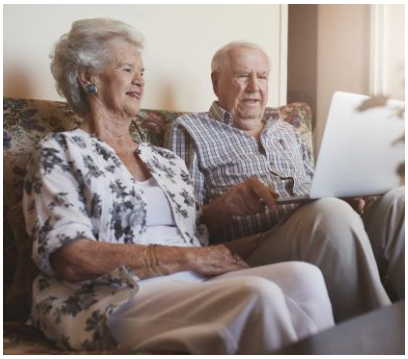
MINISTRY OF JUSTICE
Tāhū o te Ture

Annual Report 2018-2019

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



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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 spirits continues to live on.

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

INTRODUCTION

Welcome to the 2018-2019 annual report of the Chief Coroner

2019 will be remembered for the Christchurch shootings on 15 March. 51 people lost their lives and others suffered significant and traumatic injuries. The impact on the community was, and continues to be, immense.

The work of coroners includes responding to mass fatality events, but also includes the ongoing provision of a 24/7 service for reporting deaths and the investigations of such deaths. One of a coroner's most important duties is to make recommendations or comments that may prevent similar deaths in the future.

This report contains a summary of the provisional suicide statistics released by me every year. This year, the suicide rate increased slightly from a rate of 13.67 deaths per 100,000 people, to 13.97 deaths per 100,000 people. Overall, the number increased by 17 deaths from 668 to 685.

Each of those deaths represents an individual – it isn't just a number. It reflects human beings who had family/whānau and friends, emotions, dreams and desires. Coroners will continue to work with the various agencies who are striving to prevent suicide. There is hope that by working together we can support individuals who are at risk. That is a task for everyone in Aotearoa New Zealand.

The figures show another increase in the case numbers being reported and accepted by coroners. The upcoming appointment of eight relief coroners will go some way to addressing the increasing workload.

I hope you find this annual report of interest.

Judge D Marshall
Chief Coroner

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 Aotearoa *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 Whangārei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch and Dunedin.

THE FIRST 48 HOURS

The National Initial Investigation Office (NIIO) (or Duty Coroner's Office) has had another busy year.

The figures below show the 2017-18 year and the 2018-19 year to give some comparisons:

	2017-18	2018-19
Jurisdiction Accepted:	3,573	3,792
Doctors issued Certificates:	2,035	1,746
Total Cases Reported:	5,608	5,538

The number of coronial cases has increased by some 220 or so cases.

In March of this year, we were confronted with the Mosque shootings in Christchurch, where 51 people died. This necessitated a division of coroners and the NIIO team so that some dealt with the mass fatality deaths, while others progressed business as usual (BAU) deaths.

The Chief Coroner, along with two coroners from Auckland, the NIIO Service Manager and three case managers, deployed to Christchurch to focus solely on the mass fatality. Over the course of the week, other coroners and staff were rostered in and out to provide relief support. A team also worked in the Auckland NIIO Office, providing the required Directions and Releases for signature by coroners.

The Ministry has a Mass Fatality Plan, established since the Christchurch earthquakes, and this served us well. By Saturday 16 March, we had been provided with security passes and the Ministry IT team had set up the technology required to run two hearing rooms simultaneously.

On this occasion, we were fortunate to be co-located with Police in the new Christchurch Justice & Emergency Services Precinct. The Police Disaster Victim Identification (DVI) team was working in the same vicinity, which allowed coroners to see the identification methods first-hand and receive relevant explanations from Police.

Chief Coroner Deborah Marshall with Prime Minister Jacinda Ardern at the Christchurch Justice & Emergency Services Precinct following the shootings.

The Mortuary at Christchurch Hospital was able to be used for post mortems and, again, this mortuary was situated only a short distance from the Christchurch Precinct, allowing for excellent communication and visits with the Forensic Pathologists and Forensic Odontology Teams.

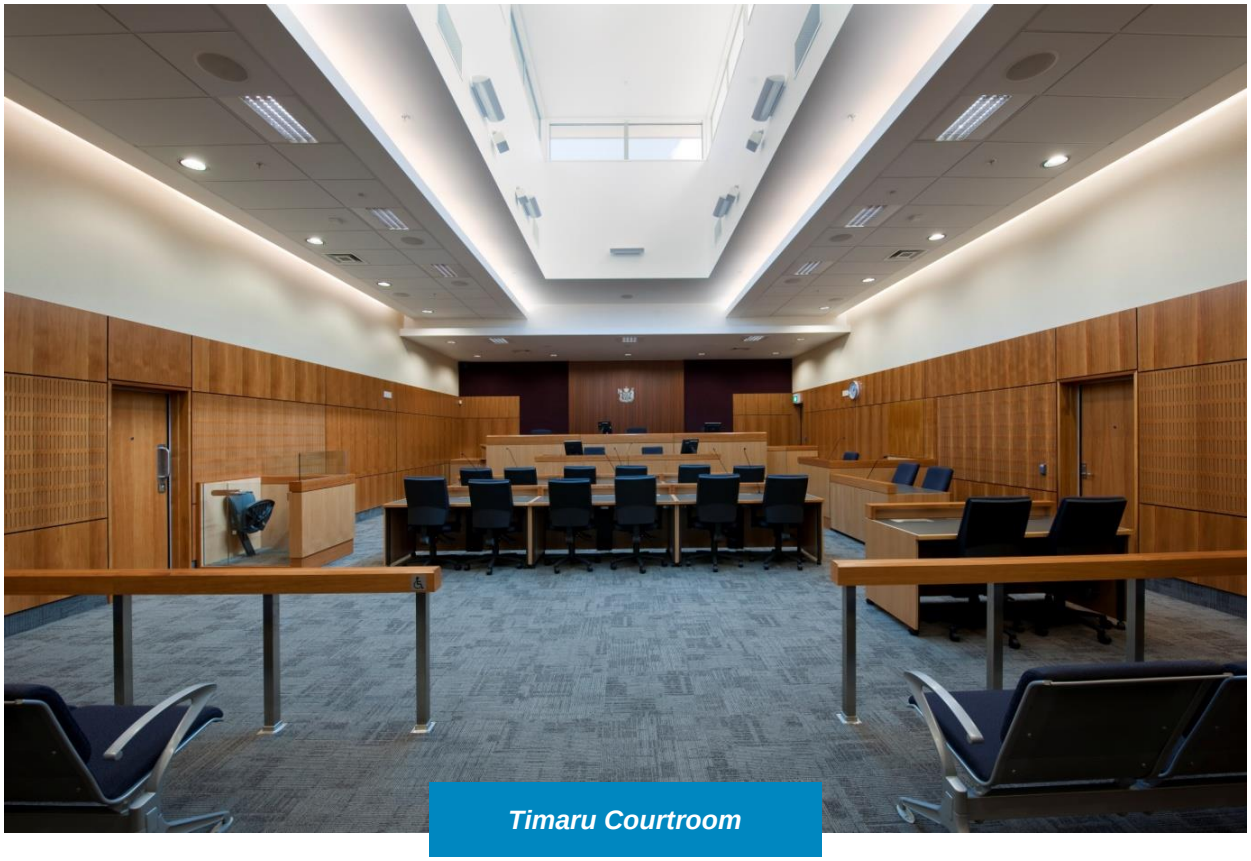
Coroners and Coronial Services staff worked in collaboration with other stakeholders to provide a service that saw 50 bodies returned to family/whānau by Thursday 21 March, allowing for a mass funeral the following day.

