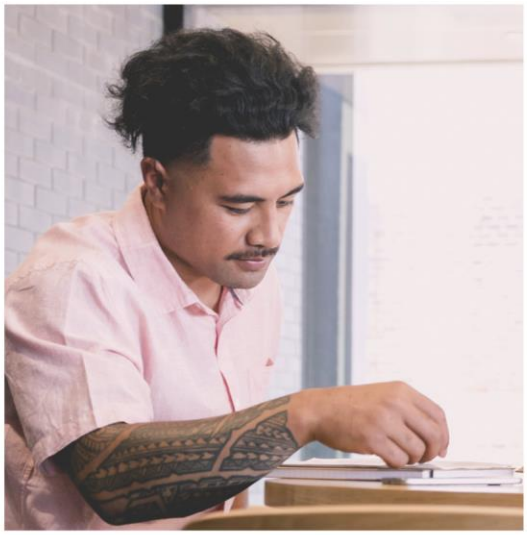
MINISTRY OF JUSTICE
Tāhū o te Ture

Annual Report 2017/18

Office of the Chief Coroner of New Zealand
Kai Tirotiro Matewhawhati Rangatira o Aotearoa



PROVIDING ANSWERS TO FAMILIES

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Ki te iwi Māori he tikanga nui tō te mate me te whakahemohemo. He taunga te whānau ki te tūpāpaku, ā, kei reira rātou mō te nuinga o ngā whakaritenga tae noa ki te nehunga. Ko te tiaki i te tūpāpaku, ko te tangi me te tuku kōrero ki a ia – puta ake ai ēnei hei whakaatu, ahakoa kua mate, ora tonu ai te wairua.

Death and dying are a central part of Māori life. The family have an intimate connection with the body of the deceased and are usually closely involved with the preparations leading up to the burial. Respect – in the form of caring for the tupāpaku, mourning the deceased and speaking to them – is shown because, although the physical remains of a person are lifeless, the spirit continues to live on.

New Zealand Law Commission, Coroners: A Review, Preliminary Paper No 36, Wellington, 1999, para 17.

INTRODUCTION

Welcome to the third annual report of the Chief Coroner

Coroners investigate death to establish the cause and circumstances of that death and to make recommendations and comments that might prevent similar deaths occurring in the future. This prevention aspect of our work is important to society and reflects the value placed on each life.

This year has been a significant one for coroners and the Coronial Service. There have been several high-profile inquests held and findings issued. Some of these are referred to later in this annual report.

The work of a coroner is somewhat relentless. The role entails balancing an active caseload of up to 300 files, together with inquest hearings and the 24/7 duty coroner role. This year, more deaths were reported to us than the previous year and we took jurisdiction over more of them. This increase in workload has increased the average number of days before a case is closed and has also increased the number of cases on hand (4089 active cases at the end of June 2018). Coroners are aware of the burden that delay can place on families, including the potential to cause further grief if coroners' findings are not released in a timely manner.

In light of the increasing workload, I would like to thank the coroners of New Zealand for their dedication to their work. I also acknowledge the support we received from Coronial Services (including case managers and staff at the duty coroner's office) and from Legal Research counsel. We all endeavour to prevent deaths and promote justice through the investigation of deaths within the resources available.

I hope you find this annual report of interest. It is a brief overview of the work we do.

Her Honour Judge Deborah Marshall
Chief Coroner

December 2018

CORONIAL SERVICES OF NEW ZEALAND

Purongo O te Ao Kakarauri

The New Zealand coronial bench consists of 17 coroners and one Chief Coroner. They are supported in their roles by the Ministry of Justice's Coronial Services Unit and operate throughout New Zealand.

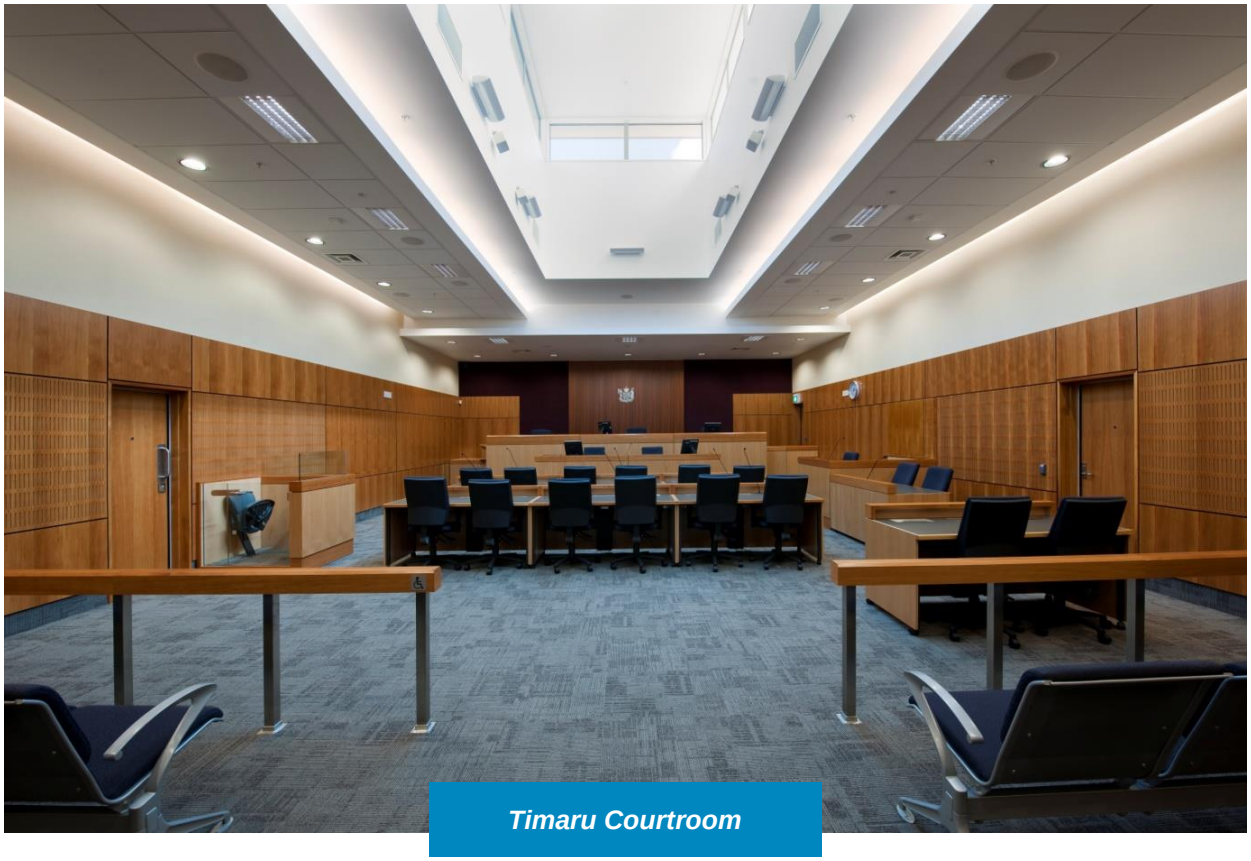
The Chief Coroner's main function is to help ensure the integrity and effectiveness of the coronial system. This includes helping to achieve consistency in coronial decision-making and other coronial practices.

Coroners are independent judicial officers with a legal background who investigate sudden, unexplained or suspicious deaths. They are based throughout the country with offices in Whangarei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch, and Dunedin.

Back row left to right: Coroner Shortland, Coroner Devonport, Coroner Scott, Coroner Ryan, Coroner Windley, Coroner Bain, Coroner Greig, Coroner Matenga, Coroner Tutton. **Front row left to right**: Coroner Bell, Coroner Elliott, Coroner McDowell, Judge Marshall (Chief Coroner), Coroner na Nagara, Coroner Johnson, Coroner Robb. **Absent:** Coroner Herdson, Coroner Robinson.

JURISDICTION OF THE CORONER

The Coroners Court of New Zealand has jurisdiction under the Coroners Act 2006 (the Act) to investigate unexpected, unexplained and unnatural deaths, as defined respectively in sections 3 and 4 of the Act.



Timaru Courtroom

The coronial process is an inquisitorial, fact-finding jurisdiction that is informed by family concerns. Part 3 of the Act gives coroners the power to hold inquests. An inquest is a hearing, normally held in a court, for the coroner to investigate the death.

As well as their statutory obligation to establish, where possible, the identity, cause and circumstances of reportable deaths, one of the purposes of the Act is the making of specified recommendations or comments to help reduce preventable deaths.

Reportable deaths

The coronial system in New Zealand is a 24 hour-a-day service. There is always a coroner on duty to receive reports of deaths. About 5700 deaths are reported to coroners each year and coroners accept jurisdiction in around 3200 of these deaths. Sections 14 and 15 of the Act state that a death must be reported if:

- the body is in New Zealand
- the death appears to have been without known cause, or self-inflicted, unnatural, or violent
- the death occurred during, or appears to have been the result of, a medical procedure and was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and was medically unexpected
- the death of a woman that occurred while she was giving birth
- the death occurred in official custody or care
- the death in relation to which no doctor has given a death certificate.

