Absolutely Positively
Wellington City Council
Me Heke Ki Pōneke

File ref: IRC-3822

1 November 2022

Roger Calkin
fyi-request-20481-31eaec34@requests.fyi.org.nz

Kia ora Roger

Death by Drowning

Thank you for your request made under the Local Government Official Information and Meetings Act 1987 (the Act), received on 7 September 2022. You requested the following information:

> 1. Copies of all correspondence/reports/emails/text messages relating to the death of Sandy Calkin held by the Wellington City Council (the Council), and its staff.
>
> 2. All reports, recommendations, and upgrades to safety made to Queens Wharf and its surrounding areas made in response to the death of my son, Sandy Calkin on 10 July 2021.
>
> 3. All reports, recommendations, and upgrades to safety made to Queens Wharf and its surrounding areas made in response to the death of Finbar Clabby in 2015. This should include all camera system upgrades and increases in coverage.
>
> 4. All incident reports held by the Wellington City Council in respect of all accidents, near misses, fatalities and injuries where people have fallen into the water or come close to falling into the water on or about Queens Wharf and the surrounding waterfront area since the death of Finbar Clabby in 2015.

My apologies for the delays in providing you with the information you are seeking. I would like to reassure you that the Council's Waterfront team is working closely with the Coroner's office and has been providing regular updates to the office regarding our progress. The Council takes health and safety in our public areas very seriously and we do regular assessments to ensure that we minimise the risk to public as much as possible.

Reasons to withhold some information:
While the Coroner's office is conducting an active investigation, material such as correspondence/reports/emails and text messages to and from the Coroner's office relating to your son's investigation is unable to be released. At this stage, this part of your request has been withheld under sections:

- 6(a) making information available would likely prejudice the maintenance of the law, including the prevention, investigation, and detection of offences, and the right to a fair trial.

The Coroner's office has advised that all requests that relate to their investigation be directed to their office. We have forwarded your request regarding all copies of correspondence/reports/emails and text messages relating to the death of your son to the Coroner's Office. The Council will continue to work with the Coroner's office on this after the investigation is completed.

Correspondence/reports/emails regarding the death of Sandy Calkin

At the time of your son's passing the Council worked closely with the Police to gather CCTV footage. For privacy reasons, we cannot release camera footage directly to the public, as it contains private information about other individuals. This part has been refused under section 7(2)(a) of the Act.

I can confirm that the Waterfront team has no other correspondence and emails relating to the death of Sandy Calkin other than the ones engaging with the Coroner's office as noted above.

Below are the documents that fall in scope of your request and my decision to release the document.

Item	Document name/description	Decision
1.	Urgent 2M 210712_3425 - 13 July 2021	Release with redactions
2.	RE_ [EXTERNAL] RE_ Missing person Sandy Calkin - 15 July 2021	Release with redactions
3.	2M 10-07-2021 - 15 July 2021	Release with redactions
4.	CCTV-Josh_OMERI-(2021-07-14)	Release with redactions
5.	WCC CCTV Urgent Footage Request IRC2120 210712_3425 - 16 July 2021	Release with redactions
6.	RE_ Re_ Urgent footage IRC 2120 - 16 July 2021	Release with redactions
7.	RE_ IRC2120 - 1 September 2021	Release with redactions
8.	RE_ IRC2120 - 1 September 2021	Release with redactions
9.	RE_ IRC2120 - 1 September 2021	Release with redactions
10.	RE_ [EXTERNAL] RE_ IRC2120 - 7 September 2021	Release with redactions

Please note, contact details have been redacted in accordance with section 7(2)(a) of the Act.

For completeness, both the CCTV and Waterfront team do not have any text messages (including text-based apps) relating to your son's passing. Your request for text messages has been refused under section 17(e) that the alleged document to contain the information requested does not exist or, despite reasonable efforts to locate it, cannot be found.

Queens Wharf Upgrades

The Wellington waterfront is a dynamic public space that has continued to evolve over the last 30 years. Council takes the health, safety and well-being of the public seriously, and have many preventative and safety precautions in place. There are regular reviews of lighting and public safety across the waterfront. We have recently received the latest lighting audit report and Crime Prevention Through Environmental Design (CPTED) and Injury Prevention Through Environmental Design (IPTED) review for the waterfront. These reports are new (2022) reports that provide an update on previous reports commissioned.

Ongoing safety improvements include:

- Well-lit and easily accessible life rings, and defibrillators have been installed.

- Temporary fencing is now used at larger events in areas where we anticipate large crowds will be close to the wharf edge, for example the Matariki Sky Show 2022.
- CCTV cameras are in place that are monitored by a trained security team.
- Handrails and upgraded lighting are used in places deemed appropriate such as bridges and access points.
- There is a kerb or nib along the wharf edge, and sleepers and seats are placed in certain locations to further define this edge.
- Providing second chance barriers to help provide separation between waterfront users and the water.
- Specific step edge definition is used to define the edge of steps to prevent trips and falls.
- Improving the lighting of sea ladders making it easier for people to find the ladders if they fall in.
- Lighting is also used to highlight edges and guide pedestrians and has been installed around wharf cut-outs to minimise the risk of entering the water at certain points.

Your request for specific reports, recommendations, and upgrades on the death of Finbar Clabby or your son Sandy Calkin has been refused under section 17(e) of the Act that the alleged document to contain the information does not exist. The Coroner is yet to report findings and should any recommendation be made to Council, these would be taken under consideration.

The Council does conduct regular reviews for health and safety. The documents listed below, are documents that were conducted around the time of Finbar Clabby and Sandy Calkin's passing that include upgrades and recommendations for the waterfront:

Item	Document name/description	Decision
11.	Waterfront Lighting Strategy 2005	Release
12.	Waterfront Edge Safety Assessment notes 2016	Release
13.	CPTED/IPTED Study – WCC Waterfront Operations 2016	Release
14.	Wellington Waterfront S&T Lighting Assessment - August 2022	Release
15.	Wellington Waterfront CPTED Report 2022	Release
16.	S&T Consultants Advice No 01 - Lighting Improvements Priority Recommendations - September 2022	Release

Incidents reported to Wellington City Council:
The attached report was pulled from our risk manager system. This logs all incidents/injuries/near misses and fatalities that was reported to Council.

Item	Document name/description	Decision
17.	Waterfront Incidents 2015- 2022	Release

Please note, there are some incidents that happen on the waterfront, where members of the public decided not to report to Council.

Right of review
If you are not satisfied with the Council's response, you may request the Office of the Ombudsman to investigate the Council's decision. Further information is available on the Ombudsman website, www.ombudsman.parliament.nz.

We are sorry for the loss of your son, if you have any questions, please feel free to contact me.

Kind regards

Asha Harry
Official Information