In the current year, there have also been changes in suppliers of services to the coroners in terms of pathology, transport and viewing services. This has meant some new learnings for the NIIO Team. The team took these learnings in its stride and handled them in such a way that coroners and families/whanau have been unaffected.

Merelyn Redstone
NIIO Service Manager

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 in sections 3 and 4 respectively 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 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 Aotearoa New Zealand is a 24-hour-a-day service. There is always a coroner on duty to receive reports of deaths. About 5,700 deaths are reported to coroners every year; of these, coroners accept jurisdiction in around 3,600 of these

deaths. Sections 14 and 15 of the Act state that a death must be reported if:

- the body is in Aotearoa 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 that was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and that was medically unexpected
- the death of a women that occurred while the woman 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 a coroner accepts 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 further investigations, wait for the results of further investigations already underway, 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 are gathered to present their evidence to the coroner. During this process, the coroner and the immediate family/whānau can ask relevant questions. After the inquest, written findings are issued. In some cases, the coroner might make recommendations or comments to help prevent similar deaths in the future.

CORONIAL RECOMMENDATIONS OR COMMENTS

In a coroner's findings, a coroner might also 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, may 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 time to respond.

In accordance with section 7 of the Act, the Chief Coroner maintains a public register of coroners' recommendations or comments. This register is publicly available on the Coronial Services of New Zealand website at coronialservices.justice.govt.nz and the New Zealand Legal Information Institute (NZLII) website at nzlii.org. In some cases, such as suicide deaths, publication restrictions prevent the publication of the recommendations.

The following are some of the recommendations or comments made and responses received by coroners during the financial year.

File Ref: CSU-2015-CCH-000286

2019 NZCorC 16 07/05/2019

Date of Finding: 7 May 2019

SUMMARY OF RECOMMENDATIONS

Kaye Marie Blance of Westport died on 3 May 2015 at 877 Wilsons Lead Road, Cape Foulwind, Westport of positional asphyxia due to a quad bike crash.

Mrs Blance was employed as a dairy farm assistant by Landcorp Farming Ltd at the Tram Road Dairy Unit. Mrs Blance had undertaken quad bike training as part of her employment.

On 3 May 2015, Mrs Blance began work at 5:00am. She completed some tasks then worked with her supervisor, Mr van der Weyden, until around 10am. They discussed other tasks for the day and Mr van der Weyden observed that Mrs Blance was in good spirits, although very tired as she had attended a concert the previous night and had three hours sleep. Mr van der Weyden was occupied until around 2:15pm when he noticed that one of Mrs Blance's tasks had not been completed. He followed Mrs Blance's quad bike tracks to an earth topped culvert located between two paddocks and found the overturned quad bike in the creek bed adjacent to the culvert crossing. Mrs Blance was lying face down on the ground directly under the quad bike with her lower half of her body in the creek water. Emergency services attended and Mrs Blance was confirmed to be deceased.

Mrs Blance's death was the second quad bike-related fatality at the Tram Road Dairy Unit. Another employee died in November 2010 from crush asphyxia as a result of a quad bike and trailer rollover.

COMMENTS OF CORONER WINDLEY:

I. The risk of harm associated with quad bike use has been well documented and coroners have for many years made recommendations aimed at reducing preventable quad bike related deaths.

II. There is no simple or singular fix. A multi-faceted approach is necessary to achieve any real and sustained reduction in preventable quad bike related serious injuries and deaths in New Zealand.

III. I am satisfied that the numerous changes Landcorp made following and in response to Mrs Blance's death have enhanced the safety of their employees who utilise quad bikes in the course of their employment, and the wider safety culture of the company.

IV. As Mrs Blance's case demonstrates, individual companies and employers are currently shouldering the major responsibility for determining what quad-bike risk minimisation looks like in their particular workplace. New Zealand government agencies and industry bodies must provide leadership in this space, and actively look for and consider options and innovations that have the potential to enhance quad bike safety at a national level.

V. WorkSafe advises that vehicles on farms (such as quad bikes) will continue to be an area of focus and are part of a new cross-sector harm prevention initiative focussing on vehicles used for work.

