being neglected or abused. As the Court has already stated, the introduction of the Privacy (Information Sharing) Amendment Bill is an important advance in the ability of various agencies charged with the safety and care of infants and children to discharge their functions effectively and well.

(v) CYFS' involvement with Macsyna King prior to the twins' admission to hospital on 13 June 2008, ceased in 2001. The notifications it had received concerning her children prior to 2001 were primarily regarding violence by her partner at the time. When CYFS closed its involvement with Ms King in 2001, she had left her violent partner and had made arrangements for her two eldest children to be cared for by their father. Before closing CYFS' involvement with Ms King, the social worker noted that she appeared to have a good understanding of the impacts of domestic violence, was working and enrolled in some educational courses, and would only have her daughter in her care. The Ministry says CYFS had no further concerns for the safety and wellbeing of her children.

(vi) There is in force a Memorandum of Understanding between CYFS, Health and Police which allows the parties to develop schedules for specific situations. A strong relationship now exists between CYFS and the Police. The Court adds that there is also in force a document titled *Memorandum of Understanding on the Safety of Children in Hospital With Suspected or Confirmed Non Accidental Injury,* the parties to which are the Chief Executive of the (former) Department of Child, Youth and Family Services, the District Health Boards and the Commissioner of Police. This Memorandum provides a framework through which the parties may formulate policy to ensure the safety of children hospitalised with suspected or confirmed non-accidental injury.

(vii) On 27 July 2011 the Minister for Social Development and Employment (the Hon Paula Bennett) released a Green Paper for Vulnerable Children, titled *Every Child Thrives, Belongs, Achieves*, the purpose of which is to engage New Zealanders in dialogue as to how the community should respond to what the Court would describe as very dark aspect of the New Zealand psyche.

[219] In October 2010 this Court issued its findings in an inquest into the death of a 15 year old boy named *Shone Delaney Young* (Decision No 109/10), issued 21 October 2010). At the time of his death, which was found to be self-inflicted, Shone was in the custody of the Chief Executive of the Ministry, in terms of S101 of the Children, Young Persons and Their Families Act. In para [49] of its findings the Court said:

> "In para [105] of *Oum* (an earlier inquest into the death of a young person who was being monitored by CYFS pursuant to a S91 Support Order) the Court said the Ministry of Social Development and its senior management were to be complimented upon their frankness in accepting that mistakes were made in the management and care of Denbora Oum. It said the fact that the Ministry should acknowledge that mistakes were made and had taken the significant steps outlined in the Findings to improve systems and practices in the light of Denbora's death goes a long way to ensuring the public that Government is conscious of the seriousness of administrative errors, deficiencies and inefficiencies on the part of Departments of State and Government agencies and is anxious to ensure the strengthening of those work practices and systems which permitted Denbora's death to occur.
>
> The Ministry is also to be complimented upon the frank, open and honest way in which it has approached this inquest. The findings in this case show that the Ministry is continuing to look carefully at its systems, practices and processes and, indeed, is

> presently reviewing them in line with the recommendations made by this Court in *Oum*. As stated by the Coroner to members of Shone's family at the inquest hearing, it is a very difficult area indeed that the Ministry has to work in. The challenges presented by children and young persons coming within the custody and care of the Chief Executive of Child, Youth and Family are often formidable in nature. It is greatly to the Ministry's credit that its senior officers should be prepared to come to this Coronial hearing and say that they accept they could have done better. Those officers went on to say that they are determined to do better and that changes are being made with a view to ensuring this."

[220] From time to time CYFS comes under severe criticism (on occasions justifiably so) for its management of often challenging and difficult cases. The public is entitled to know that its operations are well monitored and that its officers, in the Court's experience, are committed to doing the very best they can for the children of this nation. The Commissioner for Children said CYFS is in the soundest position it has been in for 20 years, adding "that is particularly so in terms of managing the pressures of child protection investigations and assessments that had led similar agencies to crisis point across the Tasman." He said CYFS' challenge now is to bring a consistent level of depth of assessment and quality of service responses to its child protection work. He said its strategic goals are the correct ones: its task is to achieve them. There can, of course, be no possible criticism of CYFS in this tragic case.

[221] One of the questions before the Court is whether there is a need for the establishment of a multi-disciplinary, multi-agency child protection agency, charged with the development of a co-ordinated national programme for the protection and care of children. Both the Commissioner for Children, Dr John Angus, and Dr Kelly think such a body to be unnecessary. The Court respectfully agrees with their views. Listen to the wise words of Dr Angus, distilled from a lifetime's experience in social work:

> "This case demonstrates the complexity of the systems involved in the care and protection of children and highlights the importance of comprehensive assessments of families/whanau who may require support to fulfil their responsibility for the safety of their children. In addition to issues related to social work training there is clearly room for improvement at a systemic level. *Care and protection of children begins with families and communities. Although there will always need to be a formal system, this should be the safety net and not the primary focus of efforts to ensure care and protection.* A public health approach is needed to build safer and more responsive communities within which children can be protected.
>
> The key to improvement appears to lie in a clearer understanding of the shared responsibility for care and protection of children and a legislative amendment has been proposed to clarify the responsibility of those working in health and education. Effective intervention to ensure the care and protection of children is dependent upon well-informed, proactive, and co-ordinated responses to families/whanau. This necessitates a multi-agency approach, most appropriately organised at a community level. I am not persuaded that the creation of a new agency at a national level is required or would be helpful. A greater priority would be to mandate, if not require, closer coordination of information and actions within the health sector, and between the health sector and Child, Youth and Family." (Italics added)

