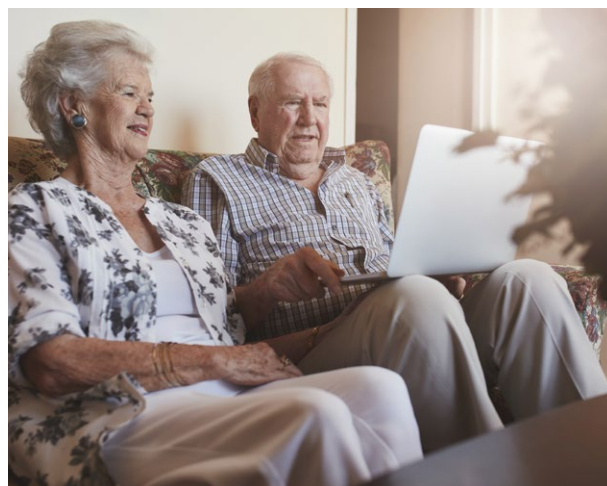


Annual Report

1 July 2015 to 30 June 2016

Office of the Chief Coroner of New Zealand

Kai Tirotiro Matewhawhati Rangatira o Aotearoa



A photograph of a city street lined with large, mature trees. The trees have thick, textured trunks and dense canopies of leaves in shades of green and yellow, indicating autumn. Sunlight filters through the leaves, creating dappled shadows on the pavement. On the left, several cars are parked along the curb. On the right, a paved sidewalk runs parallel to the street, with a few people walking in the distance. A green trash bin is visible on the sidewalk. The overall atmosphere is peaceful and scenic.

Providing answers for families



contents

| | |
|--|----|
| Welcome | 3 |
| Coronial Services of New Zealand | 4 |
| Coroners' contributions | 5 |
| Coronial Services Unit | 7 |
| National Initial Investigation Office | 8 |
| Coroner's jurisdiction | 10 |
| Coronial investigations and court operations | 11 |
| Coronial recommendations or comments | 12 |
| Coroners Amendment Act 2016 | 20 |
| Performance measures | 22 |
| National statistics | 24 |
| Coroners | 32 |

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 tūpāpaku, 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.

Welcome

Welcome to the first annual report of the Chief Coroner

The role of a coroner is often not well understood. Some think coroners are pathologists or medical examiners – the types that appear on well known television programmes. Others know that a coroner will be contacted when there is a death but are unclear as to what the role involves and what types of deaths will be investigated. People are generally surprised when they are told that coroners are on duty at night, on weekends and during public holidays. This is in addition to our large caseload of investigation files, inquest hearings and presentations.

Coroners investigate deaths to establish the cause and circumstances of the death and to help prevent similar deaths occurring in the future. We carry out our investigations in a thoughtful way and recognise the spiritual and cultural needs of each individual family. We understand this can be a difficult time for families and we strive to assist people wherever possible.

Since I became Chief Coroner in February 2015, there have been many changes to the coronial bench. These include the amendment of the Coroners Act 2006 and the appointment of 5 new coroners: 2 in Christchurch, one in Dunedin, one in Hamilton, and one in Auckland.

I am privileged to be the Chief Coroner of New Zealand and am proud of the work coroners do to ensure we have a robust death investigation system.



Her Honour Judge Deborah Marshall
Chief Coroner

29 JULY 2016



Coronial Services of New Zealand Purongo O te Ao Kakarauri

The New Zealand coronial bench consists of 1 Chief Coroner and 16 coroners. 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 **Coroner Shortland, Coroner Devonport, Coroner Scott, Coroner Ryan, Coroner Windley, Coroner Bain, Coroner Greig, Coroner Matenga, Coroner Tutton.** FRONT ROW **Coroner Bell, Coroner Elliott, Coroner McDowell, Judge Marshall (Chief Coroner), Coroner na Nagara, Coroner Johnson, Coroner Robb.** ABSENT **Coroner Herdson**

Coroners' contributions



CORONER GORDON MATENGA

E ngā mana, e ngā reo, e ngā karangaranga maha, tēnā koutou katoa. E ngā tini aitua o ia marae, o ia hapu, huri noa ki te motu, haere ki te okiokinga o tātou tūpuna. E ngā kanohi ora me ngā taringa whakarongo katoa, tēnā koutou, tēnā koutou, tēnā koutou katoa.

I was first appointed as a coroner at Hamilton in 1996. I came to the role in a part-time capacity as part of my general and criminal law practice. Many of my clients at the time were Māori trusts and incorporations. They encouraged me to put myself forward for appointment as coroner to assist in what they saw as an unmet need for greater cultural consideration and sensitivity in working with the victims of sudden unnatural and violent deaths; the families. This has continued to be a motivator in my work as a coroner. I always seek opportunities to educate police, community groups, whānau, hapū and iwi in an effort to help them understand and demystify the court process. I have found that strong and effective communication is key in helping communities to understand why coroners do what they do.

The role has developed over the years and especially so since becoming a fulltime bench in June 2007. It is unique within New Zealand's judicial landscape in the sense that the coroner conducts investigations and undertakes an inquiry. There is no plaintiff or defendant, only the coroner who is charged with the responsibility of determining the facts on the evidence that they decide to consider. This is an interesting facet of being a coroner.

Death occurs at any time of the day or night and so the coronial system must respond to these demands. Working as National Duty Coroner is a challenging part of a coroner's role. I am fortunate to work with 16 other coroners across the country and, more closely with, Coroner Mike Robb and Coroner Wallace Bain within the Waikato and Bay of Plenty regions. It is a supportive and professional bench.



CORONER ANNA TUTTON

Since being sworn in as a coroner in January 2015, I've been based in Christchurch, together with 2 other coroners. The 3 of us work with the Dunedin-based coroner to cover all deaths that occur in the South Island that fall within the coronial jurisdiction. In addition, we are all rostered regularly to act as the National Duty Coroner, to provide 24-hour, 365-days-a-year coverage for all deaths reported to a coroner throughout New Zealand.

The role is demanding but satisfying. It requires each of us to conduct inquiries into coronial deaths and make findings as to the cause and circumstances of death, generally either by holding an inquest and hearing relevant evidence or conducting a hearing on the papers.

The circumstances of death vary widely – from mountaineering accidents to air accidents, surgical deaths to suicide. It requires us to acquire a body of knowledge in respect of a broad range of activities in order to be able to assess the evidence effectively and to formulate appropriate recommendations and comments designed to reduce the chances of other deaths occurring in similar circumstances.

Underpinning everything we do is the need to ensure that families understand the coronial process and have the opportunity to participate in it. As coroners, we work hard to make that happen.



CORONER BRIGITTE WINDLEY

As the newly appointed coroner in Dunedin, I'm located in the midst of the southern region's paradise of adventure activity and extreme sports attracting large numbers of locals and overseas tourists throughout the year. The mix of inquiries into the cause and circumstances of death, which the 4 South Island coroners conduct, is diverse but uniquely flavoured by the proximity of such recreational attractions.