VI. WorkSafe has agreed that a coordinated approach is necessary and reports it has well connected and effective relationships with MBIE, ACC, and agriculture industry bodies, who are "actively working together in what is, in effect, a working party." ACC advises it is committed to continue working with WorkSafe and MBIE and other relevant government agencies and industry bodies to promote measures to reduce the incidence and severity of personal injuries and improve quad bike safety. Federated Farmers also acknowledges its role "as part of a multi-faceted suite of solutions."

VII. Whether any of the approaches under consideration by the ACCC are appropriate for New Zealand is outside the scope of my inquiry. The ACCC inquiry does however provide a real opportunity to draw on international safety expertise, innovation and best practice and apply it to a New Zealand context. WorkSafe advise that the lessons it has learned from the ACCC's findings so far have contributed to the initiatives described above.

VIII. Whether the imminent Policy Clarification on CPDs from WorkSafe, a possible small-medium sized business subsidy to incentivise OPD uptake, and any ultimate regulatory reform under MBIE's Health and Safety at Work Act 2015 regulatory reform programme, is enough to effect a real reduction in current levels of preventable quad bike deaths remains to be seen. Given these initiatives relate to quad bike use in workplaces, whether there is likely to be any positive impact on quad bike safety outside of workplaces is unclear. As it currently stands, New Zealand's approach falls well short of that which has been recommended by the ACCC in terms of introducing a mandatory safety standard.

RECOMMENDATIONS OF CORONER WINDLEY:

I. On the evidence before my inquiry it is impossible to know whether a mandatory safety standard requiring fitment of an OPD to the Honda quad bike Mrs Blance was riding on 3 May 2015 may have improved her outcome, all that can be said is that it may have. On that basis, I consider the following recommendation pursuant to section 57A of the Coroners Act 2006 is indicated.

II. The responses received to my provisional Finding suggest there is a level of existing coordinated effort between relevant government agencies and industry bodies. I endorse that coordination and recommend that:

    a. A cross-sector working party with participation from WorkSafe, MBIE, ACC, and other relevant industry bodies such as Federated Farmers, collectively review the work undertaken by the ACCC, its recommended new safety standard, and give timely consideration to whether New Zealand ought to follow suit to reduce the chances of preventable quad bike deaths.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the deceased in the interests of decency and personal privacy.

4 June 2019

Judge Deborah Marshall
Chief Coroner
OfficeoftheChiefCoroner@justice.govt.nz

Dear Chief Coroner Judge Marshall

New policy on crush protection devices for quad bikes

WorkSafe will be taking a new position on crush protection devices[6] (CPDs) for quad bikes, to be released on 5 June 2019. A crush protection device is designed to provide a survival space under an overturned vehicle where the type of vehicle is not suitable for a fitted rollover protection and harness system.

Our new policy clarification explains we think CPDs are likely to prevent serious and fatal crush injuries and we strongly recommend they are installed on all quad bikes used for work. We recommend people do this now. In future we are likely to require CPDs and will then enforce compliance if necessary. A copy of the policy clarification and FAQs are attached to this letter.

Why propose this change?

Between January 2000 and October 2017, 315 people died in work-related incidents in the agriculture sector. Of these 81 (25.7%) were fatalities involving quad bikes. At least 73 (90%) of the quad-related fatalities occurred when the victim was trapped by the vehicle. Quad bike rollover accidents show they can happen on almost any part of the property – to experienced and inexperienced riders.

We do not see this recommendation as a stand-alone solution. It is very much the final protection for the operator, and should be preceded by good vehicle selection, operator competence and vehicle maintenance. WorkSafe is working with industry and regulatory partners to provide a suite of actions which, taken together, will have an effect on these other components of the system.

What does the law say?

A person conducting a business or undertaking (PCBU) must ensure, so far as is reasonably practicable, their health and safety, and the health and safety of their workers and any other workers who are influenced or directed by the business. They must also look after other people who could be at risk from work carried out on the property, such as visitors. If a risk can not be eliminated, they must take steps to minimise it so far as is reasonably practicable.

Key points for people who use Quad Bikes for Work

If there is no reasonable alternative to using a quad bike we strongly recommend a CPD is installed permanently. We recommend buying a CPD that's professionally designed and manufactured, and install it according to the CPD manufacturer's instructions.

[6] We use the term 'crush protection devices' or CPDs. They are also known as operator protection devices and rollover protection.

WORKSAFE
Mahi Haumaru Aotearoa

Everyone who uses a quad bike needs to keep themselves and others safe. This includes:

- choosing the right vehicle for the job - we recommend using an alternative vehicle or different work practices to avoid the risk of quad bike rollovers.
- having the knowledge, skills and training needed for the tasks and terrain
- maintaining the vehicle properly
- always wearing a helmet
- not letting kids under 16 ride adult-sized quad bikes

WorkSafe enforcement action

While WorkSafe strongly recommends the fitting of CPDs, we do not intend to enforce this at this stage. Our inspectors will continue to require users of vehicles to be able to recognise the risks posed by those vehicles when in use, and require the user to be able to explain what actions they have in place to eliminate or mitigate for that risk.
CPDs are not seen as a replacement for other mitigation actions, and it is essential that the main messages outlined above continue to be stressed.

How can you help

We have attached a copy of the policy clarification, and a set of FAQs for what we believe will be common questions. We request that you make these available through your channels to your members / levy payers, along with the messages reinforcing appropriate use of vehicles, the importance of operator competence, and the restriction of children from riding adult sized vehicles.

What are manufacturers saying

The Motor Industry Association, which represents some of the manufacturers in New Zealand, continue to oppose the fitting of CPDs, stating that the vehicle is safe if it is used properly. They believe that fitting a CPD poses danger to the operator in the event of a rollover, in that the operator may be restricted in their options for getting clear of the vehicle, or that the additional part may strike the operator and cause injury that may otherwise not have happened.
It is WorkSafe's view that, having assessed the evidence available, a CPD is more likely to save a life than cost one.
In this case, WorkSafe is prepared to recommend an action that is against the manufacturer's advice, a step we have not taken lightly.