Coronial process

Once a death has been reported, the coroner decides whether to accept or decline jurisdiction. If they accept jurisdiction, they can open an inquiry or direct a pathologist to perform a preliminary inspection or a post-mortem.

A preliminary inspection can consist of an external visual examination of the body and/or the use of medical imaging. This helps to ensure unnecessary and costly post-mortems are avoided. If a post-mortem is needed, it can be either a full internal and external examination of the body, or a lesser examination. Often, a pathologist tries to perform the post-mortem as soon as possible (usually the next working day), though in some cases it may take longer. After the post-mortem, the coroner decides whether to order or wait for more investigations, or put the investigation on hold (due to other processes) or make their final findings about the death.

If an inquest is held, evidence is collected. Witnesses and experts present their evidence to the coroner. During this process, the coroner and the immediate family are able to ask relevant questions. After the inquest, written findings are issued and, in some cases, the coroner might make recommendations or comments to help prevent similar deaths in the future.

THE FIRST 48 HOURS

Merelyn Redstone, Coronial Service Manager – National Initial Investigation Office

Dealing with a sudden death can be very hard. Our staff at the National Initial Investigation Office (NIIO, also known as the duty coroner's office) are at the frontline, liaising with Police and medical officials as deaths are reported, ensuring the duty coroner's directions are carried out and helping families to understand the coronial process.

NIIO is notified of all sudden, unexplained or violent deaths in New Zealand. It manages cases from the time police report the death until the body is released from the mortuary and operates 24 hours a day, seven days a week. Generally, this work is completed within 48 hours of a death.

The number of deaths reported to the coroner continues to increase each year. The figures below show the 2016/17 year and the 2017/18 year to give some comparison:

	2016/17	**2017/18**
Total Cases Reported:	5564	5608
Doctors issued Certificates:	2160	2035
Jurisdiction Accepted:	**3404**	**3573**

We are sensitive to the circumstances surrounding each death, working with a high degree of professionalism and empathy.

While almost 37% of cases are signed off by doctors, in terms of time and workload, these cases can take up as much time as a straightforward coronial case in the initial stages. For instance, many general practitioners do not work at weekends and because, in the bigger cities, they tend to move between practices, they can be difficult to locate and can have difficulty accessing the patient notes at a different medical practice.

Cases, where jurisdiction is taken by a coroner, range from those that are quite straightforward to the complex, for example, where identification is an issue.

A major role of our co-ordinators is to keep families informed during the initial stages of the coronial process. We tell families what's happening with the post-mortem, body tissue samples, and when the body will be released from the mortuary. Another large undertaking for our team is managing the transportation of deceased to and from mortuaries, which are sometimes at a distance from the scene of the death, and liaising between families and the duty coroner if families want to remain with their loved one at the mortuary

The duty coroners and the NIIO team are a very dedicated group who work closely families at a traumatic time of their lives while ensuring that we meet the requirements of the Coroners Act.

Working together to save lives

One case we were notified of in 2017/18 was the death of a two-year-old child who was found unresponsive in her cot. She had recently been unwell, as had her three siblings. Their mother had taken them to the GP the previous evening, who diagnosed a virus and recommended paracetamol for fever. The child finally settled at about 2.30am and was placed in her cot; her mother went to bed at the same time. In the morning, she found her child unresponsive.

When the death was reported to NIIO, staff immediately alerted the duty pathologist and advised that it was likely that an immediate post-mortem would be sought by the duty coroner, once she had all the information from the police. Later in the morning, NIIO staff learned that the family were Muslim. Therefore, their religious beliefs required the body to be buried as soon as possible. The child's father was very concerned about this. He had no objection to a post-mortem but wanted his child returned to the family as soon as possible. NIIO staff set about to do whatever they could to progress this case and get a good result for the distraught family.

The coroner spoke with the pathologist who was willing to do all he could to get the post-mortem completed as soon as possible, but he noted that a specialist CT scan at Starship would be required as part of the examination. He explained the potential difficulty of getting a scanning time at Starship Hospital during working hours. The coroner also spoke to the pathologist about the other siblings, as the police documents recorded they had been suffering from the same illness as the child who had died. The pathologist advised that it would be prudent for them be taken to the emergency department at Starship to be checked.

Starship agreed to squeeze in a scan for 3.30pm that day and to report the results immediately, so that a post-mortem examination could be done at 5pm. The mortuary technicians and pathologist stayed into the evening, well past their normal hours, to complete the post-mortem. The microbiology staff also agreed to stay late and process the samples immediately.

NIIO staff remained in constant contact with the father, keeping him updated and passed on the advice about the need for a medical check of the other children. By 4.30pm, the remaining children had been admitted to Starship to undergo testing. With the rapid provision of the results of the CT scan and the microbiology testing, the doctor was able to treat the children with appropriate antibiotics.

This co-operation between the duty coroner, NIIO, the pathologist and their staff as well as the radiology department laboratory technicians and the doctor at Starship, not only meant the other children in the family received immediate medical treatment but a culturally appropriate service was provided that enabled a dearly loved little one to be returned to her family on the same day.

As one of the senior clinicians involved noted, "Yesterday was a great example of a number of very complicated services all working together doing the best thing for the family."

CORONIAL INVESTIGATIONS AND COURT OPERATIONS

Coronial findings

An inquiry is a legal investigation into a death; it is not a trial. The role of a coroner is not to determine civil, criminal or disciplinary liability. Rather, it is to establish the cause and circumstances of a death and identify any lessons that can be drawn to prevent similar future deaths. In some cases, such as death from natural causes, a coroner may make a finding without opening an inquiry.

THE LEGAL AND RESEARCH TEAM

In January 2018, the Ministry of Justice, in consultation with the Chief Coroner Judge Deborah Marshall, established a legal and research team to assist New Zealand's coroners. The team consists of the manager and seven counsel.

The purpose of the team is to free up coronial capacity and decrease the average time taken for findings to be issued by coroners. The team provides advice regarding the cause and circumstances of deaths, which are considered in chambers (without an inquest), and assists with drafting the related finding. As of 19 December 2018, the team had assisted with drafting 318 coroners' findings.

The team has also assisted coroners with tasks such as providing legal opinions, contributing to research into suicide statistics and sudden unexpected death in infancy (SUDI) statistics, and assisting as counsel at inquests.

The team is committed to increasing its efficiency and effectiveness when providing services to coroners, and increasing its visibility within the Ministry of Justice and among external stakeholders.

Top (left to right): Gemma Aspell, Alexander Gee, Samantha Ward, Jodie Atkin, Evan Collins
Bottom (left to right): Caleb Smith, Peter Harris, Nicole Johnston

CORONIAL RECOMMENDATIONS OR COMMENTS

In a coroner's findings, they might make recommendations or comments to help reduce the chances of the occurrence of other deaths in similar circumstances.

The Act ensures that recommendations or comments are:

- linked to the factors that contributed to death
- based on evidence considered during the inquiry, and
- accompanied by an explanation of how recommendations, if drawn to public attention, reduce the chances of further deaths in similar circumstances.

Coroners must also notify any person or organisation to whom the recommendations or comments are directed and allow them 20 working days to respond.

In accordance with section 7 of the Act, the Chief Coroner maintains a public register of coroners' recommendations or comments. This is publicly available on the Coronial Services of New Zealand website (coronialservices.justice.govt.nz) and the New Zealand Legal Information Institute website (nzlii.org). In some cases, such as suicide deaths, recommendations can't be made public due to publication restrictions.

The following are some recommendations or comments made and responses received by coroners in 2017/18.

MULTIPLE SHARP FORCE INJURIES AS THE RESULT OF STAB WOUNDS

Marceau (Coroner Greig)[1]

SUMMARY OF RECOMMENDATIONS

Christie Alexis Lesley Marceau died on 7 November 2011 at 93 Eban Avenue, Hillcrest, Auckland from multiple sharp force injuries as the result of stab wounds inflicted by Akshay Chand.

Christie lived at home in Hillcrest, Auckland with her parents, grandmother and older sister. She previously worked part-time at a local supermarket.

Akshay Chand moved to New Zealand in 2003 with his parents and younger sister. His parents had divorced, and Mr Chand's father no longer lived in New Zealand. Mr Chand and his mother also lived in Hillcrest, only a short distance from the Marceaus' house. Mr Chand left school at the end of 2010 and started work at the local supermarket. He worked there for a short period of time before resigning, and had not got another job.

Christie and Mr Chand had attended the same primary school for a year, and for a short period in 2011 they worked at the same supermarket. While working together they had socialised occasionally and communicated on Facebook.

[1]Marceau (2018) NZCorC 18

On the morning of 6 September 2011, Mr Chand rang Christie around 10am and told her he had crushed up a number of pills and made them into a drink, and if she did not get to his house in 10 minutes he would drink them. Christie went straight to Mr Chand's house, and when she arrived Mr Chand had a knife. He held the knife to her, demanded she remove her clothes, and threatened to rape her. He eventually allowed Christie to leave. After Christie left, Mr Chand swallowed around 50 of his mother's multivitamin tablets. His sister came home at his request and called an ambulance, and he was transported to hospital. At the North Shore Hospital Emergency Department, Mr Chand told the psychiatric registrar that he had had suicidal thoughts since the beginning of 2011 and these were increasing in frequency. Mr Chand was diagnosed with depression. He was prescribed antidepressants and discharged to a community mental health team for follow-up.

