### NOTIFICATION OF CORONER'S DECISION NOT TO OPEN INQUIRY

#### Section 64(1), Coroners Act 2006

## IN THE MATTER of Masatomo ASHIKAGA

The Secretary, Ministry of Justice, Wellington

I notify you pursuant to section 64(1) of the Coroners Act 2006 of my decision not to open an inquiry in respect of the death of:

Full Name of deceased:

Masatomo ASHIKAGA

Late of:

315/35 Hobson Street, Auckland Central,

Auckland

Occupation:

**Chief Executive** 

Sex:

Male

Date of Birth:

**5 January 1959** 

The following matters are adequately disclosed in respect of the death by information arising from investigations or examinations I have made or caused to be made:

Place of Death:

315/35 Hobson Street, Auckland Central,

Auckland

Date of Death:

**21 February 2019** 

Cause(s) of Death

(a). Direct cause:

Complications of chronic alcoholism

(b). Antecedent cause (if known):

n/a

(c). Underlying condition (if known):

n/a

(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if

n/a

known):

## Circumstances of death

- [1] On 21 February 2019, Mr Ashikaga, aged 60 years, was found by his wife (from whom he had recently separated) unresponsive on the bathroom floor of his apartment. She had gone to check his wellbeing as she had been contacted by a representative from work who was concerned that Mr Ashikaga had not been to work on 18 20 February. Mr Ashikaga's wife had last seen him on Saturday 16 February.
- [2] Mr Ashikaga was pronounced dead by an attending paramedic.
- [3] It appears that Mr Ashikaga was running water for a bath and collapsed; the water was still running when he was found.



#### **Post Mortem Examination**

[4] A post mortem examination was performed, and the forensic pathologist reported that in his opinion the direct cause of death was complications of chronic ethanolism. He noted that toxicological testing did not detect ethanol (perhaps indicating alcohol withdrawal syndrome) but that all the autopsy findings were consistent with chronic use of alcohol that based on the findings of the post mortem examination overall the cause of death was complications of chronic ethanolism.

#### **Police Conclusion**

[5] Police attended and do not consider the death suspicious.

# My reasons for the decision not to open an inquiry are as follows

I have reviewed the Police evidence and the post mortem report. The cause of death has been established by post mortem examination and is the result of the effects of the chronic overuse of alcohol. I am satisfied that all matters required to be established by the Coroner pursuant to s57(2) of the Coroners Act 2006 can be established on the available evidence. Further inquiry is not necessary.

Signed at Auckland on this 7<sup>th</sup> day of May 2019.

Coroner K H Greig