If you have any further questions feel free to ring or email Al McCone on 027 705 8794
al.mccone@worksafe.govt.nz

Yours faithfully

Paula Knaap
Director Strategic Engagement & Implementation
Strategy & Performance

File Ref: CSU-2009-AUK-000932

2019 NZCorC 14 8/04/2019

Date of Finding: 8 April 2019

SUMMARY OF RECOMMENDATIONS

Zachary Gravatt of Auckland, age 22, died on 8 July 2009 at Auckland City Hospital of Neisseria Meningitidis infection (Meningococcal Septicaemia – C strain).

On 8 July 2009, Zachary was assessed by his General Practitioner with flu-like symptoms. He was referred to Auckland City Hospital, arriving at 1.43 pm. Over the subsequent hours Zachary was triaged, assessed and attended to by several clinicians. His condition continued to decline despite treatment efforts, and he died at 7.15pm that night.

Zachary's case was initially investigated by Coroner Shortland, who proceeded to make his finding as a hearing on papers and concluded the inquiry in 2011.

In September 2016, Dr Gravatt (Zachary's father) received an anonymous, unsigned typewritten letter dated 29 August 2016. Dr Gravatt sent the letter to the Crown Law Office and asked the Solicitor-General to order a new Inquiry under s 97 of the Coroners Act 2006. The requirement for the discovery of new facts relating to the circumstances of Zachary's death was satisfied, and a second inquiry was ordered.

The issues to be determined by the second inquiry included the point of diagnosis of meningococcal disease, the prescribing of ceftriaxone (an antibiotic used to treat meningococcal disease), consultant contact and attendance, whether opportunities to increase/escalate treatment options were lost, and to what extent these would have increased Zachary's chances of survival.

RECOMMENDATIONS OF CORONER MCDOWELL

To the Auckland District Health Board:

Three staff members made records about Zachary's care which did not reach the formal clinical record.

I. The accuracy of clinical notes, and that they are as complete as possible, is a cornerstone of clinical care. Clinical information about a patient's condition, or what was done or not done, should be copied into the clinical record from any private notes if it is information not otherwise in the clinical record.

II. I therefore recommend to Auckland District Health Board that it consider the issues that have arisen about such notes, and that it consider implementing a policy or protocol in relation to the writing, storage and disclosure of such notes which protects the competing interests (not least the needs of the family).

To the Ministry of Health:

I. In recognition of these issues I proposed a recommendation to the Ministry of Health (the Ministry) that it consider forming a working group to develop a national antimicrobial guideline.

II. The Ministry (through its Chief Medical Officer, Dr Andrew Simpson) provided a response to the proposed recommendation. It advised that work on improving antimicrobial stewardship has been underway since 2017 through the joint Ministry of Health and Ministry for Primary Industries Antimicrobial Resistance Action Plan and associated coordination groups. An important aspect has been to investigate the extent to which antimicrobial guidance is in existence and its consistency. This work has both identified the need for consistency alongside a need for regional variation to appropriately accommodate regional antimicrobial susceptibility profiles. Community focussed antimicrobial prescribing guidance has been disseminated to sector leaders. Propriety has also been given to support robust surveillance to understand resistance patterns across New Zealand, to communicate this information in a meaningful and timely manner to prescribers, and to facilitate incorporation into antimicrobial guidance where appropriate.

III. It appears therefore that the issues raised in the course of this inquiry are, in part, being addressed by the Action Plan and associated coordination groups. I acknowledge and endorse this current work.

IV. In light of the Ministry's actions, I therefore modify the recommendations:

That within its current Antimicrobial Action Plan and associated coordination groups, the Ministry continue to strive to achieve greater national consistency (appropriately accommodating regional antimicrobial susceptibility profiles) across current regional antimicrobial guidance.

Note: There exists a permanent non-publication order/name suppression order made by the Coroner in the last inquiry and confirmed by the High Court in relation to Dr R (referred to as such in the High Court decision of *Gravatt v the Coroners Court at Auckland and Auckland District Health Board* [2013] NZHC 390).

Note: Interim orders pursuant to s 74 are currently in place prohibiting making public the names of other medical professionals involved in the proceedings, and the content of the anonymous letter.

PERFORMANCE MEASURES

From 1 July 2018 to 30 June 2019...