Christie reported what had happened that morning, and Police arrested Mr Chand at the North Shore Hospital. The psychiatric registrar was concerned the arrest would cause an escalation of Mr Chand's suicidal thinking, and recommended he be kept on a direct watch overnight. On the evening of 6 September, Mr Chand was charged with kidnapping, assault with intent to commit sexual violation, and threatening to do grievous bodily harm. He admitted to the offending. During the Police interview, Mr Chand said the reason he attacked Christie was revenge for her not helping him with his depression, and that his desire for revenge still existed.

Mr Chand was remanded in custody until 5 October. He had a number of court appearances over the following weeks at which bail was discussed, and he had eight face-to-face assessments by mental health professionals who provided reports to the court. Mr Chand appeared for the fifth time on 5 October when he was granted bail. He was placed under a 24-hour curfew to reside at his mother's address. He was ordered not to leave the house by himself, not to associate with Christie and not to go to her address. Mr Chand was due to appear in court again on 9 November 2011.

During the period 6 October to 6 November, Police conducted 23 bail checks at Mr Chand's home at various time of the day, with the last check being on the evening of 6 November. Mr Chand was home each time. Mr Chand continued to receive mental health care while on bail and he was taking prescription antidepressants. After appointments and assessments with community mental health services, Mr Chand was discharged back to his GP on 12 October. At an appointment with his GP on 19 October, Mr Chand said he had no thoughts of harming himself or others.

At 7.04am on 7 November, Police received a 111 call from the Marceau's house. Mr Chand had pushed his way into their house and attacked Christie. Christie died as a result of her injuries. During an interview with Police that day, Mr Chand said that he had intentionally deceived mental health services. He had started to plan to kill Christie from the day he was granted bail, and left it until two days before he was due back in court so she would let her guard down. Mr Chand was found not guilty of Christie's murder by reason of insanity

Mr Chand pleaded guilty to the original charges arising from the events of 6 September, and was convicted and sentenced to three years' imprisonment.

RECOMMENDATIONS OF CORONER GREIG

To: the Secretary for Justice/Chief Executive Ministry of Justice I recommend that District Court processes are amended to provide that:

I. When an assessment report pursuant to s38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 is ordered by the Court on its own initiative while bail for a serious offence/offences is being considered, the Judge's notes pertaining to the decision to order the report are routinely made available to the health assessor appointed to prepare the report (to form part of the collateral information the health assessor will consider before making the report).

To: the Secretary for Justice/Chief Executive of the Ministry of Justice and the Commissioner of Police I recommend that, consistent with the legislative framework set out in the Victims' Rights Act 2002, particularly s12, the victim advisor service and the New Zealand Police develop:

II. A protocol identifying the types of information it is appropriate for the two organisations to share routinely on cases referred to the victim advisor service by the police, to enable police and victim advisors to work together more collaboratively in order to undertake their respective responsibilities to victims of crime better; and
III. A process whereby this information is exchanged by police and victim advisors on a nationally consistent and timely basis.
IV. To: the Secretary for Justice/Chief Executive of the Ministry of Justice I recommend that the victim advisor service review its processes for advising victims of crime who wish to provide their views to the Court on a bail application, and consider:
V. Whether the process that victim advisors use to provide victims with information about preparing letters for the Court expressing the victim's view on a bail application is sufficient to meet the needs and address specific concerns of victims (including helping victims to identify issues they wish to draw to the Court's attention, matters not appropriate to include, and the degree of specificity advisable); and
VI. If necessary, amend its processes.

To: the Secretary for Justice/Chief Executive of the Ministry of Justice, the Commissioner of Police, and the Chief Executive of the Department of Corrections I recommend that the Secretary for Justice/Chief Executive of the Ministry of Justice, the Commissioner of Police, and the Chief Executive of the Department of Corrections:

VII. Consult with key stakeholders on the most effective way(s) (including consideration of operational options and potential legislative amendment) to ensure that in all applications for bail simpliciter involving serious offences and where a 24-hour curfew is proposed as a condition of bail, evidence is provided to the Court in a suitable format (e.g., affidavit from the owner/lawful occupant of the proposed bail address), which includes:
    a. Details of the proposed address;
    b. That the occupant of the proposed address is the owner or lawful occupier, and the occupant's relationship to the defendant;

c. Whether or not the proposed bail address is acceptable to the prosecuting authority;
d. That the occupant of the proposed address has been officially informed of the nature of the charges faced by the defendant; and has been informed of the nature of any past offending by the defendant; and has been advised of and understands the effects of the 24-hour curfew condition and any other proposed conditions of bail, and the role of the occupant and the expectations of the occupant in relation to supporting the defendant while on a 24-hour curfew;
e. The level of supervision, if any, the occupant could realistically commit to; and
f. That the occupant has made an informed decision whether (or not) to consent to the defendant remaining at the bail address for an indeterminate period while on bail with a 24-hour curfew.

To: the Secretary for Justice/Chief Executive of the Ministry of Justice I recommend that:

VIII. An in-depth review of the issues relating to document management at NSDC highlighted in these findings is undertaken (including a review of the adequacy of electronic document management systems, particularly in relation to access, accuracy, and interoperability); and
IX. The changes necessary to address the issues are implemented nationally. (In particular, changes are introduced to ensure that there is an accurate court file on which it is clear what documents have been received (by whatever means), and when, and what documents have been sought (e.g., transcribed notes of decisions and reports by health assessors) and when.

In the interim, I further recommend that:

X. District Court processes are amended forthwith to ensure that court takers routinely record on the paper-based court file:
   a. that a request for a transcription of the notes of a decision has been made by a judge; and
   b. that the request for transcription has been sent to the National Transcription Service; the date of request; and whether the request was for an urgent or standard turnaround.
   c. Or an alternative process is introduced to ensure that this information is clearly recorded on the paper-based court file.
XI. There is consultation as to whether, once the notes of a draft decision that a judge has asked be transcribed are received back from the National Transcription Service, they may routinely be placed on the paper-based court file until a finalised decision is available.

To: the Commissioner of Police, I recommend that:

XII. It may be timely for the Police Prosecution Service processes to be reviewed and, where necessary, amended to ensure that:
   a. The Police Prosecution Service maintains a robust procedure to identify/triage serious high-risk cases (particularly those involving alleged offences of violence to

others) the service is responsible for managing;

b. An appropriate level of active supervision by a senior member of the Police Prosecution Service is available in relation to such serious high-risk cases;
c. A sufficiently robust written protocol setting out the information it is expected a prosecutor will record at the end of the hearing is in place to ensure effective handover of the case to another prosecutor; and that compliance with the matters identified above is audited regularly.

To: the Chairperson of Waitemata District Health Board I recommend that the Auckland Regional Forensic Psychiatry Service:

XIII. Review the June 2012 Memorandum of Understanding in respect of Forensic Court Liaison Services in the district courts to ensure that it reflects the amended version of the Court Liaison Nurse Practice Guidelines.
XIV. Adopt as a standard the requirement that clinical assessments documented in HCC by ARFPS staff include reference to any limitations of the assessment that may impact on its reliability or constrain use of the assessment (e.g., length of assessment; lack of collateral information; time constraints; uncooperative interviewee).
XV. Adopt as a standard the requirement that any limitations of an assessment that may impact on its reliability, or constrain use of that assessment, and/or limitation of any other clinical assessment or report relied upon, are included in all forensic court liaison nurse and health assessor reports to the Court.
XVI. Review the Waitemata DHB Court Liaison Nurse Practice Guidelines (issued March 2017) and the Waitemata DHB Professional Clinical Knowledge and Skills document for the Forensic Court Liaison Service (issued February 2017) and amend as required, to ensure that they reflect the recommendation contained in the external review of the care Waitemata DHB provided to Mr Chand (undertaken by Dr Ceri Evans and Ms Rachael Aitchison) that forensic court liaison nurses set out the limitations of their assessments in their reports to the court — to ensure that the requirement for there to be a circumscribed link between any risk statements and mental disorder as defined within the Mental Health (Compulsory Assessment and Treatment) Act 1992 is included.
XVII. Amend the forensic court liaison nurse template letter to the court to provide prompts for including limitations of the assessment and specific disclaimers it is important for the Court to consider when reviewing that document or opinion.

To: the Chairperson of Waitemata District Health Board and the Secretary for Justice/Chief Executive of the Ministry of Justice and the Commissioner of Police I recommend that:

XVIII. The Ministry of Justice and the Auckland Regional Forensic Psychiatry Service (if sensible in

conjunction with other regional forensic psychiatric services in New Zealand) and the New Zealand Police:

a. Work together to identify and agree the baseline court documents forensic court liaison staff throughout New Zealand should routinely be provided (e.g., summary of facts/caption summary and POTB) to enable them to work effectively with offenders they are asked to attend or advise on; and
b. Agree which organisation/agency is responsible for providing a full set of the baseline documents identified above to the forensic court liaison staff and the process for, and the timing of, delivery (or provision of electronic or other access) of these documents to forensic court liaison staff.

