Casper

Community Action on Suicide Prevention Education & Research

Submission on Review of Coroners Courts

November 2012

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Introduction

Casper (Community Action on Suicide Prevention Education & Research) is a registered Charitable Trust (CC46140). Established on 12 August 2010 by two mothers who lost children to suicide, the organisation currently has over 2800 members.

Casper's objects and purposes are :

(a) To support families who are suffering bereavement from suicide

(b) To develop and run programmes, seminars, workshops and other activities that educate the community about the causes and effects of suicide

(c) To provide assistance to families affected by suicide at inquests and other inquiries

(d) To gather and analyse national and international information on suicide and its prevention.

(e) To educate the community about the causes and effects of suicide upon families and the community.

(f) To educate community leaders and politicians about the causes and effects of suicide, and to advise on, and promote, changes to legislation, policy and practice.

CASPER welcomes the opportunity to comment on the operation and outcomes of the Coroners Court and Coroner's Act 2006. Given the ethical impossibility of conducting prospective research studies in which completed suicide is the outcome studied, we consider data collected by Coroners Courts during death investigations to be critical in identifying the causes of suicide and effective suicide prevention strategies. It is our view that the effective functioning of the Coronial system has the potential to prevent hundreds of suicides each year in New Zealand.

While the jurisdiction of Coroners includes all sudden and unexpected deaths, our comments are restricted to cases of suspected suicide. They are made in the context of our view that a targeted

review of the Coroners Court is insufficient to address the key issue facing the Court – that the Act's purpose of preventing future deaths is not being met.

> *I am concerned that we seem to be making no impact (on youth suicide rates), there's no visible downward trend at all.*[1]
>
> *Chief Coroner 3 September 2012*

Background

On 31 July 2012, the Minister for Courts announced a review of the Coroners Act 2006 in response to concerns about the coronial system and the Coroners Act 2006.

We consider that many of the concerns being raised about the system and the Act arise from the failure to implement some important recommendations made by the Law Commission in its review of Coroners in 2000. Many of the rejected reforms proposed by the Law Commission were based on submissions received by Coroners, the Chief District Court Judge and other experts. We consider many of the current difficulties with the system could have been avoided had the Law Commission's recommendations been adopted.

The Minister has announced that a targeted, rather than broad, review is "the best way to address the concerns that have been raised without using unnecessary time and resources for areas where no problems have been identified." We disagree. It is our view that the issues with the Coronial system and Coroners Act arise from the failure to conduct a first principles review of the Coroners Court in New Zealand prior to implementation of the new legislation and that in light of the evidence that the Coroners Court is not fulfilling its purpose of preventing future deaths, such a review must be undertaken.

We consider it unfortunate that the opportunity to make a real difference to suicide rates in New Zealand through death investigations was missed and that the government did not take the view of the Irish Coroners Review that

> *In making an assessment for the needs of society in the twenty-century, it is inevitable that some radical reforms are indicated and that unattended historical evolution must now give*

1 http://tvnz.co.nz/national-news/calls-talk-more-openly-suicide-5059539Calls to talk 'more openly' about suicide Published: 1:57PM Monday September 03, 2012 Source: ONE News

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way to more modern organisation structures, a focused management perspective and a dedicated funding programme to achieve specified objectives in the short and long term. Piecemeal evolution and improvements under the current organisational arrangements will not achieve the standards of public service which have now become part of the legitimate expectations of today's society.[2]

In announcing yet another piecemeal review, the Minister has identified the following concerns as those that should be addressed:

- the timeliness of coronial decisions and the impact of delay on grieving families
- a lack of consistency between regions in how coroners and coronial services staff carry out their roles, and uneven workloads between regions and coroners
- uncertainty about the role of coroners and duplication with other authorities that also investigate certain types of deaths
- the nature of recommendations that coroners should be able to make to prevent future deaths and whether formal responses to those recommendations should be required, and
- concerns about the operation of the Act raised in the context of the Law Commission's review of the Burial and Cremation Act 1964.

The stated aim of the review is to:

- better balance the needs of grieving families, including the cultural needs of Māori whānau, with the public interest in understanding the causes and circumstances of deaths
- improve the quality, consistency and timeliness of coronial investigations and decision making
- clarify the role of coroners and reduce duplication between coroners and other authorities that investigate deaths and accidents
- clarify the role coroners have in making recommendations to prevent future deaths and the relationship to agencies that have policy and operational responsibility in those areas, and
- ensure resources are used effectively.