5538 deaths were reported to the National Initial Investigation Office

Coroners took jurisdiction over **3792** cases

Compared to 2017/2018, this is an increase of **200** cases

Closing a case took

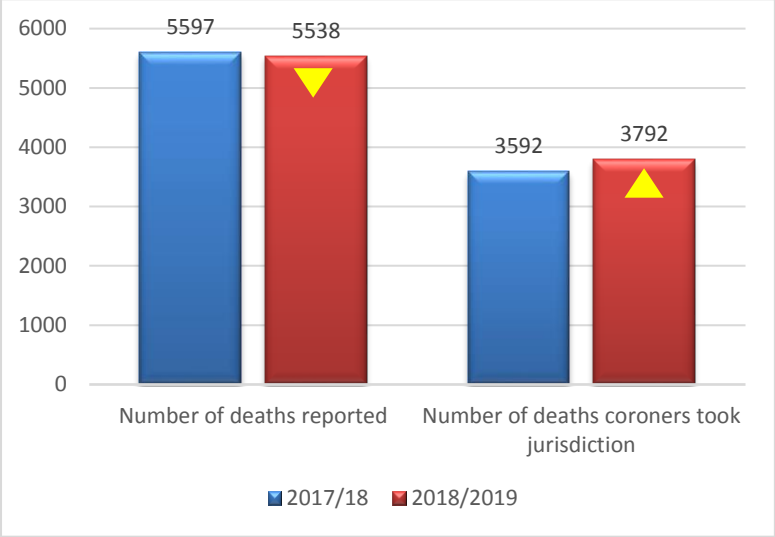
ON AVERAGE

344 days

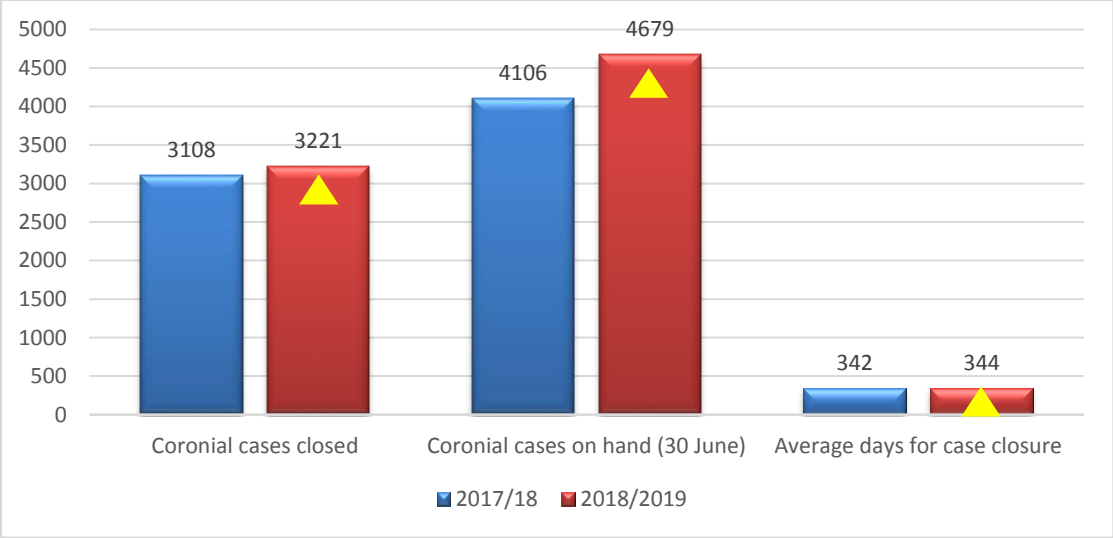
THIS IS APPROXIMATELY THE SAME AS THE PREVIOUS YEAR

Year in review: 2018-2019

During the 2018-19 year, 5,538 deaths were reported to NIIO. Of these, coroners took jurisdiction over 3,792 deaths. As of 30 June 2019, coroners are investigating 4,679 deaths. For the financial year, coroners have closed 3,221 cases, 113 more than the previous year. On average, it took 344 days to close a case, which is an increase of 2 days when compared with last year.



The number of coroners' jurisdiction deaths has increased compared to the previous year

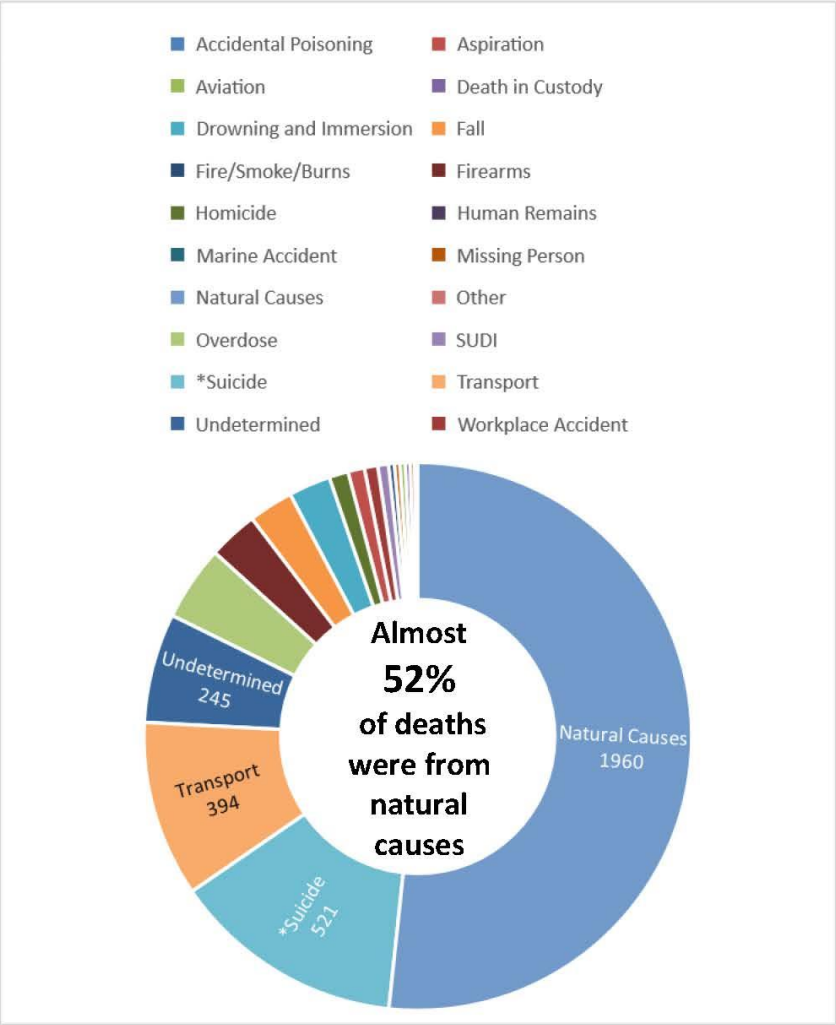


Year in review	2017-18	2018-2019	CHANGE	% CHANGE
Number of deaths reported	5597	5538	-59	-1.07%
Number of deaths coroners took jurisdiction	3592	3792	200	5.27%
Coronial cases closed	3108	3221	113	3.51%
Coronial cases on hand (30 June)	4106	4679	573	12.25%
Average days for case closure	342	344	2	0.58%

NATIONAL STATISTICS

In 2018-2019, coroners took jurisdiction over 3,792 deaths. Of these, the majority of deaths were due to natural causes, followed by suicide and then transport deaths.