To: the Commissioner of Police and Waitemata DHB I recommend that:

XIX. The Auckland Regional Forensic Psychiatry Service identifies (if sensible in conjunction with other regional forensic psychiatric services in New Zealand) whether there are types of evidence (e.g., interviews or job sheets) held by the New Zealand Police that would assist health assessors preparing reports pursuant to an order under s38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003; and, if so

XX. The New Zealand Police consider whether such information can be properly disclosed; and, to the extent it can

XXI. A process is developed for such information to be made available to health assessors prior to undertaking the s38 assessment.

To: the Chairpersons of Waitemata DHB; Waikato DHB; Capital Coast DHB; Canterbury DHB; and Southern DHB I recommend that:

XXII. National Court Liaison Nurse Clinical Guidelines are developed to foster consistency of practice in forensic court liaison nurses throughout New Zealand.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of diary notes made by Christie Marceau in the interests of personal privacy.

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Tāhū o te Ture

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14 NOV 2018

Judge Deborah Marshall
Chief Coroner
CX10079
Auckland

Dear Judge

Interagency approach to Coroner Grieg's recommendations after the death of Christie Marceau

On 5 March 2018, Coroner Grieg released her inquest findings along with a set of ten recommendations in relation to the death of Christie Marceau. This letter is an update on the joint approach taken in response to Coroner Grieg's recommendations directed to the Ministry of Justice (Justice), New Zealand Police (Police), Department of Corrections (Corrections), Waitemata District Health Board (DHB) and the four other DHBs across the country.

The Operational Deputy Chief Executive's from Justice, Police and Corrections established a National Operational Oversight Group (the Oversight Group) in May 2018. The Oversight Group is chaired by Justice and has representatives from each Justice sector agency. Other member agencies of the Oversight Group are the Ministry of Health and the Waitemata DHB who represent DHBs across the country.

The Oversight Group's purpose is to maintain visibility of all initiatives being undertaken in direct response to the Coroner's recommendations. This is to ensure that the recommendations are considered at a national level and there is a joint approach to ensure lasting impact and change. While many of the Coroner's recommendations are directed at multiple agencies, for practicality of approach, each recommendation has an agreed lead agency as outlined in the attached appendix. Early progress addressing the recommendations include:

- DHBs developing a proposal to advance Clinical Practice Guidelines for Forensic Court Liaison Nurses. These guidelines will apply nationally and aim to support consistency of practice for registered nurses working in the justice system.
- Justice and Police jointly considering the information sharing processes between the Police and Court Victim Advisors. This has highlighted opportunities for improvements as well as highlighting current strengths which need to be maintained.
- Police currently trialling two dedicated Police Victim Advisors to undertake the legislative requirements to contact all victims under the Victims' Rights Act 2002. This is a trial until 30 June 2019. Police and Justice are working closely together to ensure that the roles of the Police Victims Advisors and Court Victims Advisors are clear to ensure there is no duplication of information and contact, and ensure victims are aware of the services Court Victim Advisors offer and how to access them if required.
- Justice has established a Court Victim Advisor Reference and Process Group. This group has experienced Court Victim Advisor representatives from across the country who are undertaking a review of the processes for providing information on bail to victims. Changes to the Court Victim Advisor Knowledge Base resource will be undertaken to ensure Court Victim Advisors have clear and consistent information to rely on.

The Oversight Group meet monthly to ensure that agencies are working closely together to advance initiatives to address the Coroner's recommendations. The Oversight Group's work is expected to continue until the changes, required to address the recommendations, are embedded in the relevant agencies.

I will continue to keep you updated on our progress in our joint response to the recommendations.

Yours sincerely

Renee Smith
Chair, National Marceau Operational Oversight Group

National Operational Oversight Group Work Plan – Response to Marceau Recommendations

Item	Topic and Agencies	Coroner's Recommendation	Aim	Response Lead
1.	**Assessment Reports - Limitations** Directed to the **Chairperson of Waitemata District Health Board:**	Auckland Regional Forensic Psychiatry Service: • Review the June 2012 Memorandum of Understanding to reflect the amended version of the Court Liaison Nurse Practice Guidelines. • Standard requirements are adopted to include reference to limitations of the assessments in HCC and in reports to the Court, and associated guidelines and template letters are updated.	Standardise and clarify the responsibilities for including limitations of assessments in reports to enable Forensic Court Liaison Nurses to effectively carry out their role in informing the court.	Waitemata DHB
2.	**Information sharing –s38 assessments** Directed to **Ministry of Justice** To the **Commissioner of Police** and **Waitemata DHB**	• Where, on its own initiative, a S38 Report is ordered by the Court; and bail for a serious offence(s) is being considered, enable the Judges' notes on ordering the report are routinely made available to the health assessor appointed to prepare the report (part of the collateral information the health assessor will consider)	Discuss psychological and psychiatric information required for the purposes of bail applications with the Heads of Bench to and consult with District Health Boards and relevant stakeholders regarding what can be provided to assist with this requirement.	Ministry of Justice
3.		• The Auckland Regional Forensic Psychiatry Service identifies (in conjunction with other regional forensic psychiatric services in New Zealand), types of evidence held by the Police that would assist health assessors to prepare s38 reports. • Police to consider whether such information can be properly disclosed, and to the extent Police can share, a process for sharing this information is developed.	Setup a process to share information between Police and health assessors to assist s38 reports.	NZ Police

National Operational Oversight Group Work Plan – Response to Marceau Recommendations

4.	**Information Sharing - Police and Victims Advisors** Directed to **Ministry of Justice and Police**	• VA Service and Police to develop a joint protocol that identifies appropriate types of information that can be shared between the Ministry's VA service and Police; and a joint process is developed to exchange information on a nationally consistent and timely basis. Both the joint protocol and process are to be consistent with the Victims' Rights Act 2002, particularly s12.	Further clarify and standardise the roles and responsibilities for providing information about Victims between the Ministry and Police.	NZ Police
5.	**Information sharing - Police and Forensic Court Liaison Staff** Directed to **Ministry of Justice, Waitemata DHB and Police**	• Identify baseline court documents to be routinely provided to forensic court liaison staff, the agency responsible for providing these documents, and the timing and delivery of these documents to forensic court liaison staff	Standardise and clarify the responsibilities for information sharing between the Ministry, Police and District Health Boards to assist Forensic Court Liaison Nurses to effectively carry out their role in informing the court.	NZ Police
6.	**Victims Views for Bail** Directed to **Ministry of Justice**	• VA Service to review, and amend if necessary, its processes for advising victims who wish to provide their views to the court on a bail application to consider whether it is sufficient to meet the needs and address specific concerns of victims – including: o identifying relevant issues to draw to the court's attention o matters that are appropriate or inappropriate to include o the degree of specificity advisable	Clarify and standardise the roles and responsibilities between the Ministry and Police for getting victims' views to the court.	Ministry of Justice

National Operational Oversight Group Work Plan – Response to Marceau Recommendations

7.	**Information required for bail decisions** Directed to **Ministry of Justice, Police and Corrections**	• To identify the most effective way to ensure that, for bail applications involving serious offences where a 24-hour curfew is proposed, evidence is provided to the Court in a suitable format. This should include information of the bail address and information about information provided to the occupant, and their understanding of the bail condition.	Discussions across the justice sector and with Judiciary to understand how the appropriateness of bail conditions presented to the Court can be improved.	NZ Police
8.	**File Management** Directed to **Ministry of Justice**	• An in-depth review of the document management issues at North Shore District Court, including electronic document management and ensuring an accurate court file. Necessary changes are implemented nationally. • Ensuring that court staff routinely and clearly record on the paper-based court file information about transcription requests and turnaround type (urgent or standard) • Consideration of draft decisions returned from being placed on the paper-based court file until a finalised decision is available.	Review and standardise document management in the Ministry. Opportunity to improve and enhance the way documents are currently managed via a heavily paper-based system, and will look at how best this can be achieved to ensure judicial decision-makers are getting the information they require in the paper-based file.	Ministry of Justice
9.	**High Risk Case Supervision and Record Keeping for high-risk cases** Directed to the **Commissioner of Police:**	• Police Prosecution Service processes reviewed and, where necessary, amended, to ensure that there is a robust procedure to identify/triage serious high-risk cases, an appropriate level of active supervision of high-risk cases and a written protocol for the information a prosecutor will record at the end of the hearing, and regular auditing of compliance with these.	Processes reviewed to ensure that high-risk cases are identified and appropriately reviewed, and relevant information recorded.	NZ Police

SELF-INFLICTED INJURIES AMOUNTING TO SUICIDE

Bain (Coroner Windley)[2]

SUMMARY OF RECOMMENDATIONS

Michael John Bain of Christchurch died on 21 December 2015 at his home of self-inflicted injuries amounting to suicide.

Michael, aged 18 at the time of his death, had recently finished Year 13 at St Andrews College (StAC) in Christchurch. Michael had seen a psychiatrist for anxiety and St Andrews College had been made aware of his anxiety problem before he enrolled in early 2014. Michael's anxiety had become a point of concern for staff of St Andrews College in mid-2015.