2 Department of Justice, Equality & Law Reform, 2000 Review of the Coroner's Service: Report of the working Group retrieved from http://www.justice.ie/en/JELR/ReviewCoronerService.pdf/Files/ReviewCoronerService.pdf

The Coronial Services website advises that the Ministry of Justice

> *is writing to government agencies and other professional stakeholder groups with an interest in the coronial system (including Māori with a particular interest in the coronial process) to seek comment on how well the current Act and Coronial Services are working and any suggestions for improvement.*

And that

> *If significant new issues are raised during the consultation, the Ministry will discuss with the Minister whether they should be included in the review.*

We are concerned that the terms of reference for the review fail to identify many of the concerns that CASPER has raised over recent years on behalf of families bereaved by suicide. We note that the Law Commission, in reviewing the Coroner's Act did not consult with experts on suicide, including bereaved families.

Successive Courts Ministers appear to be of the view that families of the deceased are primarily concerned with quick disposal of the remains of their dead and that the desire to investigate the cause of a sudden and unexpected death is the province of the state and in conflict with the desire of the family. Former Minister Rick Barker, during the development of the Coroners Act 2006, commented that

> *There is, of course, an inherent tension between, on the one hand, the family's right to mourn and bury its deceased, and, on the other hand, the State's obligation to ascertain the cause of death.* [3]

While the current Minister's statement in relation to the present review is that he is

> *keen to look at how we can improve the timeliness and efficiency of the coronial process to reduce the impact on...families.*[4]

While we do not dispute that timely return of the body of their loved one and timely conduct of inquiries are issues for families our experience is that the many concerns families of suicide victims have about the Coronial System are far broader and generally accorded far higher priority than those of timeliness and efficiency.

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3 Coroners Bill — Second Reading Hansard and Journals Hansard (debates) [Volume:630;Page:2664] 2 May 2006 http://www.parliament.nz/en-NZ/PB/Debates/Debates/6/3/e/48HansD_20060502_00001310-Coroners-Bill-Second-Reading.htm

4 Hon Chester Borrows 31 July 2012 Coronial System to be Reviewed, National Party Website http://www.national.org.nz/Article.aspx?articleId=39061

Our experience is that families prioritise thoroughness over timeliness in relation to suicide deaths. Where families are not convinced that inquiries will be thorough or result in useful outcomes however, they are likely to consider delays unacceptable because they deliver no benefits. In our view, improving processes and outcomes will both improve timeliness and make families more tolerant of the delays inherent in conducting proper investigations.

We are concerned that the systematic exclusion of the families of suicide victims from consultation around Coroners Court processes by Ministers and the Ministry has led to a very poor understanding of the needs and imperatives of these key stakeholders. This is in sharp contrast to the recognition of court users and agencies representing them in other New Zealand courts and in Coroners courts around the world.

The Ministry of Justice Family Court Review for example, involved wide consultation with court users, while the review of the Coroners Court in Ireland acknowledged that "the coroner service is a service for the living and indeed for a very precious segment of the living – those traumatised by sudden andunexpected death."[5] This jurisdiction included the Samaritans at every level of its process to review and improve the Coroners Court to ensure the views of court users were accurately represented.

We wonder how the Minister intends to identify and weigh the needs of bereaved families when he does not identify court users as key stakeholders in the review, advising that the Ministry of Justice will seek the views of "professional groups who work closely with the coronial system, such as coroners, doctors, funeral directors and pathologists."

Failure to recognise families who participate in inquests as key informants represents both disrespect to those families and and a lack of commitment to ensuring the best possible outcome of the review. Given that what is at stake with the Coroner's court is the lives of New Zealand citizens, we would have thought the Minister would have been strongly committed to gathering the best possible information to inform the review.

It is CASPER's experience that while they have a range of concerns about the operation of the Coroner's Court, families bereaved by suicide are primarily concerned that Court achieve its purpose of reducing future suicide deaths. Concern with process and 'court culture' issues around accuracy, consistency and respect are driven by concerns about outcomes. Were the Courts to provide evidence that their processes resulted in accurate findings on the circumstances leading to self-inflicted deaths and suicide reduction, families would have a far greater stake in court processes.

5 Department of Justice, Equality & Law Reform, 2000 Review of the Coroner's Service: Report of the working Group retrieved from http://www.justice.ie/en/JELR/ReviewCoronerService.pdf/Files/ReviewCoronerService.pdf

We believe that a targeted review which ignores outcome achievement in favour of a focus on tinkering with process is inappropriate. The failure of the Ministry to conduct a thorough review of how Coroners Courts should best operate to achieve its aims, is what has led to the current situation in which legislation which is only six years old is being reviewed in response to concerns from a range of stakeholders that the system is not working.

We believe, in the context of steeply rising youth suicide rates, that a first principles review of the Coroners Court is required. It is our strongly held view that such a review should investigate the purpose, role and operation of a modern coronial service and the development of a set of proposed reforms informed by wide consultation. We note the absence of consultation with families bereaved by suicide in the Law Commission's review.