[222] Should there be mandatory reporting by health professionals of child abuse? Here is what Dr Kelly had to say on the subject:

> "Despite New Zealand's lack of statutory "mandatory reporting", notifications to Child Youth and Family have increased exponentially in recent years – exceeding the rate of rise in countries which do have reporting mandated by law. While I sympathise with the problems that mandatory reporting creates for statutory authorities, I note that (by virtue of the protocols signed between CYFS and the Ministry of Health in 1996), all District Health Boards are meant to have (in effect) mandatory reporting already. That is, DHB policies (like those in CMDHB) require that suspected abuse must be notified to CYFS.
>
> Although this practice has never been audited, I believe it is likely to have had a significant effect on the reporting behaviour of health professionals in many DHBs. Certainly, from a clinician's perspective, the fact that a policy of mandatory reporting exists makes it much easier for front-line staff to explain to families (in a non-confrontational manner) their decision to notify CYFS. In contrast, the rate of reporting from General Practitioners is extremely low (something like 1% of annual notifications), and based on my experience I believe it is likely that the rate of reporting from Midwives would be even lower (although I have seen no statistics on that issue).
>
> With regard to the Kahui twins of course, CMDHB already had a form of mandatory reporting, so it is difficult to argue that it would have made a difference in their case."

[223] In a paper titled *The Role of Health Services in Child Protection* Dr Kelly said, of relevance to the issue of mandatory reporting:

- Many children eventually diagnosed with abusive injuries are found to have been injured before, and have often been seen by health providers who did not realise the significance of earlier symptoms. Appropriate health provider training and supervision could have a significant effect in the prevention of serious abuse.

- Most infants and children diagnosed with serious abuse are not known to Child Youth and Family at the time their abuse is first recognised (although their extended families may well be). It may therefore be impossible for the statutory authorities, in many cases, to prevent that abuse.
- In contrast, all children born in New Zealand are known to a health practitioner – if one includes lead maternity carers and all primary healthcare providers. If there is any possibility for early intervention, health practitioners are a key to it.

- There are many more health professionals in new Zealand with expertise in the care of children and young people then there are Child Youth and Family social workers. A conservative estimate suggests that there are at least 11,000 such health providers, in comparison to less than 1,000 statutory social workers.

- The health system will remain engaged with children and families, through one provider or another, long after the statutory authorities have closed the file.

- There is an extremely low rate of notification from many healthcare providers to statutory authorities. Many have limited experience of child protection processes and distrust the statutory authorities. For many healthcare providers, there is no infrastructure of advice and support within the health system to guide them in making decisions about what to do when they suspect abuse and neglect.

- Child health professionals have the necessary background to assess and interpret child health and behaviour, but have minimal training and support in the recognition and management of child abuse and neglect. With such training and support they could become a very competent child protection workforce.

The points made by Dr Kelly have relevance both to the establishment of child protection teams (which is the subject of a recommendation by the Court) and the question of mandatory reporting (which the Court recommends to the Minister for consideration).

[224] The Commissioner for Children does not favour mandatory reporting. He supports strengthening of child protection services. At the present time the reporting of child abuse is *discretionary* in statutory terms. S15 of the Children, Young Persons, and their Families Act provides that any person who believes that any child or young person has been or is likely to be harmed, ill-treated, abused, neglected or deprived *may* report the matter to a social worker or a Constable. S16 of the Act provides immunity from civil, criminal or disciplinary proceedings for those who make such disclosure.

[225] Should not the discretionary power to report become a statutory duty, in line with the enlargement of the legal duties owed to children and young persons effected by the Crimes Amendment Act (No 3), and the freeing up of the ability to share information? If the answer to that question is yes, why should that duty in law not be extended to embrace health professionals, as is the case under S18 of the Land Transport Act (reporting of unfit drivers)? Is one more important than the other? As stated by Michael Heron et al in 2001,[231] New Zealand is out of step with Australia, Canada and the United States in the area of mandatory reporting by health professionals, most if not all jurisdictions within those countries having mandatory reporting legislation.

[226] Heron et al point out that common features of such legislation are (i) an obligation to report to child protection agencies or the police where there are reasonable grounds to suspect child abuse; (ii) criminal and civil liability for failure to report; (iii) complete immunity for good faith reporting; (iv) report anonymity; and (v) a requirement on a broader group than just health professionals (including child care workers, teachers, law enforcement officers and others). The authors of the article say there is much debate as to whether we in New Zealand should follow the other jurisdictions. They say that one consistent theme emerges: the implementation of duties to report is only a small part of any solution. It must be combined with the training and resources to assist the accurate identification and investigation of such abuse. This is the point made by Dr Kelly. This is the reason for the establishment of child protection teams.