Two of Michael's friends had informed staff at the college that Michael had expressed suicidal ideation. Staff state that they discussed this concern with Michael's mother; however, she disputes that Michael's suicidal ideation was raised with her. Staff of the college state that the Michael's suicidal ideation was raised as a concern informally and likely at a Pastoral Care Committee meeting. However, the notes do not adequately record this. Staff also stated that they had discussed their concerns and Michael's suicidal thoughts with his mother, and a safety plan for him. His mother did not accept that this discussion included reference to suicidal thoughts or a safety plan.

Michael met with his psychiatrist in mid-2015 and she noted that he had experienced some suicidal ideation but that this did not present as him wanting to harm himself. She noted that Michael's anxiety took the form of moderately severe social phobia and that he had been unable to form friendships at college; he had experienced significant panic attacks, especially during class breaks; he feared that his peers would judge him negatively; and that he described symptoms of a major depressive episode that was secondary to his anxiety. Michael's psychiatrist had prescribed diazepam for his anxiety and had trialled him on anti-depressants. In his subsequent meeting with her, she noted that he had remarkably improved.

On 9 November 2015, Michael was taken to Christchurch Hospital after an incident of self-harm. Michael was adamant that the incident was accidental. Both Michael's psychiatrist and his mother believed that this incident was not deliberate. The Canterbury District Health Board Specialist Mental Health Service received a referral from the hospital for Michael; however, it was withdrawn before contact had been made with him. Two of Michael's friends recalled that in Michael frequently discussed self-harm before his death. His psychiatrist reported that Michael strongly denied any suicidal ideation.

RECOMMENDATIONS OF CORONER WINDLEY

I. I make the following recommendations pursuant to section 57(3) of the Coroners Act 2006 to the Rector and Board of Governors of StAC:
A. Review and revise the StAC Pastoral Care Practice Guidelines to make clear:

i. the primacy of the PCC fora in providing oversight of the management of students of concern. Specifically, the expectation that informal discussions in relation to students of concern involving new issues, assessments, or contact with parents or external parties must be captured on the concern database and do not substitute for referral and discussion at a formal PCC forum;

[2]Bain (2018) NZCorC 27

ii. the importance and expectation that all staff who are engaged in pastoral care for a student of concern, maintain appropriate records of their pastoral care interactions and activities;
iii. the responsibilities and key leadership role the school counsellor has in managing high risk students, irrespective of the existence of a current therapeutic relationship;
iv. the thresholds for escalation of concerns to the Rector, in particular what constitutes a "significant mental illness" and who is qualified and responsible for making that assessment.

B. Consider mandating the recording on the concern database details of agreed information sharing protocols and safety plans with periodic review prompts.

C. Provide training to all StAC teaching staff in relation to the identifying students of concern, referral pathways, and the functionality of the concern database in providing a central repository for relevant information.

D. Provide a regularly scheduled proactive review process to ensure StAC's pastoral care structure and processes align with best practices identified in government agency guidelines in relation to youth suicide prevention and postvention (such as the shortly anticipated MoE Resource Kit update).

II. IMPLEMENTATION OF RECOMMENDATIONS

In response to my provisional Findings and an invitation to comment on my proposed recommendations, counsel for StAC advise that the recommendations made above are accepted by StAC. Following the independent report commissioned by StAC in 2017, and advice of my proposed recommendations, I am advised that a further internal review has taken place and that steps have been taken by StAC that fully address the recommendations.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name, identifying particulars and any medical information of the Michael's mother in the interests of justice.

Note: Pursuant to section 71 of the Coroners Act 2006, the Coroner has authorised the publication of the circumstances of Michael's death, other than the method of death and as otherwise stated in the final publication prohibition order, and the recommendations made.

MULTIPLE INJURIES SUSTAINED IN AN ACCIDENTAL AIRCRAFT CRASH

Hertz (Coroner Matenga)[3]

SUMMARY OF RECOMMENDATIONS

Eric Bennett Hertz and Katherine Picone Hertz of Parnell, Auckland died 11 nautical miles north-west of Kaiwhia Harbour on 30 March 2013 of multiple injuries sustained in an accidental aircraft crash. Their injuries were immediately fatal.

At 11:47 am on 30 March 2013, Eric Bennett Hertz, piloting his Beechcraft Baron aircraft, N254F, took off from Ardmore Aerodrome bound for Timaru Aerodrome via Mount Cook Aerodrome. On board with Mr Hertz was his wife, Mrs Hertz. Mr and Mrs Hertz were on their way to visit their daughter with a stop-over at Mount Cook for the night.

As at 30 March 2013, Mr Hertz was not entitled to be issued a medical certificate by FAA or CAA.

N254F departed from Ardmore, climbing to Flight Level 180 towards New Plymouth Aerodrome and over the Tasman Sea off the Raglan coast. At around 30 minutes into the flight, N254F was operating in cloud. N254F departed from controlled flight and entered a spin from which it did not recover. N254F crashed into the Tasman Sea. Police with the assistance of the New Zealand Navy located the wreckage of N254F using sonar. Navy divers recovered the bodies of Katherine Picone Hertz and Eric Bennett Hertz on 6 and 7 April 2013, respectively.

N254F departed from controlled flight because airspeed decreased to a point where control of the aircraft could not be maintained. N254F's airspeed decreased because the left engine failed. No findings can be made as to the cause of the failure of the left engine.

Mr Hertz lost situational awareness and became disorientated during and subsequent to the departure from controlled flight because he was in cloud.

RECOMMENDATIONS OF CORONER MATENGA

Pursuant to sections 57(3) and 143A Coroners Act 2006 I recommend that:

CAA and the Ministry of Transport review Part 67 Subpart B Civil Aviation Rules to consider an amendment which:

- In relation to an Application for a Medical Certificate (Form 24067/001 -referred to as the Application) requires, in addition to the applicant, that the applicant's GP or usual medical practitioner (GP) complete question 20 of the Application which shall be submitted to the Medical Examiner who will assess the Application; or
- Devise a questionnaire to be completed by the applicant's GP which will provide the Medical Examiner with an up to date medical history of the applicant.

A copy of these findings is to be sent to Transport Accident Investigation Commission and the Federal Aviation Administration (USA).

RESPONSE ON BEHALF OF CIVIAL AVIATION AUTHORITY

Mr Ferrier filed submissions on behalf of CAA [Civil Aviation Authority].

In relation to the proposed recommendations, Mr Ferrier helpfully pointed me to the Addendum report of the Transport Accident Investigation Commission (TAIC) [Aviation Inquiry AO-2015-002 mast bump and in-flight break up, Robinson R44, ZK-IPY, Lochy River, near Quenstown, 19 February 2015]

[3]Hertz (2018) NZCorC 23

regarding what became known as the Lochy River investigation. The Lochy River investigation involved a helicopter crash which killed the instructor and a student pilot. After TAIC had completed its report new evidence came to light concerning the mental health of the instructor pilot. TAIC resumed its inquiry to evaluate the new evidence. The Addendum report was the result. Safety concerns were noted. After finding that it was likely that the instructor was medically fit to fly TAIC found that there were too many ways for a holder of an aviation document to circumvent the civil aviation process designed to prevent pilots flying if they are not medically fit to do so and that there was a low awareness amongst medical practitioners of their duty to report to CAA if they became aware that a pilot had developed a medical condition that would otherwise render them unfit to fly. TAIC, with input from CAA recommended that the Director of Civil Aviation (the Director) improve the mechanisms for informing medical practitioners of the requirements to report to CAA, that the Director review the medical application process to ensure that it is more robust in identifying potentially serious health issues with pilots. TAIC also recommended that the Chief Executive of the Ministry of Health add some functionality to the national electronic health record database under development to add a person's occupation and a mechanism which draws the attention of all health practitioners to their obligation to notify the appropriate authority when a patient has a health condition which could pose a threat to public safety.

Mr Ferrier submitted that any recommendations from this Court should be aimed at a policy level rather than recommending a specific outcome. He also submitted that these findings be communicated to FAA [Federal Aviation Administration (USA)].

Having considered the submissions and the additional material provided, I remain of the view that the recommendation as originally drafted is appropriate in the circumstances of this inquiry. An adjustment has been made to ensure that TAIC and FAA are sent a copy of these findings. I acknowledge that implementation of the recommendation would involve legislative amendment but in my view, legislative amendment is appropriate in the circumstances of this inquiry.

I endorse the recommendations of TAIC made in the Lochy River investigation.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr and Mrs Hertz following their deaths in the interests of decency.

IDENTIFYING TRENDS – SYNTHETIC DRUGS

The Chief Coroner, Judge Deborah Marshall, has issued three public health warnings in the past year about the dangerous consequences of using synthetic drugs.

In July 2017, the Chief Coroner was first alerted by an Auckland-based coroner who, as duty coroner, noticed several deaths in that week where the deceased is believed to have used synthetic drugs recently or were found with the drug on them. After inquiring with Coronial Services, it was found there had been more in the two weeks before. St John's medical director also contacted Coronial Services to raise his concern at the number of people they were transporting to hospital.