The Importance of Inquests to Families and to Suicide Prevention

The Chief Coroner reports that 547 New Zealanders died from suicide in 2011/12. His figures reveal a shocking 46% increase in suicides of 15-19 year olds across ethnic groups and a 76% increase in Maori youth suicide in the last 12 month reporting period.

Undermining New Zealand's efforts to implement effective suicide prevention strategies is a lack of good quality data on the causes of suicide in the New Zealand population.

Suicide is a difficult issue on which to gather robust data. By definition the gathering of direct information from suicide victims is impossible. The only exception, is the gathering of post mortem data. The collection of all available data on the circumstances leading to the suicides of those who have died and the mining of post-mortem data to the fullest possible extent provides an important evidence base for suicide prevention and should be a priority activity.

Thorough and systematic investigations into the suicides of its citizens and analysis of the data gathered over time, presents a critical opportunity for New Zealand to understand suicide and reverse current trends. Ensuring the New Zealand coronial service operates effectively is essential to development of accurate understanding of the causes of suicide in New Zealand and the development of effective, evidence-based suicide prevention strategies.

When a loved one dies from suicide, families almost invariably begin a quest to understand why. An inquest is an opportunity for families to have answered the many questions they are left with following a suicide death. Inquests also provide an opportunity for the voice of the family to be heard in an environment where the voices of Coroners, medical and mental health professionals and others who often did not know the person who died, are privileged.

Contrary to popular opinion, inquests do not provide 'closure' for families of suicide victims or facilitate their 'recovery' or 'moving on.' Families have no wish to close the door on the life they had with their loved one or to construct a life that does include them. Their desire is to maintain an ongoing, daily relationship with their loved one despite the absence of their physical presence.

The following quote from State University of New York bereavement expert Dr Louis E. LaGrand, reflects current thinking on the issue of closure

> *Those mourning the death of a loved one are often told to find closure, let go of the deceased loved one, and go on with their lives. For most, this admonition is tantamount to saying forget about the person. In truth, no one ever forgets the beloved and never wants to since our memories and our love will never allow it. Thus additional stress is heaped on the mourner as a conflict arises between the carrier of the "forget message" and the survivor.*
>
> *Only until recently was the go-on-with-your-life-and-forget-your-deceased-loved-one message endorsed by counsellors and mental health experts. It finally was realized that we never forget our loved ones, they are close to our hearts, and in fact it is healthy and important to establish a continuing bond with them, if it is desired.*
>
> *Obviously, this new way of relating is different (no physical presence) as it must be, yet it can still be nourishing and comforting. Nevertheless, there are many associated with the mourner who still fear that holding on to the deceased in this manner is pathological, a precursor to additional suffering and emotional problems*.

The suicide of a loved one often involves families learning more about the person who has died and their relationship with that person. Inquests can help families better understand how their loved one saw the world and their relationships and facilitate the development of the new relationship between the person who has died and those they have left behind.

Inquests provide an opportunity to ensure the story of the person who has died is accurately reported in official records and that their death is able to contribute to preventing other suicides. They provide an opportunity for families to give their loved one a legacy and to make a difference to the world that their untimely death has prevented them doing in person.

Families gain relatively little from participating in inquests. No compensation for their loss is available, no one who contributed to the death of their loved one can be held accountable and recommendations, where made, are rarely implemented. The motivation for most families attending inquest is the wish to understand what led their loved one to take their lives and a deep desire to prevent others suffering suicide loss.

Those who stand to benefit most from investigations into suicide deaths are those who have not experienced the suicide of a loved one, and who may avoid this experience where the lessons learned

from suicide investigations inform better suicide prevention policy. As such, participation in inquests is in a very real sense, an act of community service by the families of the deceased.

To what extent are the aims of the court being achieved?

The stated aim of the New Zealand coronial system is to "identify practices that have cost human lives and then to modify or eliminate them."[6] The Coronial Services website advises that

> *In order to achieve this, consistent coronial practices and accurate statistics relevant to external causes of death are fundamental to the development of effective regional and national injury prevention strategies.*[7]

In its review of the Coroners Act, the Law Commission notes that

> *In recent years, the role of the coroner has increasingly been recognised as one in which the thorough investigation of a death can lead to a reduction in future injury and preventable deaths. However, the ability of coroners to fulfil their many functions, and in particular to assist in death and injury prevention and thus influence the development of public health policy, has been limited by the systemic problems identified in our preliminary paper and confirmed in the submissions.*[8]

Clearly the Courts aims are not being met in relation to suicide. The potential for reducing suicide deaths not being realised with rising suicide rates overall and particularly steep rises for youth, women, the unemployed and students.