With a background in criminal law and investigations, I enjoy the inquisitorial nature of the coroner role. A coroner has a unique and broad perspective of the medical, social and environmental facets and context of a death. While all cases have death as a starting point, the scope of the coroner's jurisdiction provides for positive outcomes.

The opportunity afforded to the coroner under legislation to assist those affected by a death to understand the cause and circumstances, and to potentially recommend safeguards or improvements that may prevent similar deaths in the future, are particularly rewarding aspects of the work.

Coronial Services Unit

The Coronial Services Unit employs approximately 56 people. It includes case managers, administration and chambers management, business services and legal research counsel.

Each coroner has a case manager who assists them with particular aspects of their investigations until the findings are released and then closed.

Office of the Chief Coroner

The Office of the Chief Coroner is based in central Auckland. It is made up of one judicial support manager, one personal assistant and 2 legal and research counsel. A central role of the office is to provide support to coroners and assistance to families.

The main responsibility of the legal research counsel is to assist all coroners with legal research, inquest preparation, and inquest hearings. They also support

coroners in their roles to educate and liaise with the public to promote understanding of, and cooperation with, the coronial process.

On 1 April 2016 the team became part of the new Specialist Courts Judicial and Business Services Team.



National Initial Investigation Office

The National Initial Investigation Office (NIIO) is notified of all sudden deaths in New Zealand. It has operated as a 24/7 service since October 2012. Our staff members deal with all reportable deaths from the time of death until the body has been released. The role of NIIO coordinators is to keep families informed during the initial stages of the coronial process.

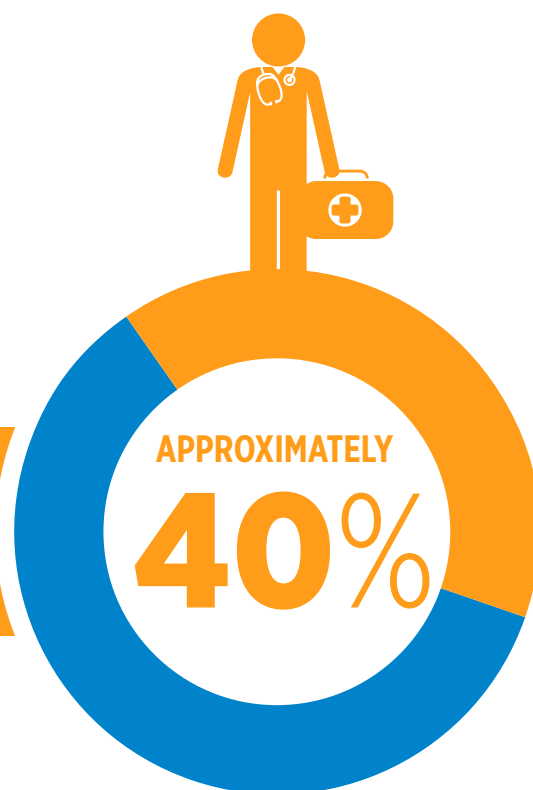
NIIO received

5585

notifications for the duty coroner

FROM 1 JULY 2015 TO 30 JUNE 2016

Deaths from natural causes where community or hospital doctors issued a death certificate after consulting with the coroner made up



In the other **60%**
a coroner took jurisdiction
& THE CASES WENT THROUGH
the coronial process



CORONIAL SERVICE MANAGER NIIO

Merelyn Redstone

The work at NIIO is reactive in nature. Our staff members are the gatherers and disseminators of information on behalf of the duty coroner. We work closely with police, family members, pathologists, mortuaries, transporting funeral directors and family-appointed funeral directors.

Our aim is to assist families through the difficult process of dealing with a sudden death in the family and to get loved ones back with their families in the shortest possible time. This is achieved with the cooperation of our stakeholders who also have the welfare of families at the heart of all decision-making.

We navigate our way through the frustration and anger of some families and guide them as best we can. We are always mindful of the fact that we are representatives of the coroner and remain empathetic to families without becoming counsellors or victim support advisors.

If you ask an NIIO staff member why they do the job they do, the overwhelming response will be their desire 'to assist families during a difficult time'.

As a team, we are very supportive of each other to ensure that, as far as possible, everyone can achieve a good work and home life balance, which is not always easy with a small group covering rostered shifts. Our success is based on collegiality and a good sense of humour, together with a determination to make NIIO a success, and to serve the public of New Zealand with respect, integrity, service, and excellence.



SENIOR NIIO COORDINATOR

Carlene Harris

'I don't know how people like you do your job.' This was a comment made to me recently by a grieving husband over the loss of his wife to suicide. My response was 'People like me do this job to help families through a process that they may not understand in their time of grieving'. This is one of many similar experiences I have had with families and the reason why I am passionate about my role and what I find most rewarding. The only thing I am certain of when I answer the phone is my name; after that, I could be dealing with a simple or a complicated matter.

I started with Coronial Services in 2009 when our unit only worked after hours and weekends. By 2013, we had morphed into a 24/7 operation, having the responsibility of not only providing administrative support to the duty coroner but receiving notifications of reportable deaths nationwide. Our next biggest challenge came in 2014 when we took on the responsibility of facilitating national transport of the deceased from place of death to mortuaries, a task originally facilitated through Police Communications.

I now belong to a team of 17 people, including our Service Manager, who all bring a multitude of life skills that are integral to our operation and allow us to build important relationships with our many internal and external stakeholders.

Coroners jurisdiction

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.

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 the 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. 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 that was medically unexpected

- the death occurred while the person concerned was affected by anaesthetic and that was medically unexpected
- the death of a woman that occurred while she was giving birth, or that appears to have been as a result of the woman being pregnant or 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 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 are gathered to 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.

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 learnt to prevent similar future deaths. In some cases, such as death from natural causes, a coroner may make a finding without opening an inquiry.



Research Legal Counsel Leah Taylor, Coroner Shortland, Judicial Support Manager Jackie Andrews, Research Legal Counsel Helen Curtis

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.

Since July 2016, 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 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.

A TWO FATALITY DROWNING

Paasi and Paea-I-Muli (Coroner Greig)¹

The coroner makes the following recommendation for consideration by the Government:

- That as part of the upcoming review of the regulation of the use of life jackets/personal flotation devices in recreational craft, consideration be given to whether occupants of vessels of six metres or less in length should be required to wear life jackets/personal flotation devices at all times whilst at sea.

The response from Associate Minister of Transport, Hon Craig Foss:

- The Coroner's recommendation that consideration be given to requiring occupants of vessels of 6 metres or less in length to wear life jackets at all times while at sea is being considered as part of Maritime New Zealand's review. I am expecting Maritime New Zealand's advice in April this year.

¹ Paasi [2015] NZCorC 8; [2015] NZCorC 9.