The Chief Coroner decided it was imperative that the public were warned as soon as possible and worked with the Police, St John and the Auckland District Health Board to issue her warnings.

A number of the synthetic drugs cases have been assigned to Coroner Morag McDowell, to ensure all of the available information is before one coroner who can then liaise with other agencies. The coroner is carrying out a joint enquiry into five of the deaths from the Auckland region.

Coronial Services has been working closely with the Ministry of Health, Police, District Health Boards, ESR (the Institute of Environmental Science and Research) and pathologists to identify the substances involved and the circumstances around each death. The majority were found to have the dangerous chemical AMB-FUBINACA in their systems. The coroner has also directed that expert reports be prepared for her inquiry.

Several coronial inquiries into synthetic drugs have been completed in other areas around the country. Coroner Gordon Matenga commented in his findings into the death of Andrew McCallister that all efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. He endorsed the advice of Dr Paul Quigley that

> "…if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay."

As at early December 2018, there were seven cases where the cause of death was confirmed as synthetic cannabis toxicity and 45-50 cases which provisionally appeared to be attributable to synthetic cannabis toxicity, a total of 50-55 deaths since June 1, 2017. There were also some deaths where, while synthetic cannabis contributed to the death, synthetic cannabis toxicity was not the ultimate cause of death.

PERFORMANCE MEASURES

FROM 1 JULY TO 30 JUNE 2018

5580

Deaths were reported to the NIIO

3579

Number of cases in which coroners had jurisdiction

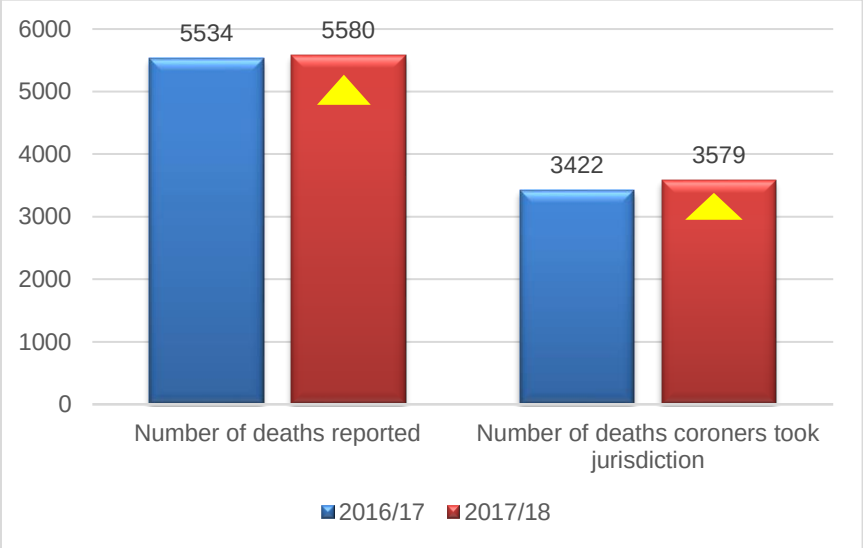
Compared to 2016/17, this is an increase of **157**

Closing a case took an average of **345** days

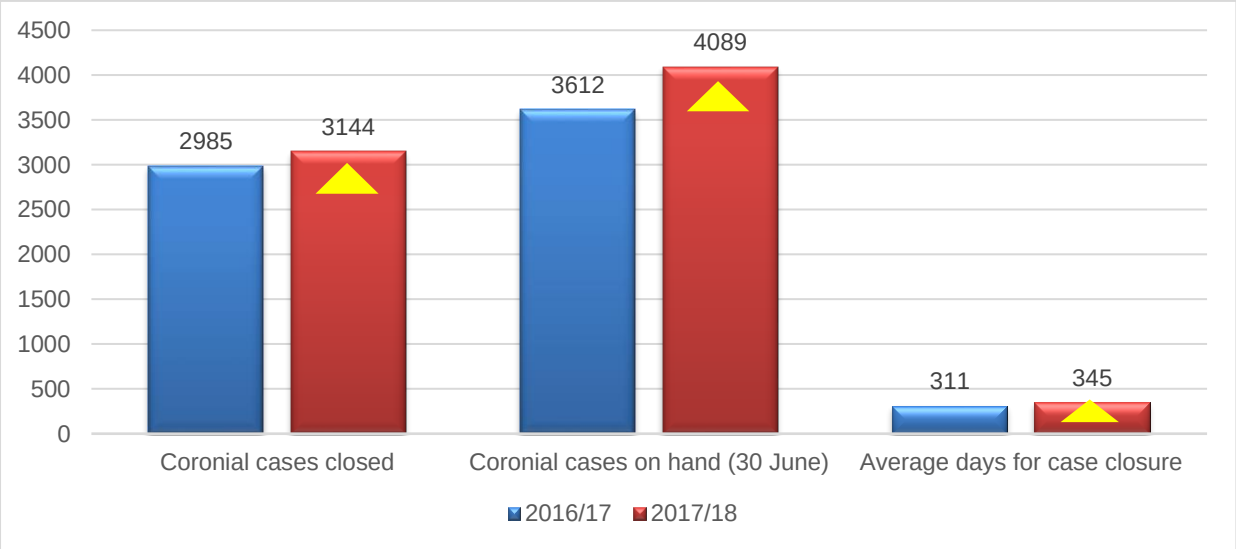
This is slightly higher than in 2016/17

Year in review: 2017/18

During the 2017/18 year, 5580 deaths were reported to NIIO. Of these, coroners took jurisdiction over 3579 deaths. As of 30 June 2018, coroners were investigating 4089 deaths. In 2017/18, coroners closed 3144 cases, 159 more than in 2016/17. On average, it took 345 days to close a case, which is an increase of 34 days when compared with 2016/17.



The number of deaths in the coroner's jurisdiction increased compared to 2016/17

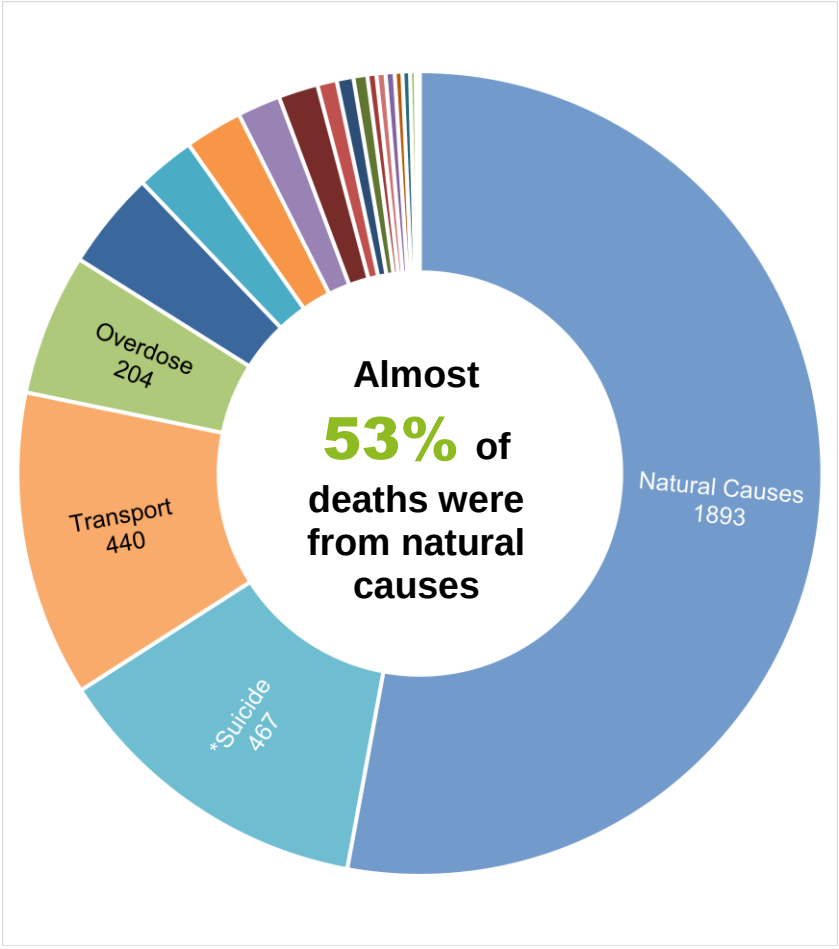


Year in review	2016/17	2017/18	CHANGE	% CHANGE
Number of deaths reported	5534	**5580**	46	0.83%
Number of deaths in which coroners had jurisdiction	3422	**3579**	157	4.58%
Coronial cases closed	2985	**3144**	159	5.32%
Coronial cases on hand (30 June)	3612	**4089**	477	13.20%
Average days for case closure	311	**345**	34	10.93%

NATIONAL STATISTICS

In 2017/18, coroners took jurisdiction over 3579 deaths. Of these, the majority of deaths were due to natural causes, followed by suicide and transport deaths.