CASPER believes that there are a number of factors contributing to the failure of the New Zealand Coroner's Court to achieve its potential in preventing suicide. These include the failure to

- conduct full and thorough investigations into suicide deaths
- gather and analyse relevant data
- hold individuals and agencies accountable for implementing recommendations for change
- provide adequate training for Coroners
- ensure a sound evidence base for findings and recommendations

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6 Coronial Services of NZ website http://www.courts.govt.nz/courts/coroners-court/coronial-data-collection

7 Coronial Services of NZ website http://www.courts.govt.nz/courts/coroners-court/coronial-data-collection

8 Law Commission 2000 NZLC *R 62* Coroners

- engage constructively with and provide appropriate support to families
- provide best practice standards for Coroners, pathologists and police
- hold the police to an acceptable standard of investigation

Our submission outlines our concerns and makes suggestions for change, in these areas.

Investigations into suicide deaths

In their submission to the Law Commission, Coroners Bain and Douthwaite commented that a key advantage of the Coroner's Court is its ability to get to the core of many issues and emphasised that it is crucial that coroners obtain all of the relevant facts if they are to make appropriate recommendations for future prevention of deaths.[9]

The Coroner's Council submitted that

> *Consideration could be given (in the interests of consistency including that of data collection) to increasing the category of compulsory inquests.*

The submission from the Chief District Court Judge's Chambers stated that

> *the function of a coroner in making recommendations and comments under section 15(1)(b) is also an important one* ***and one which realistically requires the hearing of evidence.*** *(emphasis added)*

Despite these submissions, the Coroners Act 2006 abolished the requirement for mandatory inquests in cases of suspected suicide with the result that 90% of cases now being determined 'on the papers.'

Data provided by the Chief Coroner shows a rapid decline in the number of deaths subject to full examination through the inquest process, from 100% of cases in 2006 to only 10% in 2010. Coronial Services has advised CASPER that where hearings are on the papers and chambers findings are made "no evidence is generally heard for the purposes of the enquiry."[10]

Hearing Type	2006	2007	2008	2009	2010
On papers	0	34	295	377	408
Inquest	514	468	142	68	43
Total	514	502	437	445	451
% on papers	0	7	68	85	90
% inquest	100	93	32	15	10

9 Law Commission 2000 NZLC *R 62* Coroners

10 Correspondence to CASPER from the Ministry of Justice dated 24 April 2012

CASPER has serious concerns that in the face of rising suicide rates and despite improved data collection being a key plank of the New Zealand Suicide Prevention Strategy, the Coroner's Court is collecting less, and lower quality data, than was collected prior to the implementation of the new legislation.

On this basis, we consider the implementation of the Coroner's Act 2006 to be a significant backward step in suicide prevention in New Zealand and submit that full and thorough investigation into every case of suspected suicide is necessary to collect the range and quality of data required to make effective recommendations and to inform good public policy.

Inquests

The mandatory requirement for suspected suicides to be subject to inquest under the 1998 Coroners Act was rescinded in the Coroners Act 2006 in favour of allowing Coroners to hold hearings on the papers and make chambers findings where they are satisfied that no one who could help them with their investigations "wishes to give evidence in person."

CASPER does not consider that a decision on whether evidence should be heard in relation to a suicide death should rest on the wishes of those involved to give evidence. We know of no other court or tribunal whose decision to hold a hearing is made on this basis and consider it completely inappropriate. It is our view that all suspected suicide deaths should be subject to an inquest and that consideration of the wishes of potential witnesses to give evidence should occur during the process of agreeing witness lists.

We consider that the holding of a full inquest is necessary to achieve the aims of the Act and of the Coroner's Court. We believe the quality of Coroners findings and recommendations is diminished by failure to test the evidence provided by the police and medical professionals and that as a consequence the role of the Court in suicide prevention is undermined.

Our view that all suspected suicides should be subject to inquest is based on our experience of the poor quality of evidence provided to Coroners by the police and medical and other professionals and the impact the absence of sound evidence has on the quality of Coroners findings and recommendations.

We note that in the Ministry of Justice review of the family court, an examination of a sample of file types was undertaken to identify key issues and inform the development of proposals for reform. We are confident that a review of Coroners Court files would show the extent of the misinformation provided to Coroners in police and medical files and highlight the fact that the testing of evidence at inquest is essential to ensuring that findings are accurate and recommendations based on sound evidence.

The Coroner's Court employs an inquisitorial rather than adversarial process. It is our view that if the role of the Coroner is to conduct an inquiry with a view to preventing future deaths, he or she must be more than a passive recipient of the information gathered by the police. The Coroner must ensure all lines of enquiry are pursued, all relevant evidence gathered and accurately recorded, assess the credibility of the evidence, determine relative weight to be given to conflicting evidence and satisfy themselves, the parties and the public that their findings and recommendations are based on a thorough investigation of all relevant information.