A MOTOR VEHICLE CRASH AT AN INTERSECTION WHERE THERE HAD BEEN PREVIOUS CRASHES

Tucker (Coroner McDowell)²

The coroner makes the following recommendation to Auckland Transport:

- The coroner recommends that [Auckland Transport] reconsider the filter right-hand turning phase at this intersection (east bound traffic turning right from West Coast Road onto Glendale Road) – taking into account all factors (including the crash pattern that [Auckland Transport] previously identified) and not just visibility issues.

The response from Auckland Transport:

- [Auckland Transport] can confirm that the filter right turn was removed from this intersection in August 2015 as a trial, with no significant impact on the efficiency, and is still operating as a non-filter right turn intersection now.

² Tucker [2015] NZCorC 48.

A 3 FATALITY HOMICIDE-SUICIDE AGAINST A BACKGROUND OF DOMESTIC VIOLENCE

Livingstone (Chief Coroner Judge Marshall)³

The coroner makes the following recommendations to New Zealand Police, Ministry of Social Development, Department of Corrections, Women's Refuge, Shakti, and VIP:

- During their national review of family violence policies and training, police should institute training to all front line officers and family violence specialists to reinforce the message that any incident of family violence must be treated as a serious incident as it may be part of a series of incidents that, taken together, will enable a proper risk assessment to be made.
- Police should review how incidents of family violence are recorded to ensure that there is a central repository of such information that can be accessed by any officer attending a family violence incident and by family violence coordinators attending interagency meetings.
- Police should review whether the changes to the ASA (adult sexual assault) regime in Southern District should be implemented nationally and the new ASA regime should be audited to ensure there is proper supervision of ASA staff and that the policies and procedures instituted since this tragedy are being followed.
- The FVIARS partners should institute regular audits of the way in which cases are chosen for discussion, what information is made available at the meetings and what actions are taken following the meeting to ensure that information available to each FVIAR partner is made available to the group and that actions arising from the meetings are specific, completed and reported back to the group.

Responses were received from the Psychotherapists Board of Aotearoa New Zealand and Family Violence Interagency Response System (FVIARS).

Psychotherapists Board of Aotearoa New Zealand:

- The Psychotherapists Board of Aotearoa New Zealand (the Board) received and discussed this report during its July Board meeting. The report was discussed in its entirety but specially addressed were the areas directed to by her Honour.
- The Board will use these findings to educate practitioners and will be investigating ways in which this may occur. The Board is addressing this under section 118(k) of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and has added this item to the Board's Business Plan. As part of the Board Business Plan this will be addressed appropriately and fully as soon as practicable.

The response of the Family Violence Interagency Response System (FVIARS) *is on the next page.*

³ Livingstone [2015] NZCorC 50; [2015] NZCorC 51; [2015] NZCorC 52.



14 September 2015

To whom it may concern,

Response to recommendations by Judge Marshall's findings in Livingstone Inquest

Refer paragraph 176, bullet point four

On 16 June 2015, Judge Marshall released her findings into the deaths of Bradley, Ellen and Edward Livingstone following the coronial inquest held on 21 – 24 April 2015. As part of the findings, four recommendations were made, one Which specifically referred to the Family Violence Interagency Response System (FVIARS) in Dunedin:

"The FVIARS members should institute regular audits of the way in which cases are chosen for discussion, what information is made available at the meetings and what actions are taken following the meeting ensure information available to each FVIAR partner is made available to the group and actions arising from the meetings are specific, completed and reported back to the group."

The FVIARS members meet weekly on a Thursday at the Dunedin Central police station to discuss the at risk families as identified by each agency involved. The meeting has a structured format and is regularly attended by all members.

In specifically addressing Judge Marshall's recommendation, the FVIARS members have implemented the following under each item:

"...institute regular audits of the way in which cases are chosen for discussion..."

Prior to each meeting, all FVIARS members receive an email agenda from police that contains the at-risk families identified by police. All members are required to review this agenda and flag any other families they deem to be at risk (from their agency information) for discussion prior to the weekly meeting. These are added to the agenda.

"...what information is made available at the meetings..."

All FVIARS members are provided with information on all reported FV incidents. They are required to check all families within their agencies systems and to identify which are deemed at risk for their agency. Members provide information of how their agency has interacted with the victim/offender in the past.

Members also now bring a networked device to the meetings (relevant access is catered for at the meeting location) so information can be identified and shared during discussions where necessary.

"...what actions are taken following the meeting ensure information available to each FVIAR partner is made available to the group..."

All FVIARS members are now in regular contact with each other, and an email group has been set up to distribute key information before and after the regular meetings. This ensures a timely exchange of information that can be actioned immediately where needed.

"...actions arising from the meetings are specific, completed and reported back to the group..."

Each FVIARS meeting has a minute keeper present who details what is discussed so each meeting can be referred to. This includes the identification of action points for particular FVIARS members to complete within set timeframes. These action points are addressed each week and members are held accountable to these.

For more information on the changes implemented as a result of the recommendation, please contact Inspector Mel Aitken, Area Prevention Manager for Otago Coastal Police.

Regards

Mel Aitken

Relieving Area Commander

Otago Coastal

AN INQUIRY INVOLVING AMBULANCE DISPATCH AND RESPONSE

Laloava (Coroner Greig)⁴

The coroner makes the following recommendation:

- I recommend that St John instigates a review of whether the questions used by its call handlers and/or the processes by which information given by call makers is clarified are robust enough to ensure appropriate prioritisation of patients such as [the deceased].

The response from the Order of St John's Medical Director, Tony Smith:

- Thank you for the opportunity to comment. We have no comment and we think the recommendations are appropriate. We have a specific committee tasked to reviewing recommendations and implementing change when appropriate. This recommendation will go to that committee.

A HOMICIDE WHERE A SECURITY GUARD WAS THE VICTIM

Dhaliwal (Coroner Ryan)⁵

The coroner makes the following recommendations:

- That consideration be given to strengthening training requirements for property security guards by prescribing specific measures to be employed to avoid guards confronting persons found to be unlawfully on premises. This recommendation is directed to the New Zealand Qualifications Authority and/or such other agency or organisation involved in devising unit standards for the training of security guards.
- That the training regulations relating to security guards be amended either to prevent the issuance of a provisional Certificate of Approval until the mandatory training is completed, or alternatively to ensure that security officers cannot work on their own until they have completed the training and obtained their full Certificate of Approval. This recommendation is directed to the Ministry of Justice and/or such other agency or organisation involved in reviewing training regulations pertaining to security guards.
- That consideration be given to devising an Approved Code of Practice which codifies best practice within the security industry, in consultation with significant stakeholders within that industry.

This recommendation is directed to the Ministry of Business, Innovation and Employment, and Worksafe New Zealand, and/or such other agency involved in developing Approved Codes of Practice.

Responses were received from the New Zealand Qualifications Authority (NZQA), the Skills Organisation and WorkSafe New Zealand.