[227] The authors of the article go on to say:

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[231] *Health Professionals and Mandatory Reporting*, New Zealand Law Journal May 2001, 139

"In terms of the disclosure requirement, the real change would be in the mandatory nature of it. There currently exists the ability to disclose with immunity under the CYPF Act and arguably under the [Health Information Privacy] Code. If we are prepared to have mandatory reporting for infectious diseases and unfit drivers, then that small part of the solution is not a major step. Objection has been raised on the grounds that mandatory reporting breaches s14 NZ Bill of Rights Act 1990 – freedom of expression. Of greater concern is that patients may not provide accurate or full information to the provider when seeking assistance, or alternatively do not seek assistance at all, because of mandatory reporting. Despite these and other criticisms (too reactive and interventionist) voiced of mandatory reporting in each jurisdiction, the mandatory reporting regimes have not been repealed.

If mandatory reporting is to be implemented, however, it will make significant inroads into the professional confidence required of providers. Other mandated reporters may not have the same obligations, and therefore less conflict. In the current climate of intense scrutiny on the health sector, the implementation of mandatory reporting on health professionals without further assistance and resources would be unfair and likely to be counter-productive.

CONCLUSION

The populist thought that health professionals should be required to prevent risks posed by patients or report crimes is fraught with difficulty. Whilst some may be better able to detect crimes such as child abuse or prevent danger such as infectious diseases, all will be faced with ethical and legal dilemmas. It is little wonder that providers err on the side of caution unless required to disclose by statute. If we expect their assistance, then clear requirements are needed, rather than a maze of discretion."

RECOMMENDATIONS

[228] The Court makes the following recommendations:

TO The Minister of Social Development and Employment –

1. THAT Government give favourable consideration to the establishment of effective and appropriately-resourced child protection teams (of the kinds proposed by Drs Patrick Kelly and Nick Baker) in each Health Board District, the operations of such teams to be under the management and control of the District Health Board and such teams:

   (i) Having the ability to identify children and young persons at risk and to intervene in the interests of their health and safety;

   (ii) Working closely with maternal and antenatal health services;

   (iii) Having responsibility for the training and support of Primary and

Secondary health care providers in each Health Board District;

(iv) Being responsible for the development of safe child protection systems and processes within each Health Board District; and

(v) Working in partnership with CYFS, the Police and other agencies concerned with child protection.

2. THAT Government give favourable consideration to amendment of the Education Act 1989 and the Health and Disability Services (Safety) Act 2001, so as to charge health and education authorities with statutory responsibility for child protection, together with an obligation to work in cooperation with other State agencies concerned with the protection of children.

3. THAT consideration be given to the desirability of introducing legislation creating an obligation on the part of health professionals to report to CYFS (or other body) documented instances of physical child abuse or situations where there are reasonable grounds to suspect abuse.

[229] The Court wishes to thank Mr Adam Ross, Ms Adams and Ms Campbell, Mr Lewis, Mr Waalkens, Ms Jury, Ms Holden, Ms Bowman, Ms Rose and all those other bodies (including the Families Commission and the Family Help Trust) and persons who have so willingly assisted the Court in this part of its inquiry. The Court is grateful to each for the time expended in compiling evidence and making submissions.

[230] A copy of these Findings was sent in provisional form to Counsel for Mr Kahui, Mrs Wilkinson-Smith, on 29 November 2011, for the purposes of S15(2) of the Act. Written submissions were received from her on 13 December 2011. On 31 January 2012 the Coroner received from Dr Rodney Harrison QC supplementary submissions on behalf of Mr Kahui. A copy of the submissions received from Mrs Wilkinson-Smith and Dr Harrison, together with a copy of the provisional Findings, were sent to Counsel for Police (Mr Mount) and Counsel for Ms Macsyna King (Ms Dyhrberg) on 22 February 2012. Written submissions were received from them on 10 and 4 February 2012, respectively. Copies of their submissions were sent to Dr Harrison, from whom submissions in reply were received on 7 May 2012.

[231] Counsels' submissions were the subject of careful consideration by the Court. A summary of those submissions, and the Court's comments thereon, is contained in a document titled *Comments of Coroner in respect of Submissions received from Counsel following issuing of Findings in provisional form*, issued separately to these Findings. That document contains five Schedules, constituted as follows:

First Schedule

Submissions received from Mrs Wilkinson-Smith and comments by Coroner.

Second Schedule

Submissions received from Dr Rodney Harrison QC and Coroner's comments.

Third Schedule

Submissions received from Counsel for Police (Mr Mount) and Counsel for Ms Macsyna King (Ms Dyhrberg) and Coroner's comments.

Fourth Schedule

Further submissions received from Dr Harrison, in response to those received from Mr Mount and Ms Dyhrberg, with Coroner's comments.

Fifth Schedule

Amendments to provisional Findings not already recorded in para 10 of First Schedule and para 34 of Second Schedule.

Dated at Wellington this 2nd day of July 2012

G L Evans
Coroner