A key feature of inquisitorial processes is the role of the Judge in actively seeking and critiquing evidence. The Public issues Committee of the ADLS describes an inquisitorial process as "based upon seeking the truth, where the Judge inquires actively into the facts..."[11] The Law Commission describes the role of a Judge in an inquisitorial system as an active role in which "he or she may interview witnesses before trial; direct further lines of investigation; decide which witnesses should be called at trial; and play the dominant role at trial, including doing most of the questioning." [12]

It is not our experience that Coroners take the active role in suicide inquiries described by ADLS and the Law Commission. Given the poor quality of the evidence provided to Coroners by police and medical professionals, it is our submission that the adoption of this role by Coroners is essential to ensure investigation findings represent the truth, inquisitorial processes are designed to seek.

CASPER can provide numerous examples of police reports and medical files of suicide victims where the name, age, family circumstances and other basic information about the child who died from suicide are incorrect. We can provide evidence that police frequently fail to collect phone and text records of the deceased, destroy evidence present at the scene and fail to interview families and those who last saw the deceased alive. We can provide files where DHBs have recorded meetings with suicide victims after they have died.

Our experience is that when subject to cross examination, the information provided to the Coroner by the Police and Medical profession is often found to be inaccurate, incomplete and at times deliberately misleading. Without testing this evidence, the issues with its credibility would not be uncovered and the findings and recommendations of the Coroner would be informed by an unsafe evidential base. In many cases, the fact that the evidence provided in police and medical files is incorrect only occurs because families conduct their own inquiries and pro-actively place the evidence before a coroner who is often reluctant to receive it.

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11 Paper issued by the Public Issues Committee ADLS, 20 June 2002.

12 New Zealand Law Commission, 2012, Alternative Trial Processes Consultation retrieved from http://www.lawcom.govt.nz/book/export/html/2249

We are aware that where families express a wish for an inquest into their loved ones death, this is generally granted. We repeatedly hear from families however that they are actively discouraged by Coroners and Coronial Services staff from requesting an inquest.

This is generally done on the grounds that an inquest is unnecessary and that it will cause undue distress to the family 'who do not need to put themselves through that'. In the face of the submission of the Coroner's Council to the Law Commission that

> *Concerning suicide inquests, it is the experience of Coroners' Council members that family attending suicide hearings frequently obtain comfort and benefit from the process.*

we assume that pressure being applied to Coroners to dispose of cases quickly and cheaply, is overriding their desire to provide families with the comfort and benefit they know inquest hearings can bring.

We do not know of any families who have been provided with information on the benefits of going to inquest. We do however know many families who bitterly regret not having requested that an inquest be held, not having provided a list of witnesses they would like to question and not having put evidence they consider is critical to an understanding of their loved ones death before a Coroner. Many feel their one opportunity to get the answers they need has been lost forever because they were discouraged from requesting or attending an inquest or provided with insufficient support to participate to the extent they wished.

Notwithstanding the comment made by current Attorney General Chris Findlayson during debate on the Coroner's Act 2006 that

> *Coroners obviously cannot be permitted to cut corners in order to reach a quick result* [13]

we are concerned that the backlog of cases in the Coroner's Court has given rise to pressure being applied to Coroners to dispose of cases quickly and to prioritise timeliness over quality and support for families.

13 Coroners Bill — Second Reading Hansard and Journals Hansard (debates) [Volume:630;Page:2664] 2 May 2006 http://www.parliament.nz/en-NZ/PB/Debates/Debates/6/3/e/48HansD_20060502_00001310-Coroners-Bill-Second-Reading.htm

Data Reporting and Analysis

In addition to decreases in data gathering, the aims of the Coroner's Act are undermined by government departments reporting conflicting data. The obvious example is the discrepancies in the data collected and reported by the Chief Coroner and the Ministry of Health on suicide deaths.

We are repeatedly advised that the differences between the numbers reported by Coronial Services and the Ministry are a result of different reporting periods and the fact that the Chief Coroner reports provisional data. In our view, these are red herrings. In particular, the claim that the difference reflects the fact that the Chief Coroner's data is provisional holds no weight when the Ministry's data also clearly states it is provisional, excluding those suspected suicides which have not yet reached inquest.

The fact that the Ministry of Health announced in 2010 that the number of suicides in 2008 for example was 497 but subsequently changed that figure to 520 in 2012 shows the Ministry's figures are just as provisional as those of the Coroner. We consider the Ministry's practice of reporting data which excludes approximately 5% of cases and claiming their figures are both official, and reflect a reduction on the previous year's figures is deliberately misleading. Standardised reporting of suicide figures and clear statements about what deaths are included or excluded from the figures is necessary to ensure trends and patterns can be identified.

The Chief Coroner and the Department of Corrections also differ on their numbers of apparent suicides amongst prisoners, with the following figures being released by each

	Suspected Suicides	
Year	Chief Coroner	Corrections
2007/08	4	4
2008/09	3	4
2009/10	5	6
2010/11	9	10
Total	21	24

John Langley of the Injury Prevention Research Unit (IPRU) in Dunedin submitted to the Law Commission that the ongoing systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event . . . is used in planning, implementing, and evaluating interventions and programs which impact on the health of the public and that such data are used both to determine the need for public health action and to assess the effectiveness of the programs.[14] The provision of conflicting figures by the Chief Coroner and Ministry of Health does not assist this process.