Responses are on the following pages.

4 Laloava [2015] NZCorC 79.

5 Dhaliwal [2015] NZCorC 95.



NEW ZEALAND QUALIFICATIONS AUTHORITY
MANA TOHU MĀTAURANGA O AOTEAROA

QUALIFY FOR THE FUTURE WORLD
KIA NOHO TAKATŪ KI TŌ ĀMUA AO!

16 December 2015

Kim Elliot
Kim.Elliot@justice.govt.nz

Dear Ms Elliot

Ministry of Justice: Coroner's findings including a recommendation directed to the New Zealand Qualifications Authority (NZQA)

Thank you for your email of 15 October 2015 regarding the findings of Coroner JP Ryan of an inquiry into the death of Mr Charanpreet Singh Dhaliwal (the report). The report contained the following recommendation directed to the NZQA and/or such agency or organisation involved in devising unit standards for the training of security guards.

That consideration be given to strengthening training requirements for property security guards by prescribing specific measures to be employed to avoid guards confronting persons found unlawfully on premises.

NZQA has forwarded a copy of the report to The Skills Organisation which was involved in devising unit standards for the training of security guards.

NZQA has directed The Skills Organisation's attention to the recommendation quoted above and asked for a response. The Skills Organisation has undertaken to respond to NZQA before Christmas 2015. When we receive this response, we will send it to you.

If you have any questions, please feel free to contact Chris Wilson, Senior Policy Analyst, Quality Assurance Strategy, on (04) 463 4211 or Chris.Wilson@nzqa.govt.nz.

Yours sincerely

Karen Poutasi (Dr)
Chief Executive

Wednesday, 18 December 2015

Belinda Himiona
Manager, Quality Assurance Strategy
Quality Assurance Division
New Zealand Qualifications Authority Te Mana Tohu Matauranga o Aotearoa

Dear Belinda,

With regards to the Coroner's findings in the matter of Charanpreet Singh Dhalwal please find below The Skills Organisation's response. This response is in relation to section [91] (a) of the Coroner's findings.

Coroner's Recommendation

That consideration be given to strengthening training requirements for property security guards by prescribing specific measures to be employed to avoid guards confronting persons found unlawfully on premises.

The Skills Organisation's Response

During the time between the incident in question and the release of the Coroner's report, the Associate Minister of Justice Chesler Burrows announced, in August 2013, mandatory training requirements for the security industry. The training included 3 unit standards which cover:

- introductory knowledge essential to working in a security role, including relevant law, communication skills, emergency procedures, health and safety, reporting incidents; and
- the ability to respond to conflict, or potential conflict, appropriately, such as using communication to defuse tension, and exiting a situation safely.

Both Unit Standard 27360 (Demonstrate knowledge of managing conflict situations in a security context) and Unit Standard 27361 (Manage conflict situations in a security context) lend themselves to an approach which ensures that safety of the security guard and members of the public and support the behaviour to 'observe and report' instead of intervention at all costs.

The 2 key elements in the conflict management units are:

- a. Understanding the Assault Cycle
- b. A 5-stage process for managing conflict

The Assault cycle gives the trainee the requisite tools to identify and effectively deal with escalating conflict and, in particular, watch for critical behaviour **when the subject may physically threaten the security person or present a weapon.**

The 5-stage process for managing conflict further equips the security guard to:

1. Assess the situation, including where and how to approach subjects and identify exit routes if need be.
2. Develop an action plan which includes tactical withdrawal should the situation deteriorate.
3. Take appropriate action which includes ensuring that consideration is given to the position of the security guard to the subject's position.
4. Carry out post-incident action.
5. Debrief and report the situation.

In response to the suggestion [311] by Mr. Winstone regarding the strengthening of the units. The Skills Organisation advises that security qualifications are currently under review through the TRoQ process.

The Coroner's second recommendation to 'prevent the issuance of a provisional Certificate of Approval until the mandatory training is completed...' is wholly supported by The Skills Organisation.

In the isolated instances where security guards have not undergone the required training or not paid attention to the 'reasonable' use of force, it may be that the intended outcomes of the unit standards have been compromised. In the vast majority of instances, however, it can be said that, when correctly understood and applied, the mandatory training has led to security guards with a greater degree of professionalism and engagement with the public.

Kind regards,



Gary Fissenden
Chief Executive Officer
The Skills Organisation

12 April 2016

Coroner Ryan
Coronial Services Unit
Auckland

Email: csu.auckland@justice.govt.nz

Dear Coroner Ryan

Re: Charanpreet Singh Dhaliwal CSU-2011-AUK-001532

Thank you for sending WorkSafe New Zealand (WorkSafe) your Findings into the circumstances of the death of Mr Charanpreet Dhaliwal who died as a result of head wounds sustained while working as a security guard at a construction depot in the early hours of 18 November 2011. We appreciate the opportunity to respond.

We note that you have made the following recommendations pursuant to Section 4 of the *Coroners Act 2006*:

(c) That consideration be given to devising an Approved Code of Practice which codifies best practice within the security industry, in consultation with significant stakeholders within that industry. Without intending to limit the scope of such an Approved Code of Practice, it should cover the following specific matters:

- The need for a formal risk assessment of a site to be performed by the security company contracted to provide security for that site, including updating details of previous security incidents at the site and informing guards of that history, and the factors to be considered for robust risk assessment;*
- Appropriate and specific training for security guards with an emphasis on avoiding confrontation and conflict resolution, and highlighting the underlying principle of 'observe and report';*
- The equipment to be provided to property guards performing static guard duty on industrial sites at night should include a radio telephone with a one-touch emergency call button;*
- The need for regular welfare checks on property guards performing static guard duty on industrial sites at night, such checks to be initiated by a control room or some other external source rather than the guard.*

WorkSafe recognises that there are some clear shortcomings in the guidance material and best practice guides currently utilised by the security industry, and that as the lead regulator for work health and safety, WorkSafe has a role to play in encouraging improved health and safety performance within the security industry.

WorkSafe is focused on encouraging duty-holders to better understand the risks associated with their businesses, and take steps to eliminate or minimise those risks. In the coming months, we will be engaging with the security industry. As part of that discussion, WorkSafe will consider how the specific matters you have recommended above can be incorporated into industry practice, whether through an ACOP or another form of guidance.

Yours Sincerely



Phil Parkes
General Manager, Operational Policy

A JOINT INQUEST INTO THE DEATHS OF 4 GIRLS IN FLAXMERE

Flaxmere Joint Inquest (Coroner na Nagara)⁶

The coroner makes the following comment:

- I reiterate the point made by Professor Collings in her report: It should be noted that self-harm such as cutting, if it occurs in the context of other risk factors, should never be dismissed as ‘attention-seeking behaviour’, as it is actually a known risk factor for future suicide death. Furthermore, any suicide or frank suicide attempt where there is high potential for lethality should always be regarded as significantly increasing future risk, even at times when matters appear to be improving or stabilising.