Cause of death 2017/18	Deaths
Accidental poisoning	3
Aspiration	28
Aviation	8
Death in custody	13
Drowning and immersion	85
Fall	83
Fire/smoke/burns	24
Firearms	57
Homicide	20
Human remains	3
Marine accident	11
Missing person	11
Natural causes	1893
Other	13
Overdose	204
SUDI	62
*Suicide	467
Transport	440
Undetermined	141
Workplace accident	13
Total	**3579**



13% Suicide
12% Transport
4% Undetermined

Less than 5%: Firearms, Fall, Drowning and immersion, Undetermined
Less than 1%: Accidental poisoning, Aspiration, Aviation, Death in custody, Drowning and immersion, Fire/smoke/burns, Homicide, Human remains, Marine accident, Missing person, Other, Workplace accident

***NOTE:** **Cause of Death categories are a broad description. Where there are multiple causes of death, one major cause category is used. For example, Death in custody must be recorded as the primary category even if the death was a result of suicide or natural causes.**

Suicide reporting

Last year, approximately 668 New Zealanders took their lives. This is the highest number of suicides since these statistics began in 2007. As part of the collective effort to reduce the rate of suicide, the Chief Coroner releases her national provisional suicide statistics each year. A full report is available on the Coronial Services website at coronialservices.justice.govt.nz

It is important to note that the Chief Coroner's data is provisional. It includes all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally coded as suicides may later be determined not to be suicides.

In New Zealand, the legal position is that a person dies by suicide if their death was self-inflicted with the intention of taking their own life and knowing the probable consequence of their actions. The coroner must be satisfied there is clear evidence from which an intention to end one's life can be inferred.

Provisional suicide statistics: Men and Women

PROVISIONAL SUICIDE RATE 2007/18

By sex

Rate per 100,000 people

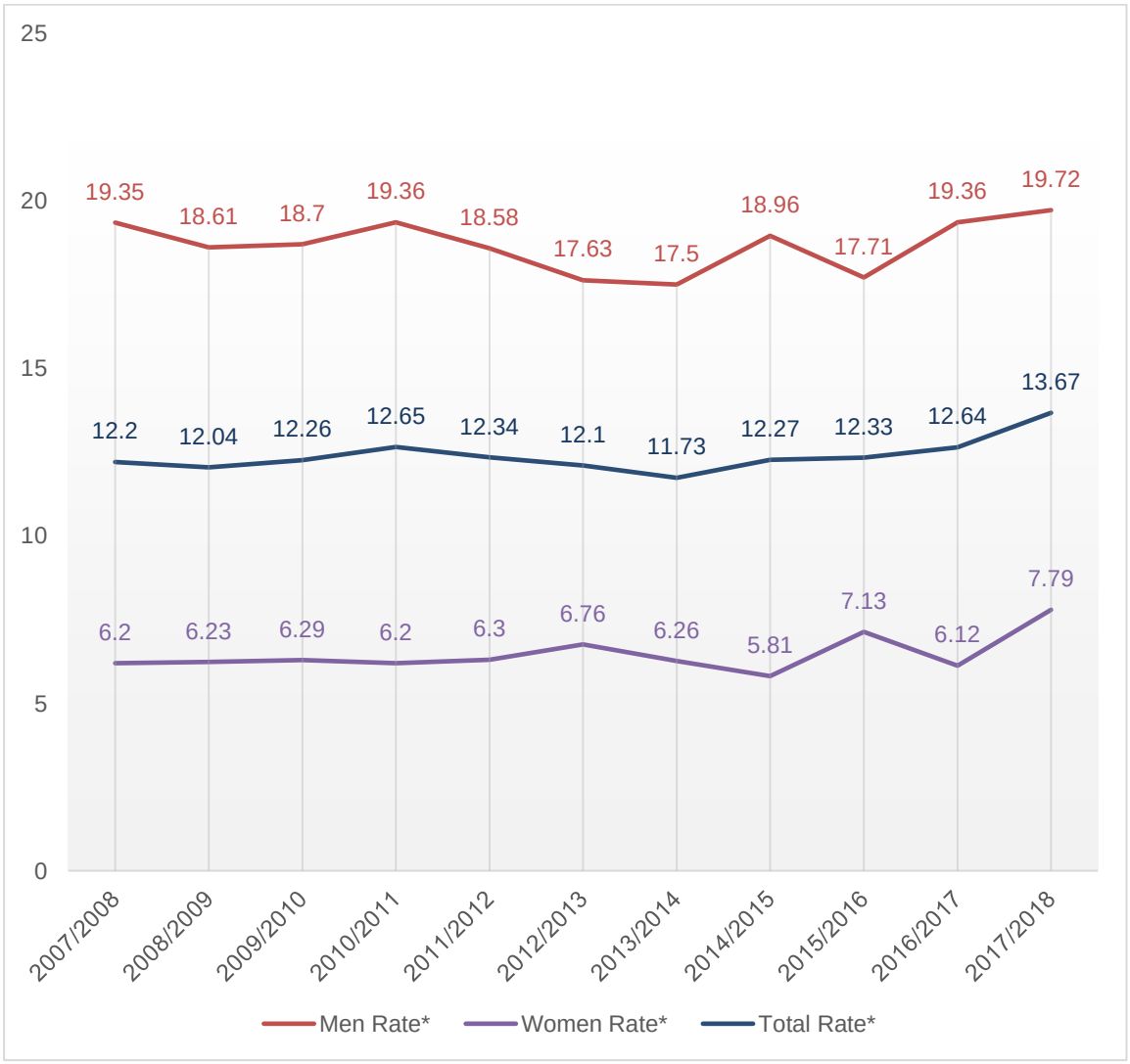
Year	Men		Women		Rate	Total	
	Number	Rate*	Number	Rate*	(Men:Women)	Number	Rate*
2007/08	405	19.35	135	6.2	3.00 :1	540	12.2
2008/09	394	18.61	137	6.23	2.87 :1	531	12.04
2009/10	401	18.7	140	6.29	2.85 :1	541	12.26
2010/11	419	19.36	139	6.2	3.01 :1	558	12.65
2011/12	405	18.58	142	6.3	2.85 :1	547	12.34
2012/13	388	17.63	153	6.76	2.54 :1	541	12.1
2013/14	385	17.5	144	6.26	2.67 :1	529	11.73
2014/15	428	18.96	136	5.81	3.14 :1	564	12.27
2015/16	409	17.71	170	7.13	2.41 :1	579	12.33
2016/17	457	19.36	149	6.12	3.06	606	12.64
2017/18	**475**	**19.72**	**193**	**7.79**	**2.46:1**	**668**	**13.67**

Note: The per 100,000 population rates shown have been calculated using Statistics New Zealand annual population estimates.

PROVISIONAL SUICIDE RATE 2007/18

By sex

Rate per 100,000 people



Year (1 July to 30 June)