Cause of death 2018-19	Deaths
Accidental Poisoning	2
Aspiration	37
Aviation	12
Death in Custody	11
Drowning and Immersion	94
Fall	100
Fire/Smoke/Burns	13
Firearms	111
Homicide	43
Human Remains	1
Marine Accident	4
Missing Person	12
Natural Causes	1960
Other	10
Overdose	168
SUDI	24
*Suicide	521
Transport	394
Undetermined	245
Workplace Accident	30
Total	3792



14% Suicide
10% Transport
6% 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: **The cause of death categories is 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 685 New Zealanders took their lives, which is the highest number of suicides since these statistics began in 2007. As part of the collective effort to reduce Aotearoa New Zealand's rate of suicide, the Chief Coroner releases the 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 Aotearoa 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 inferring an intention to end one's life.

Provisional suicide statistics: Men-Women

PROVISIONAL SUICIDE RATE 2008-2019

By sex

Rate per 100,000 people

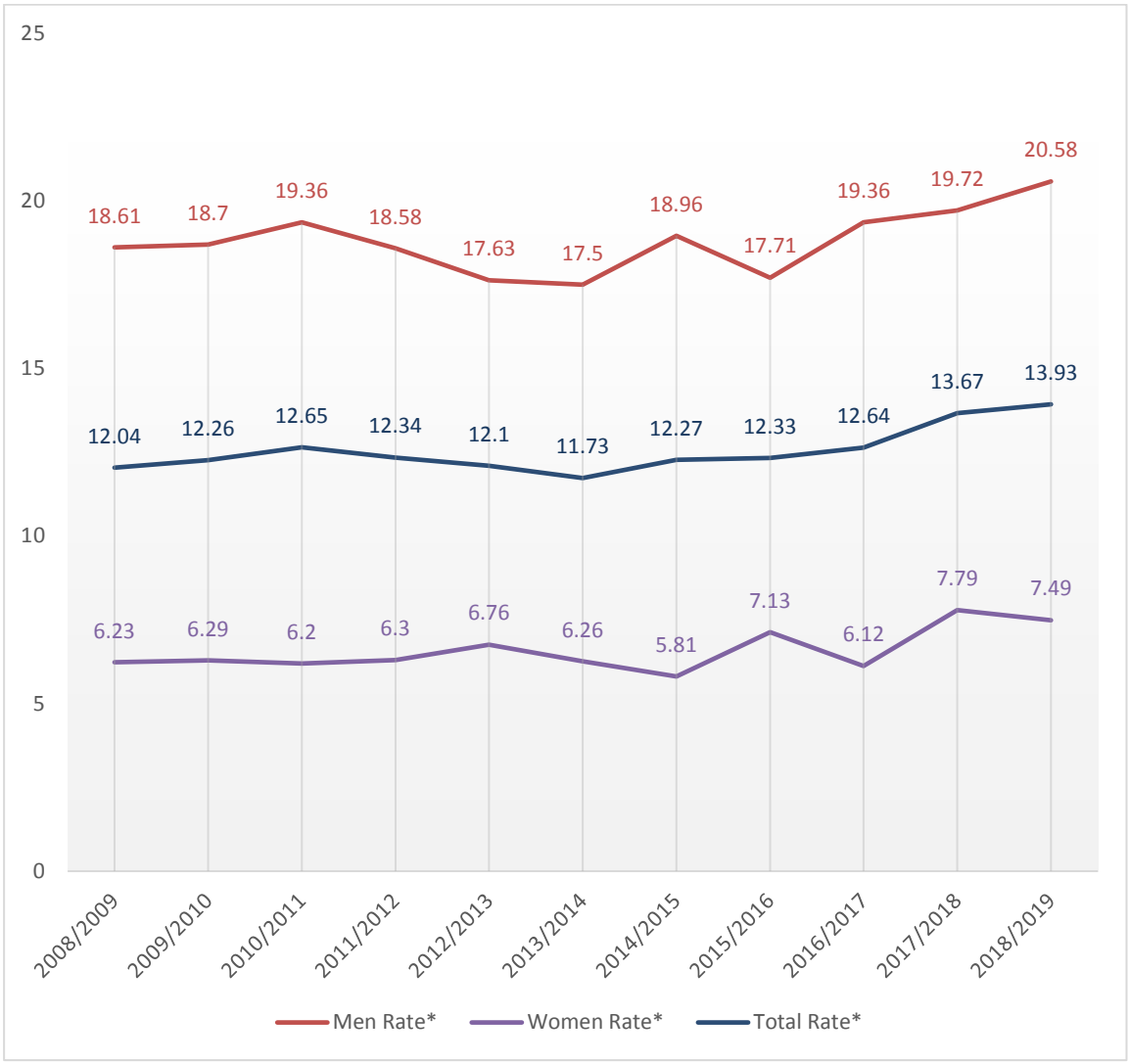
Year	Men		Women		Rate	Total	
	Number	Rate*	Number	Rate*	(Men:Women)	Number	Rate*
2008/2009	394	18.61	137	6.23	2.87 :1	531	12.04
2009/2010	401	18.7	140	6.29	2.85 :1	541	12.26
2010/2011	419	19.36	139	6.2	3.01 :1	558	12.65
2011/2012	405	18.58	142	6.3	2.85 :1	547	12.34
2012/2013	388	17.63	153	6.76	2.54 :1	541	12.1
2013/2014	385	17.5	144	6.26	2.67 :1	529	11.73
2014/2015	428	18.96	136	5.81	3.14 :1	564	12.27
2015/2016	409	17.71	170	7.13	2.41 :1	579	12.33
2016/2017	457	19.36	149	6.12	3.06 :1	606	12.64
2017/2018	475	19.72	193	7.79	2.46 :1	668	13.67
2018-2019	**498**	**20.58**	**187**	**7.49**	**2.66 :1**	**685**	**13.93**

Note: The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates for the 2019 year.