The coroner makes the following recommendations:

To the Hawke’s Bay District Health Board and the Ministry of Health:

- A coordinator is appointed to set up a multi-agency platform for the reporting and coordination of response to young persons whose situations are such that the possibility or risk of suicide is maximised. This could include children and young persons living in homes where domestic violence is common, where alcohol and drug use and abuse are common, where the child or young person is consistently in disciplinary trouble at school, where the child or young person is coming to the attention of police.
- Such a response includes short, medium and long term actions, clarity about who is going to do what, and what to do should the situation change or if an action is not followed through. The response should also attend to the requirements of the child and the social system around the child.
- The coordinator be funded by the DHB, and operate in a similar way as the CAFS/MHS High Complex Needs User coordinator.
- Sufficient funding is provided to enable the implementation of this recommendation.
- In the event that the Hawke’s Bay Regional Children’s Team, when implemented, is able to assume the responsibilities of the coordinator, the coordinator’s role is devolved to that Team.

- The Hawke’s Bay District Health Board set up a whanau wellbeing facility in Flaxmere, to provide a place for families and young people to drop in whenever they feel like the support and camaraderie of a community of people trying to live without alcohol, drugs, violence and abuse, or trying to change negative behaviours/family dynamics.
- The facility could be modelled on the Te Whare Manaaki facility in Palmerston North referred to in these findings, but need not be modelled exclusively on an alcohol and drug addiction recovery paradigm. Its development might usefully be informed by consultation with the community and potential users of the facility.
- Sufficient funding is provided to enable the implementation of this recommendation.
- If such a facility is a substantial duplication of programmes or facilities that exist already in Flaxmere itself, greater support and publicity should be given to these programmes or facilities so that families are aware of their existence and are supported to access them.

To the Minister of Justice and the Chief Executive of the Ministry of Justice⁷

- Relevant aspects of the Care of Children Act 2004 and administrative processes under that Act be reviewed with a view to:
 - Ensuring the automatic appointment of a Lawyer for Child in cases involving allegations of family violence;
 - Ensuring Judges have the power to direct counselling for children exposed to childhood trauma including exposure to family violence.

Responses are still pending.

⁶ Ngatuere [2016] NZCorC 39; Staples [2016] NZCorC 40; Karangaroa-McKenzie [2016] NZCorC 41; and Whaanga [2016] NZCorC 42.

⁷ In their capacity as persons overseeing the Ministry responsible for administering the Care of Children Act 2004.

Coroners Amendment Act 2016

The Coroners Amendment Bill was introduced into Parliament on 31 July 2014. The first reading took place on 19 February 2015 and, on 22 July 2016, the Coroners Amendment Bill came into force.



Significant changes

DEATHS IN HOSTILE ACTION

Section 59A seeks to avoid duplication of investigations. The Act prohibits coroners from opening an inquiry into a death that arose from hostilities in which the New Zealand Defence Force or an allied force was engaged, unless directed to do so by the Attorney-General.

MEDICALLY UNEXPECTED

The Act requires deaths that occurred during or as a result of medical procedures to be reported if they are medically unexpected. A death is medically unexpected if it wouldn't reasonably have been expected by a health practitioner who was competent to carry out the procedure and had knowledge of the deceased's medical condition before the procedure began.

INQUESTS INTO DEATHS IN OFFICIAL CUSTODY OR CARE

The Act enhances the discretionary scope of coroners. It specifies that inquests are no longer mandatory, although coroners are still required to undertake inquiries.

PRELIMINARY INSPECTIONS

Sections 21A(1) and (2) allow the coroner to direct a pathologist to perform a preliminary inspection of the body. Preliminary inspections consist of external visual examinations and the use of medical imaging technology.

RECOMMENDATIONS AND COMMENTS

The Act ensures that recommendations and comments made by coroners are focused and relevant and requires coroners to consult with interested parties before they are finalised.

RESTRICTIONS ON REPORTING SUICIDES

The Act narrows the restrictions on reporting suicides. A death may be reported as a 'suspected suicide' before the coroner delivers their findings. However, only limited information is allowed to be reported, broadcast or posted on the internet without the Chief Coroner's permission. The Chief Coroner has the assistance of a suicide and media expert panel when deciding on exemptions. The purpose behind this is to prevent reporting that's likely to be detrimental to public safety – in particular, copycat suicides.

MORE PUBLIC REPORTING MECHANISMS

The Act requires the Chief Coroner to monitor inquiries not completed within one year. The Chief Coroner must publish information at regular intervals about inquiries in relation to which an inquest, or a hearing on the papers, has been held but no certificate of findings has been released.

INTERESTED PERSON

The Act clarifies the definition of an interested person. An interested person specifically includes a person whose conduct is likely to be called into question during the course of any inquiry. It includes any other person or organisation that the coroner considers has an interest in the death greater than that of the general public.

OTHER CHANGES

The Act provides for a dispute resolution mechanism involving the Commissioner of Police and the Chief Coroner in the event of a dispute concerning coronial direction of police investigation.

The Act allows for the appointment of a Deputy Chief Coroner.

Performance measures

From 1 July 2015 to 30 June 2016 ...