Provisional suicide statistics: By sex and age

PROVISIONAL SUICIDE RATES 2017/18

By sex and age

Rate per 100,000 people

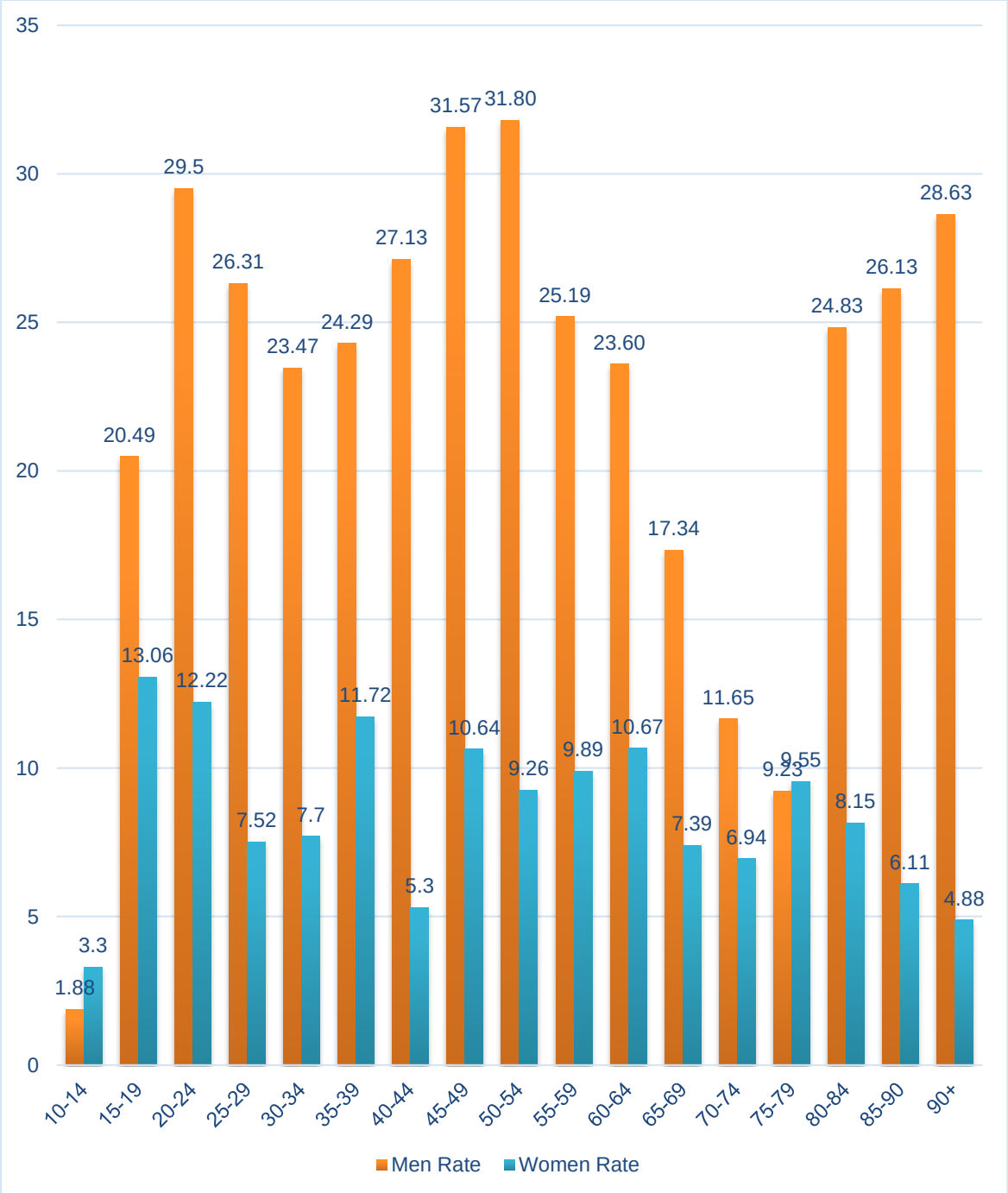
Age Group (Years)	Men		Women		Total	
	Number	Rate*	Number	Rate*	Number	Rate*
10-14	3	1.88	5	3.30	8	2.57
15-19	33	20.49	20	13.06	53	16.88
20-24	55	29.50	21	12.22	76	21.21
25-29	51	26.31	14	7.52	65	17.10
30-34	38	23.47	13	7.70	51	15.42
35-39	35	24.29	18	11.72	53	17.81
40-44	38	27.13	8	5.30	46	15.80
45-49	49	31.57	18	10.64	67	20.65
50-54	48	31.8	15	9.26	63	20.13
55-59	38	25.19	16	9.89	54	17.27
60-64	31	23.6	15	10.67	46	19.91
65-69	20	17.34	9	7.39	29	12.23
70-74	11	11.65	7	6.94	18	9.22
75-79	6	9.23	7	9.55	13	9.4
80-84	10	24.83	4	8.15	14	15.67
85-90	6	26.13	2	6.11	8	14.36
90+	3	28.63	1	4.88	4	12.91
Total	**475**	**19.72**	**193**	**7.79**	**668**	**13.67**

Note: The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates as at 30 June 2018.

PROVISIONAL SUICIDE RATES 2017/18

By sex and age

Rate per 100,000 people



Provisional Suicide statistics: Ethnicity

PROVISIONAL SUICIDE RATE 2007/18

By ethnic group

Rate per 100,000 people

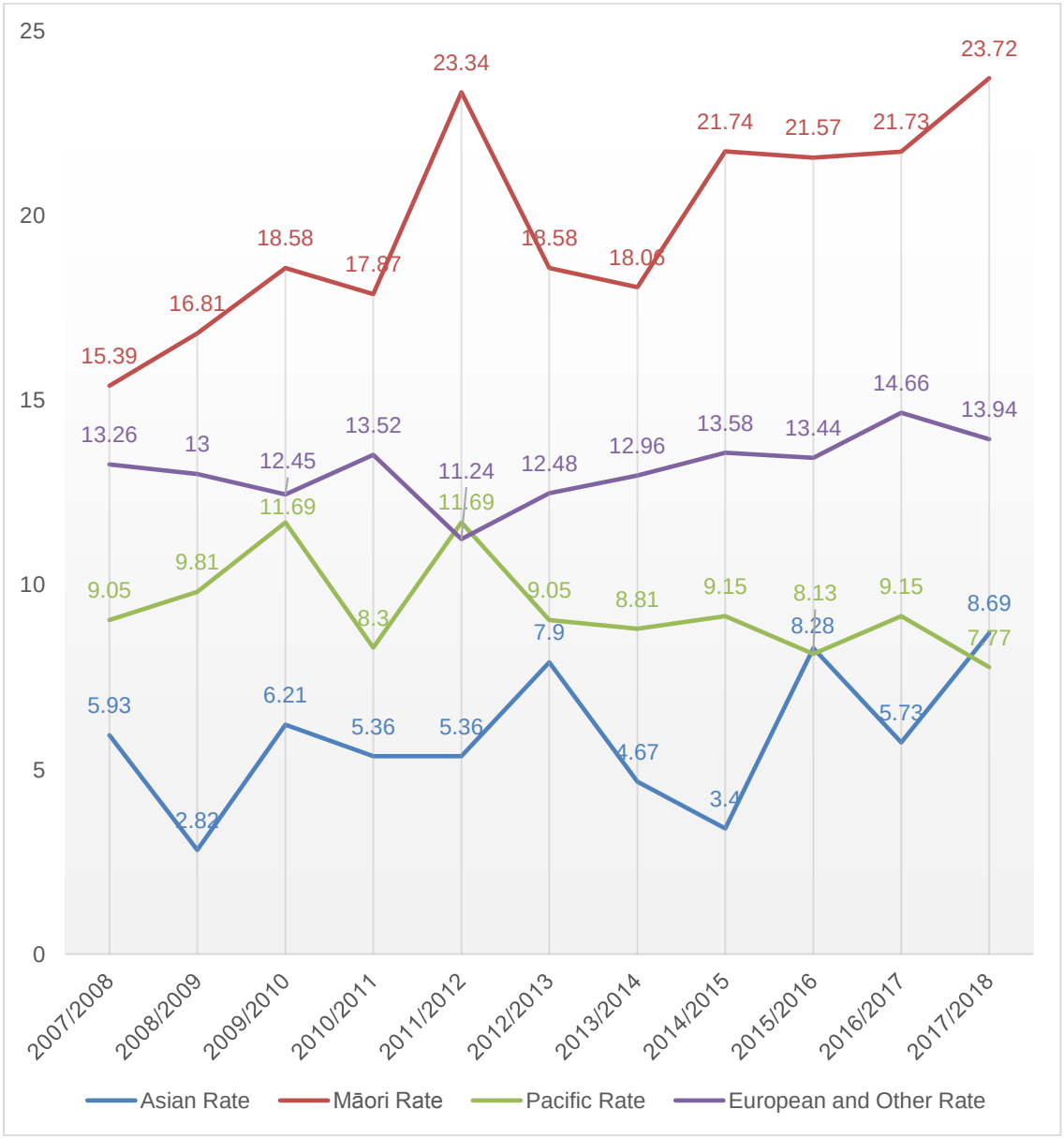
Year	Asian		Māori		Pacific		European and Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2007/08	21	5.93	87	15.39	24	9.05	408	13.26
2008/09	10	2.82	95	16.81	26	9.81	400	13.00
2009/10	22	6.21	105	18.58	31	11.69	383	12.45
2010/11	19	5.36	101	17.87	22	8.30	416	13.52
2011/12	19	5.36	132	23.34	31	11.69	365	11.24
2012/13	28	7.90	105	18.58	24	9.05	384	12.48
2013/14	22	4.67	108	18.06	26	8.81	373	12.96
2014/15	16	3.40	130	21.74	27	9.15	391	13.58
2015/16	39	8.28	129	21.57	24	8.13	387	13.44
2016/17	27	5.73	130	21.73	27	9.15	422	14.66
2017/18	**41**	8.69	**142**	**23.72**	**23**	**7.77**	**462**	**13.94**

Note: The per 100,000 population rate shown has been calculated using Statistics New Zealand annual population information as published following the 2006 and 2013 censuses. The table shows provisional suicide deaths by ethnicity between July 2007 and June 2018. The small numbers and volatile nature of this data for Pacific and Asian peoples makes reliable estimation of the patterns very difficult and may be misleading.

PROVISIONAL SUICIDE RATE 2007/18

By ethnic group

Rate per 100,000 people



Year (1 July to 30 June)

Note: The per 100,000 population rate shown has been calculated using Statistics New Zealand annual population information as published following the 2006 and 2013 censuses.
Ethnic groups have been classified in the following groups: Māori, Pacific peoples, Asian, European and other (including European, Not Elsewhere classified and New Zealand European).
The small numbers and volatile nature of this data for Pacific and Asian peoples makes reliable estimation of the patterns very difficult and may be misleading.

CORONERS

Office of the Chief Coroner
Judge D Marshall

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Deputy Chief Coroner B Shortland

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Coroner M McDowell
Coroner S Herdson
Coroner D Bell

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Coroner G Matenga
Coroner M Robb

Rotorua
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Contact the Coronial Offices

For more information
The Office of the Chief Coroner
Email: OfficeoftheChiefCoroner@justice.govt.nz

Report a death to the Coroner
National Initial Investigation Office (NIIO)
Phone: 0800 266 800
Email: NIIO@justice.govt.nz

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