PROVISIONAL SUICIDE RATE 2008-2019

By sex

Rate per 100,000 people



Year (1 July to 30 June)

Provisional suicide statistics: By sex and age

PROVISIONAL SUICIDE RATES 2018-2019

By sex and age

Rate per 100,000 people

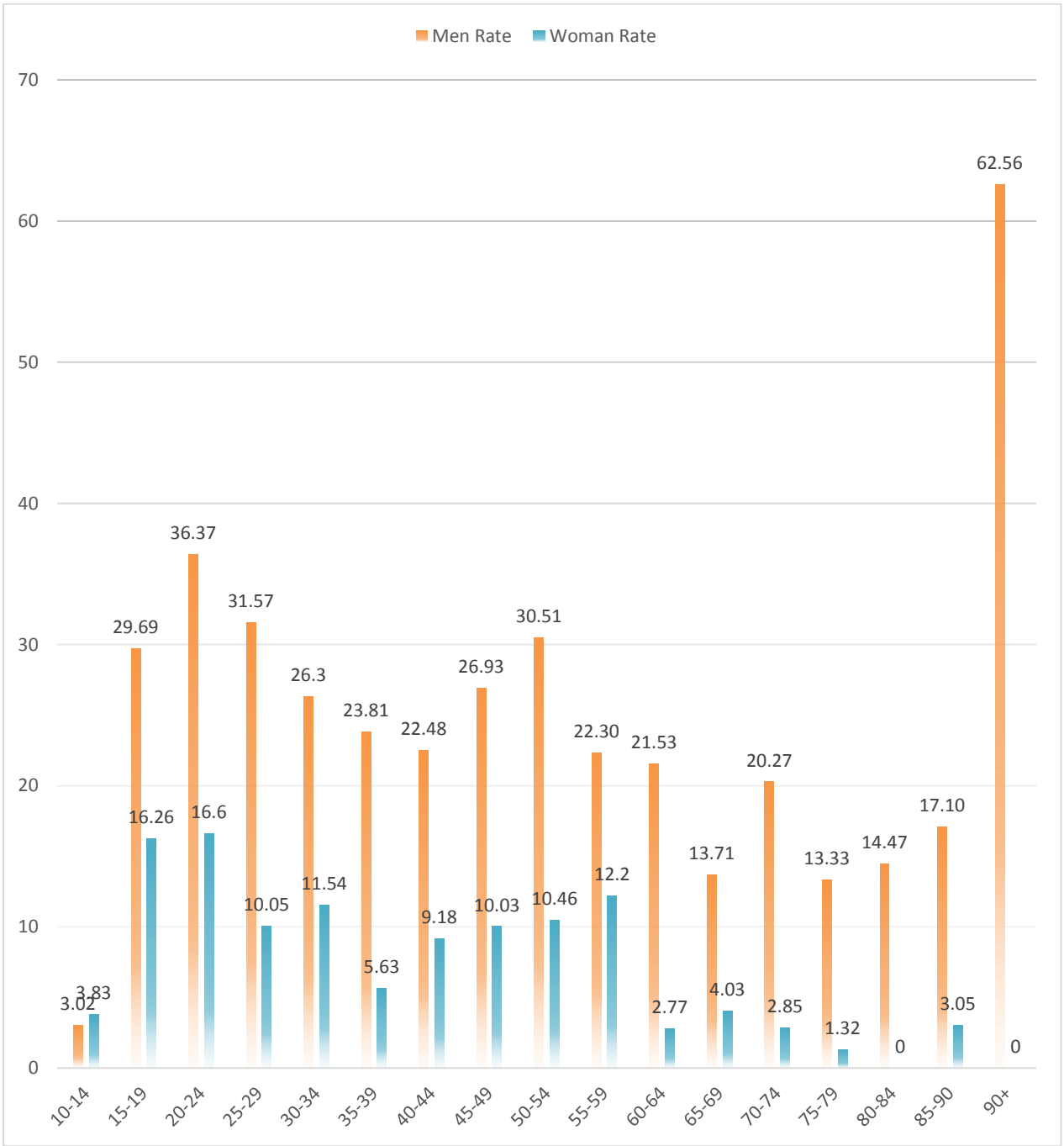
Age Group (Years)	Men		Women			
	Number	Rate*	Number	Rate*	Number	Rate*
10-14	5	3.02	6	3.83	11	3.41
15-19	48	29.69	25	16.26	73	23.14
20-24	64	36.37	27	16.6	91	26.87
25-29	57	31.57	18	10.05	75	20.85
30-34	43	26.3	20	11.54	63	18.71
35-39	36	23.81	9	5.63	45	14.46
40-44	32	22.48	14	9.18	46	15.6
45-49	42	26.93	17	10.03	59	18.12
50-54	46	30.51	17	10.46	63	20.11
55-59	34	22.30	20	12.2	54	17.07
60-64	29	21.53	4	2.77	33	11.82
65-69	16	13.71	5	4.03	21	8.72
70-74	20	20.27	3	2.85	23	11.27
75-79	9	13.33	1	1.32	10	6.99
80-84	6	14.47	0	0	6	6.49
85-90	4	17.10	1	3.05	5	8.9
90+	7	62.56	0	0	7	21.72
Total	**498**	**20.58**	**187**	**7.49**	**685**	**13.93**

Note: The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates for the 2019 year.

PROVISIONAL SUICIDE RATES 2018-2019

By sex and age

Rate per 100,000 people



Note: This table uses Statistics New Zealand population estimates for each age group, rather than for the overall population. This means some rates may appear high, due to having smaller population estimates than other age groups.