5585

deaths were reported to the
National Initial Investigation Office

Coroners took jurisdiction over

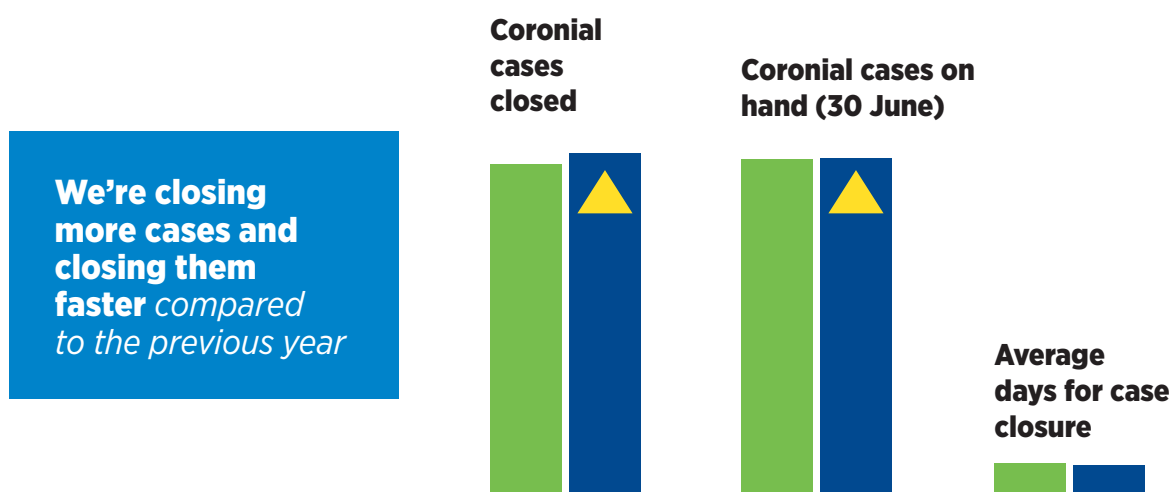
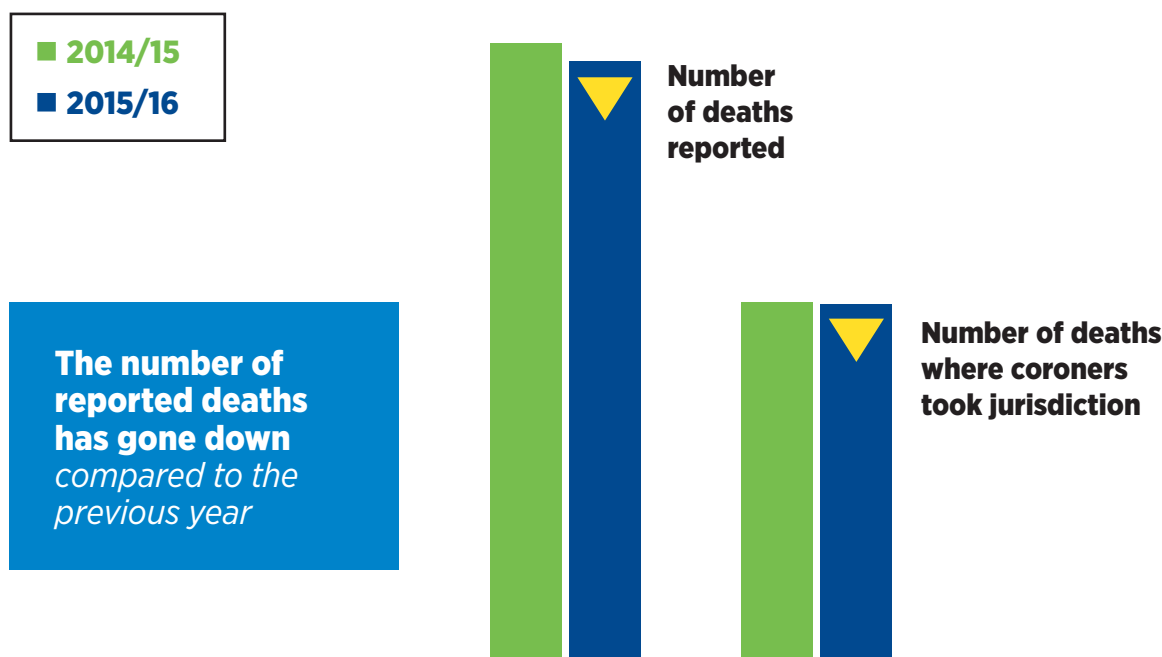
3326

**We're
closing
more cases
& closing
them faster**

Coroners closed
3211
cases
109 more
THAN LAST YEAR

Closing a case took
ON AVERAGE
312
days
22 less
THAN LAST YEAR

Year in review



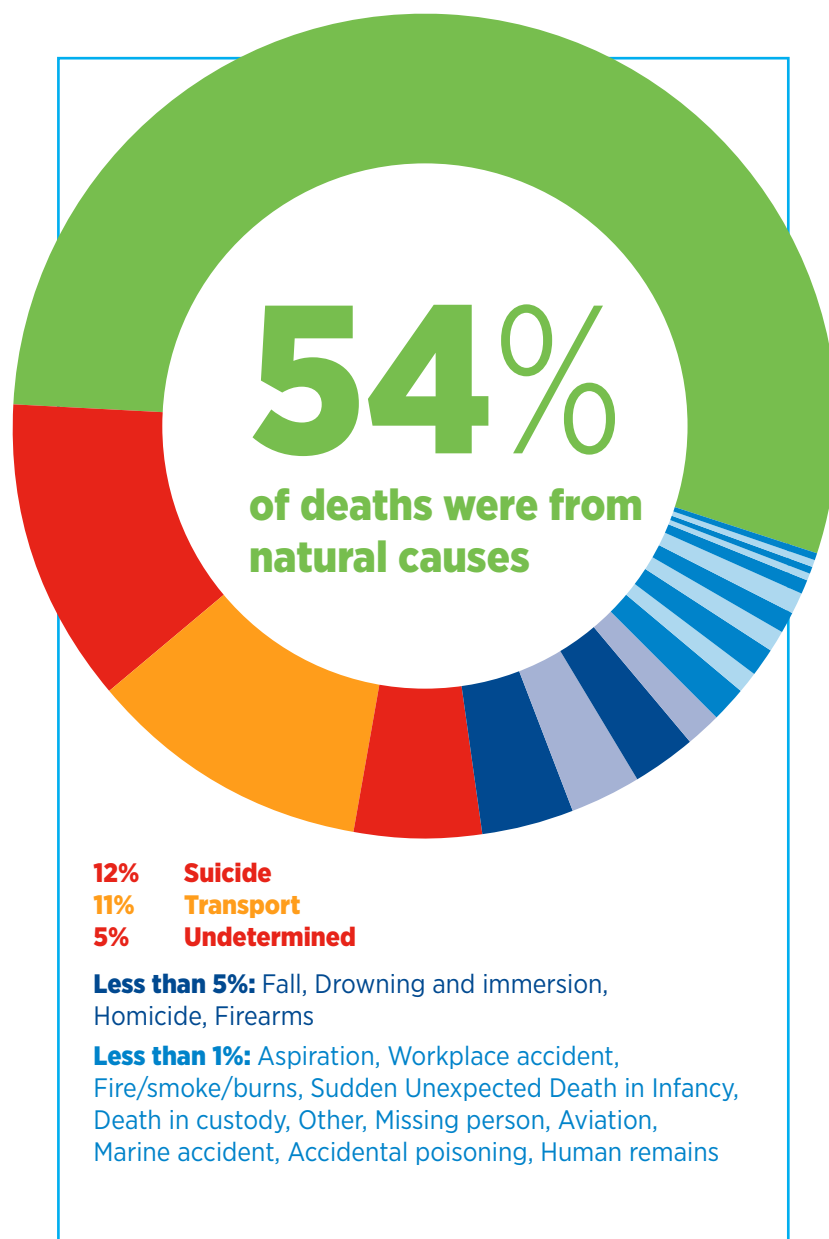
| Year in review | 2014/15 | 2015/16 | CHANGE | % CHANGE |
|---|---------|---------|--------|----------|
| Number of deaths reported | 5755 | 5585 | 170 | 3% |
| Number of deaths coroners took jurisdiction | 3349 | 3326 | (23) | -1% |
| Coronial cases closed | 3102 | 3211 | 109 | 4% |
| Coronial cases on hand (30 June) | 3150 | 3161 | (11) | -1% |
| Average days for case closure | 334 | 312 | (22) | -7% |

National statistics

In 2015-16, coroners took jurisdiction over 3326 deaths. Of these, 1798 (54%) deaths were from natural causes. The second highest category was suicide. Deaths by suicide accounted for 398 deaths (12%), followed by transport deaths, 366 (11%).