CASPER applauds both the establishment of a national coronial database and the practice of the Chief Coroner in releasing annual suicide statistics. We believe the Chief Coroner's collection and reporting of this data has done much to raise awareness of suicide in New Zealand and to engender a sense of urgency around suicide prevention which has been lacking during the time the Ministry of Health were the sole providers of suicide data.

We have however four concerns in respect of data collection in the Coroner's Court. These are that

- important data is not being captured;
- some of the data collected is not reported;
- data being collected is not subject to in-depth analysis; and
- data is not freely available to the public

The Courts Case Management System (CMS) contains a range of data fields which include:

- Name
- Date of notification of death
- Age
- Sex
- Date of birth
- Place of usual residence
- Period of residence in New Zealand
- Country of birth
- Employment status
- Usual occupation
- If a work-related incident
- Occupation at the time of incident
- Industry at the time of incident
- Marital status
- Ethnicity
- Sexual Orientation
- Time/location of incident

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- ❍ Activity at time of incident
- ❍ Intent (both suspected at time death reported and final)
- ❍ Mechanism of injury (primary, secondary and tertiary)
- ❍ Object or substance involved (primary, secondary and tertiary)
- ❍ Medical cause(s) of death (as specified in post mortem report)
- ❍ Coroner's provisional and Final Finding as to cause(s) and circumstances of death
- ❍ Where the death is related to a motor vehicle accident:
  - vehicle type
  - driver/passenger
  - Counterpart
  - context
  - user

Additional text field summaries are used for location events. They include a brief synopsis of the following reports:

- ❍ Police narrative of circumstances
- ❍ Witness testimony
- ❍ Toxicology report

CMS also contains the following additional coded fields:

- ❍ ICD-10 Cause of Death codes (underlying cause codes)
- ❍ ICECI external causes of injury codes

From 2007, New Zealand Coronial Reports have been uploaded to Australia's National Coronial Information System (NCIS). Access to Coronial de-identified closed case information, requires an annual subscription to Australia's NCIS, with the Coronial Services website advising the data will not be available until late 2012 and that applications for direct online access to NCIS data are required to be approved by the Research Ethics Committee. Alternatively, the NCIS team will conduct a search of the NCIS to retrieve data at the hourly rate of $110 AUD.

The website advises that "alternatively, researchers and external government agencies with a bona fide interest in de-identified data, may contact the Office of the Chief Coroner." Our experience however is that requests for anonymised data in respect of suicide deaths are declined by the Chief Coroner, and that this is done without reasons being provided.

We are pleased to note that the Chief Coroner, in his recent speech to the Asia Pacific Coroner's Coference recognised the need to ensure closed case information is available to New Zealanders free of charge in the future.[15]

New Zealand Coroners have identified prescription drugs as being implicated in suicide. Their concerns are supported by findings in clinical trials that a range of prescription drugs induce suicide and at least double the risk of suicide in those who use them. Following a meeting to discuss the role of SSRI antidepressants in suicide cases with Coroner Ian Smith in 2008, the New Zealand Medicines Adverse Reactions Committee "recommended that a formal request be made to the Coroner's Office to forward the decisions relating to medication related cases directly to the NZPhvC."[16]

The Chief Coroner estimates that a third of suicide victims had current prescriptions for psychiatric drugs at the time of their death in the same year.[17] In the United States, these drugs come with the FDA's highest warning of lethality, the Black Box Warning, advising they may cause worsening depression and suicidality. We note that we are advised that reports are not governed by any direction from the Chief Coroner but are at the discretion of individual coroners. Their utility is limited therefore in that they do not provide a complete dataset.

Given the strength of evidence that these drugs are causally associated with suicide, we believe that the failure of the Coroner's Court to systematically collect data on prescription drug use is a significant gap in data collection. Similarly the use of legal drugs (such as alcohol and over the counter pain killers) and illegal drugs are associated with suicide and we believe data on their use by suicide victims should be collected and analysed.

CASPER is currently working with four families whose children suicided suddenly on the antibiotic Doxycycline, prescribed for mild acne. The New Zealand Centre for Adverse Reaction Monitoring has recently published research showing a causal link between smoking cessation drug Champix (Venlafaxine) and suicide. The links between anti-acne drug Isotretinoin (Isotane, Orotane, Accutane, Roaccutane) and suicide are well documented. There is good research evidence to suggest these drugs (along with a range of other commonly prescribed drugs) are causally linked to suicide. Some of these suicide cases have been to inquest. Had Coroners published information on drugs being taken by those dying by suicide in the year they occurred, the subsequent deaths of others may have been avoided.