Provisional Suicide statistics: Ethnicity

PROVISIONAL SUICIDE RATE 2008-2019

By ethnic group

Rate per 100,000 people

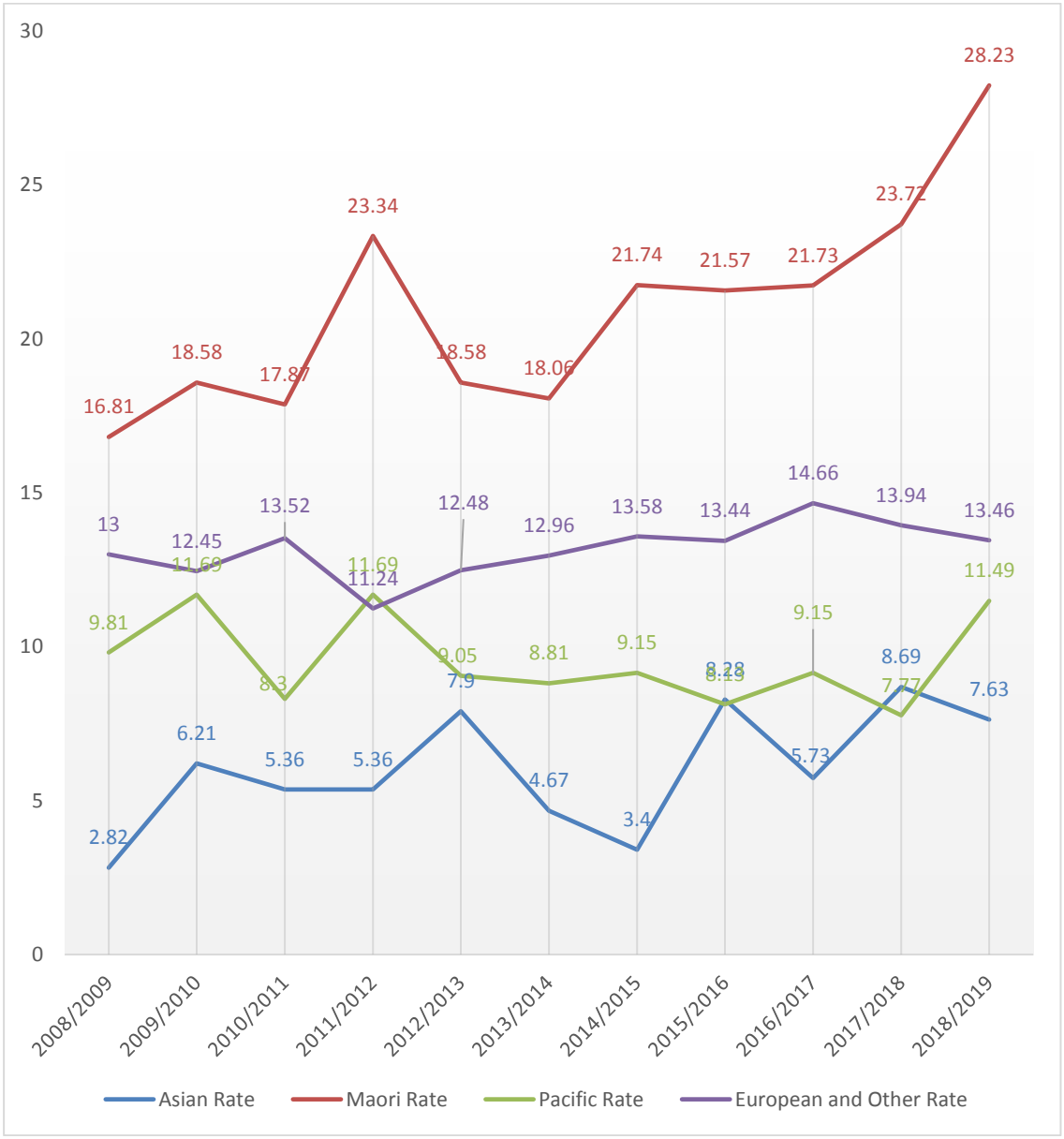
Year	Asian		Māori		Pacific		European and Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2008-2009	10	2.82	95	16.81	26	9.81	400	13.00
2009-2010	22	6.21	105	18.58	31	11.69	383	12.45
2010-2011	19	5.36	101	17.87	22	8.30	416	13.52
2011-2012	19	5.36	132	23.34	31	11.69	365	11.24
2012-2013	28	7.90	105	18.58	24	9.05	384	12.48
2013-2014	22	4.67	108	18.06	26	8.81	373	12.96
2014-2015	16	3.40	130	21.74	27	9.15	391	13.58
2015-2016	39	8.28	129	21.57	24	8.13	387	13.44
2016-2017	27	5.73	130	21.73	27	9.15	422	14.66
2017-2018	41	8.69	142	23.72	23	7.77	462	13.94
2018-2019	**36**	**7.63**	**169**	**28.23**	**34**	**11.49**	**446**	**13.46**

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 2017. 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 2008-2019

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 AS AT 30 JUNE 2019

Office of the Chief Coroner
Judge D Marshall

Whangarei
Deputy Chief Coroner B Shortland

Auckland
Coroner K Greig
Coroner M McDowell
Coroner S Herdson
Coroner D Bell

Hamilton
Coroner G Matenga
Coroner M Robb

Rotorua
Coroner W Bain

Hastings
Coroner T Fitzgibbon

Palmerston North
Coroner T Scott
Coroner C na Nagara

Wellington
Coroner P Ryan
Coroner B Windley

Christchurch
Coroner S Johnson
Coroner A Tutton
Coroner M Elliot

Dunedin
Coroner D Robinson

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

Media liaison

Jerram Watts
Email: Jerram.Watts@justice.govt.nz
Phone: 04 918 8980

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