Cause of death 2015-16 Deaths

| | |
|------------------------------------|------|
| Accidental poisoning | 8 |
| Aspiration | 32 |
| Aviation | 10 |
| Death in custody | 26 |
| Drowning and immersion | 81 |
| Fall | 92 |
| Fire/smoke/burns | 30 |
| Firearms | 43 |
| Homicide | 46 |
| Human remains | 2 |
| Marine accident | 9 |
| Missing person | 11 |
| Natural causes | 1798 |
| Other | 23 |
| Overdose | 121 |
| Sudden Unexpected Death in Infancy | 27 |
| Suicide | 398 |
| Transport | 366 |
| Undetermined | 171 |
| Workplace accident | 32 |



The 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 as a result of suicide or natural causes.

Enhancing suicide reporting

Last year, approximately 579 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 New Zealand's 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.

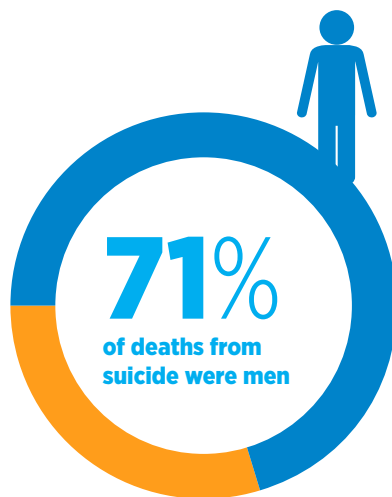
2015–16 had the 2nd highest recorded suicide rate *since these statistics began in 2007.*

There were 12.33 suicide deaths per 100,000 population.

Provisional suicide statistics: Men–Women

Female suicides increased

This year, the number of female suicide deaths rose from 136 to its recorded high of 170. The number of male suicide deaths fell from its recorded high of 428 to 409.



The male suicide rate continues to be higher than the female suicide rate

The ratio of male to female suicides was 2.41:1

PROVISIONAL SUICIDE RATE 2007–2016

By sex

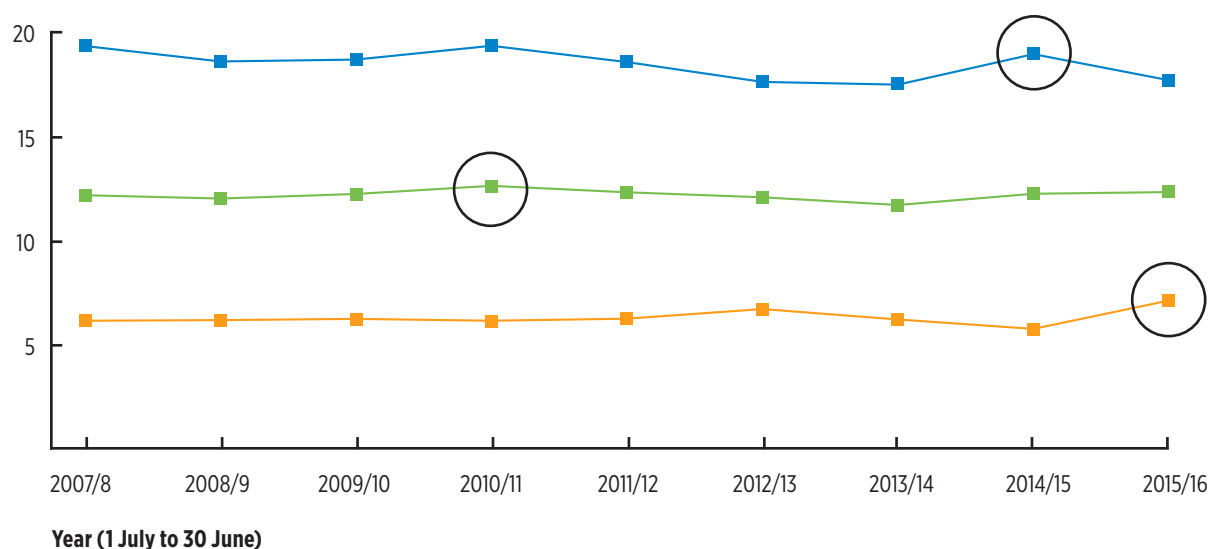
| Year | Men | | Women | | Rate (Men : Women) | Total | |
|------------------|------------|--------------|------------|-------------|-----------------------|------------|--------------|
| | Number | Rate* | Number | Rate* | | Number | Rate* |
| 2007/2008 | 405 | 19.35 | 135 | 6.20 | 3.00:1 | 540 | 12.20 |
| 2008/2009 | 394 | 18.61 | 137 | 6.23 | 2.87:1 | 531 | 12.04 |
| 2009/2010 | 401 | 18.70 | 140 | 6.29 | 2.85:1 | 541 | 12.26 |
| 2010/2011 | 419 | 19.36 | 139 | 6.20 | 3.01:1 | 558 | 12.65 |
| 2011/2012 | 405 | 18.58 | 142 | 6.30 | 2.85:1 | 547 | 12.34 |
| 2012/2013 | 388 | 17.63 | 153 | 6.76 | 2.54:1 | 541 | 12.10 |
| 2013/2014 | 385 | 17.50 | 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 |

Care needs to be taken in interpreting and reporting figures relating to suicide. *Rate per 100,000 people. The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates.