15 Judge Neil Maclean Chief Coroner of New Zealand Asia Pacific Coroners' Society 2012 Conference An Inquisitorial Cuckoo in an Adversarial Nest: Five Years of Coronial Reform in New Zealand

16 MEDICINES ADVERSE REACTIONS COMMITTEE 136th Meeting - 11 December 2008 MEETING MINUTES

17 Correspondence between Chief Coroner and a Mediaworks journalist.

The Chief Coroner is on record as stating that relationship breakdown is the leading cause of suicide. We believe data on relationship breakdown, financial pressure, school and work difficulties, bullying and a range of other factors known to trigger suicide should be collected by the Coroner's Court. This information would assist with building a picture of suicide in New Zealand and inform suicide prevention strategies.

The Chief Coroner has been clear in his statements to the media that parents are telling him they needed to know more about the subject of suicide. He is quoted as saying:

> *They (parents) are saying, 'we need to know more about this. What is normal behaviour, when do we press the panic button, what can we do?' This is coming through very strongly now.*[18]

We believe the appropriate response to this request is the collection, analysis and reporting data to assist families and communities to identify and address social and environmental factors associated with suicide. We hear many families whose loved ones suicide following a relationship break up lament the fact they had no idea a broken heart could be fatal. Similarly, families whose loved ones suicide on prescription drugs feel betrayed they did not know these drugs could induce suicide. The information families and communities are seeking to protect their members from suicide is available from the Coroners Court. It should be shared.

Of the data currently collected by the Coroner's Court, we consider there are three important pieces of data which are are not being reported. These are:

- substance involved;
- sexual orientation; and
- time of residence in New Zealand

It is our view that, in line with his educative role, the Coroner should report information on the substances involved in suicide. We believe that information such as that on the increasing use of Helium in suicide, could save lives. We consider that in the face of the refusal of the Ministers of the Environment and Consumer Affairs to reclassify and restrict the sale of Helium, public knowledge of the role and prevalence of this substance in suicides is necessary.

The collection of data on the sexual orientation of suicide victims is important to determine the level of risk and to inform suicide prevention strategies for the New Zealand LGBT community. The current figures published by the Chief Coroner and the Ministry of Health render this community, which international data suggests is particularly vulnerable to suicide, invisible.

18 Timaru Herald 16 June 2012 Coroner calls for more openness of suicide

Data on time of residence in New Zealand could provide important information on the suicide risk for new immigrants to New Zealand and may suggest suicide prevention strategies to families and agencies supporting new arrivals.

Implementation of Recommendations

Section 9 of the Coroners Act defines "specified recommendations or comments" as recommendations or comments by the coroner on:

(a) the avoidance of circumstances similar to those in which the death occurred:

(b) the way in which people should act in circumstances of that kind.

CASPER sympathises with the frustration reported by the Chief Coroner in the following statement

> *We do get responses to recommendations, but in a number of areas, I think coroners are feeling a sense of frustration that what they're saying seems not to be making any difference.*[19]

Families who participate in inquests for the primary purpose of ensuring the lessons that can be learned from the suicides of their loved ones are used to inform change, are equally frustrated that Coroners recommendations are largely ignored by those to whom they are directed.

They are even more frustrated that agencies claim to have implemented recommendations where the evidence is clear that they have not done so. A review of Coroners recommendations supports our experience that suicide deaths frequently occur in circumstances which mirror those previously dealt with by Coroners and which have been the subject of Coroners recommendations for change.

We believe that these refusing to implement the recommendations of Coroners should be required to provide reasons in writing and that, as in other jurisdictions, these should be published. We further believe that where agencies claim to have implemented recommendations, independent verification of this should be obtained.

It is however our view that where a Court identifies failings which if remedied may save lives, it should be empowered to make more than recommendations. We note that the relatively minor matters dealt with in other tribunals including the Disputes Tribunal, result in legally enforceable orders and consider it insulting both to the families of suicide victims and to Coroners that their power to effect change is limited to making recommendations only.

Training for Coroners

In its review of the Coroners Court, the Law Society recommended that the Department for Courts establish suitable post-appointment and ongoing training programmes for coroners and that the Chief Coroner's role be to monitor and further develop training programmes. We imagine the Commission

19 TVNZ Q+A: Transcript of Chief Coroner Judge Neil MacLean http://tvnz.co.nz/q-and-a-news/transcript-chief-coroner-judge-neil-maclean-4884956

expected this training would be developed and delivered by the Institute of Judicial Studies in collaboration with the Chief Coroner.

The stated aim of the Institute of Judicial Studies is to provide education, training and information that enables judges to achieve the following goals.