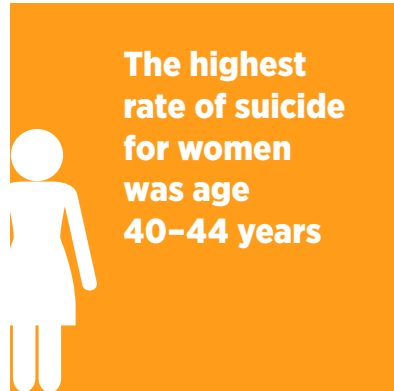
PROVISIONAL SUICIDE RATE 2007-2016

By sex

Rate per 100,000 people



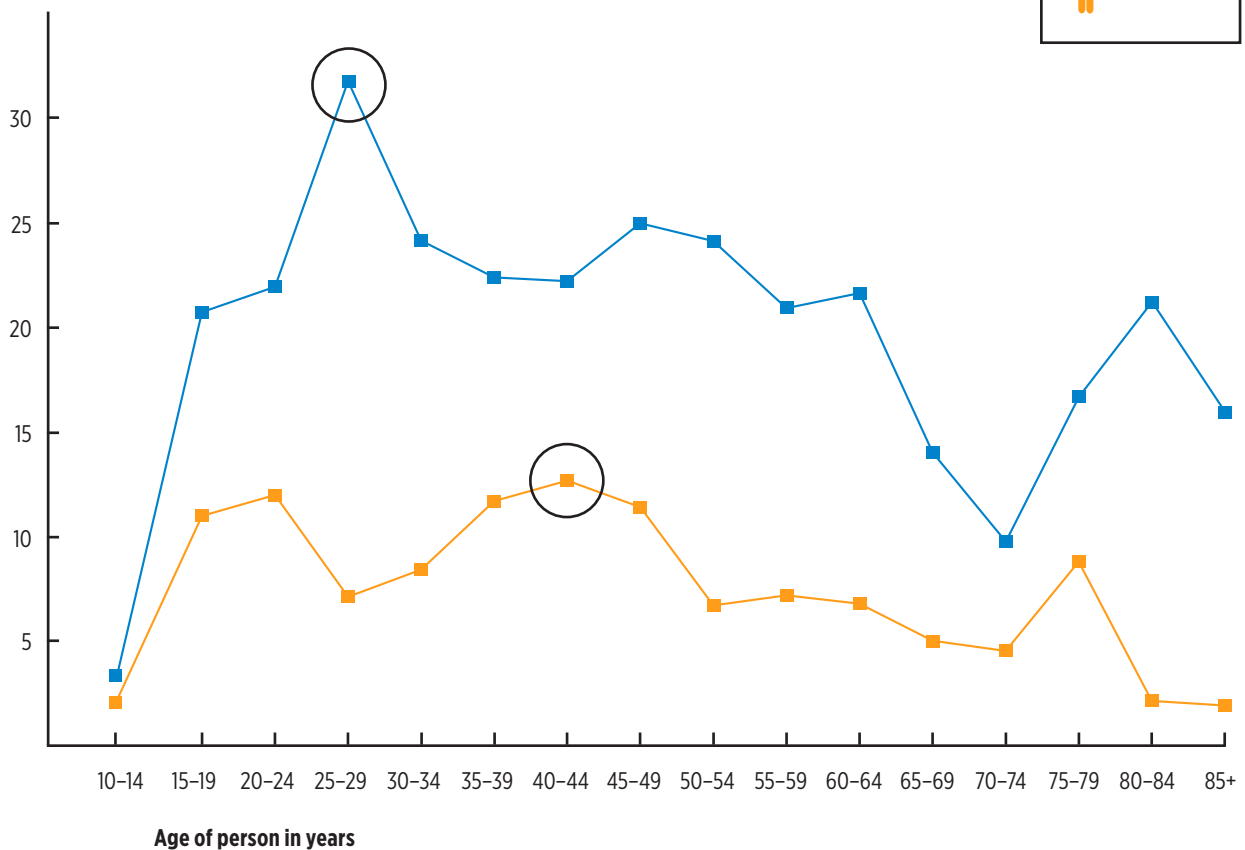
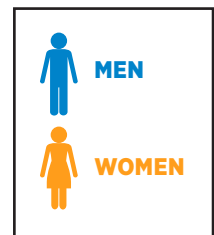
Provisional suicide statistics: Age



PROVISIONAL SUICIDE RATES 2015-2016

By sex and age

Rate per 100,000 people



PROVISIONAL SUICIDE RATES 2015–2016

By sex and age

| Age Group (Years) | Men | | Women | | Total | |
|----------------------|------------|--------------|------------|-------------|------------|--------------|
| | Number | Rate* | Number | Rate* | Number | Rate* |
| 0–4 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| 5–9 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| 10–14 | 5 | 3.32 | 3 | 2.09 | 8 | 2.72 |
| 15–19 | 34 | 20.75 | 17 | 11.00 | 51 | 16.02 |
| 20–24 | 40 | 21.96 | 20 | 12.00 | 60 | 17.20 |
| 25–29 | 54 | 31.80 | 12 | 7.13 | 66 | 19.51 |
| 30–34 | 35 | 24.17 | 13 | 8.43 | 48 | 16.06 |
| 35–39 | 30 | 22.41 | 17 | 11.71 | 47 | 16.84 |
| 40–44 | 32 | 22.23 | 20 | 12.69 | 52 | 17.25 |
| 45–49 | 38 | 25.00 | 19 | 11.42 | 57 | 17.90 |
| 50–54 | 37 | 24.15 | 11 | 6.72 | 48 | 15.15 |
| 55–59 | 30 | 20.94 | 11 | 7.20 | 41 | 13.85 |
| 60–64 | 27 | 21.66 | 9 | 6.80 | 36 | 14.01 |
| 65–69 | 16 | 14.03 | 6 | 5.03 | 22 | 9.43 |
| 70–74 | 8 | 9.77 | 4 | 4.54 | 12 | 7.06 |
| 75–79 | 10 | 16.70 | 6 | 8.81 | 16 | 12.50 |
| 80–84 | 8 | 21.24 | 1 | 2.15 | 9 | 10.70 |
| 85 + | 5 | 15.97 | 1 | 1.93 | 6 | 7.23 |
| Total | 409 | 17.71 | 170 | 7.13 | 579 | 12.33 |

Care needs to be taken in interpreting and reporting figures relating to suicide. *Rate per 100,000 people.

The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates.

Provisional suicide statistics: Ethnicity



In 2015–16, Asian people accounted for 7% of all suicide deaths

Pacific people accounted for 4% of all suicide deaths

Māori have the highest rate of suicide of all ethnicities

There were 129 suicides by Māori, 22% of all suicide deaths

PROVISIONAL SUICIDE RATES 2007–2016

By ethnic group

| Year | Asian | | Māori | | Pacific | | Other | |
|------------------|-----------|-------------|------------|--------------|-----------|-------------|------------|--------------|
| | Number | Rate* | Number | Rate* | Number | Rate* | Number | Rate* |
| 2007/2008 | 21 | 5.93 | 87 | 15.39 | 24 | 9.05 | 408 | 13.26 |
| 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 |

Care needs to be taken in interpreting and reporting figures relating to suicide.

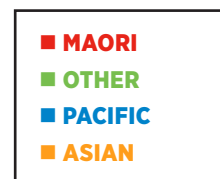
*Rate per 100,000 people.

'Other' people includes European, not elsewhere classified and New Zealand European

The small number of some ethnic groups means rates are variable and it is difficult to draw any conclusion or trends from the data. The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates.

PROVISIONAL SUICIDE RATES 2007-2016

By ethnic group



Rate per 100,000 people





Coroners

Office of the Chief Coroner

Judge D Marshall

Whangarei

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 C Devonport

Palmerston North

Coroner C na Nagara

Coroner T Scott

Wellington

Coroner P Ryan

Christchurch

Coroner S Johnson

Coroner A Tutton

Coroner M Elliott

Dunedin

Coroner B Windley

Contact the Office of the Chief Coroner

OfficeoftheChiefCoroner@justice.govt.nz

Report a death to the Coroner

National Initial Investigation Office (NIIO)

P 0800 266 800

E NIIO@justice.govt.nz

Media liaison

Matt Torbit

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