- To fulfil the constitutional role of the judiciary and uphold the rule of law.
- To advance and enhance the personal and professional skills required to perform their roles effectively.
- In the case of newly-appointed judges, to perform their duties with confidence and create a platform for their judicial career.
- To gain the skills and knowledge they require to operate effectively in their generalist and specialist jurisdictions.
- Where appropriate, to gain the skills and knowledge required to work effectively in solution-focused courts and to translate the solution-focused approach into the mainstream courts.
- To operate within the principles of the Treaty of Waitangi with an understanding of New Zealand conditions, history and traditions.
- To orient to the current and changing diversity of New Zealand communities.
- To operate effectively in an increasingly complex international legal environment.

In addition to meeting the education and training needs of judicial officers, the Australian Law Commission makes the point that collegial interaction is enhanced by judges, magistrates and tribunal members sharing experiences and discussing common problems and successful (or sometimes unsuccessful) outcomes during training.

Given the aims of the Institute of Judicial Studies and the clear benefits of training, we are not surprised that the Chief Coroner

> *was a little bemused and indeed continued to be that the Institute of Judicial Studies does not consider it part of its mandate to provide [training] for Coroners, so had to do it [him]self.* [20]

We think it is inappropriate that the head of bench of a court whose purpose is to save the lives of New Zealand citizens, reports having to develop and run training for his judicial officers without the support of the Institute . We congratulate the Chief Coroner on maintaining a twice yearly residential training regime but are concerned at his comment that

20 Speech Notes for Public Lecture NZ Centre for Public Law Wednesday 20 July 12.30 at Victoria University Law School, Government Buildings, 15 Lambton Quay Wednesday, 20 July 2011, 12.30pm REFLECTIONS ON THE FIRST FOUR YEARS OF THE CHIEF CORONER UNDER THE CORONERS ACT 2006

This is quite expensive and time consuming and I'm not sure that we can continue with it."[21]

We believe that as with all other benches, information about the training programmes undertaken by Coroners should be made public. We believe this would enhance public confidence in the Coroners Court.

The Chief Coroner has repeatedly stated in the media that Coroners are not experts on suicide but responsible only for ascertaining the facts in relation to suicide deaths.

> *I am concerned that we seem to be making no impact - there has been no visible downward trend at all. Our job is to tell the public the facts - I am no more qualified to suggest an answer or a solution than anyone,*[22]

While it is not expected that Coroners become suicide experts, it is necessary that in conducting inquisitorial proceedings Coroners have an understanding of the causes of suicide in order to ensure the appropriate lines of inquiry are followed, all relevant evidence is gathered and the right questions are asked.

We note that the Principal Youth Court Judge takes a different view of his role and often suggests solutions to the issue of youth suicide. We consider that heads of specialist courts *are* in fact qualified to suggest solutions to the issues their Courts deal with and should be using the data gathered by their courts to do so.

We are concerned that despite growing evidence that suicide is a social, not mental health issue, Coroners continue to conduct their inquiries based on the erroneous belief that suicide and mental illness are synonymous. The recent report of the Chief Coroner reflects this view in having the heading 'Mental Illness' in his report with the instruction underneath to 'see self-inflicted deaths'[23] We think training on issues associated with suicide, similar to training on sexual cases, be provided to Coroners.

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21 Speech Notes for Public Lecture NZ Centre for Public Law Wednesday 20 July 12.30 at Victoria University Law School, Government Buildings, 15 Lambton Quay Wednesday, 20 July 2011, 12.30pm REFLECTIONS ON THE FIRST FOUR YEARS OF THE CHIEF CORONER UNDER THE CORONERS ACT 2006

22 Rebecca Quilliam Coroner lashes out at suicide reporting rules 8:50 PM Friday Oct 26, 2012

23 http://www.justice.govt.nz/courts/coroners-court/documents/Recommendations%20Recap%20-%20Issue%202.pdf

The Law Commission has acknowledged that

> *In difficult areas such as sexual offending, where there is a great deal of community misunderstanding and prejudice, it is highly desirable that judges have appropriate training in that particular area before presiding over trials in that area.*[24]

The commission argues that

> *Moreover, in the absence of any training or additional information, they may approach particular sorts of cases (notably sexual violence and family violence cases) with some of the array of myths and prejudices about such offending that jurors will bring to the task.*[25]

We believe suicide is one of those areas characterised by misunderstandings, myths and prejudices, We consider that the reasons provided by the Commission for providing specialist training to judges in sexual violence and family violence cases, applies equally to the need for training for Coroners on the issue of suicide.

We consider the use of psychological autopsies rather than sociological autopsy methodologies to be an example of the Coroners Court falling victim to myths about suicide.

Support for families

The Law Commission has acknowledged that

> *consultation with the family is essential in enhancing the mutual interest both of the coronial process and the family in ascertaining the cause of death.*[26]

And that

> *the conveyance of accurate and ongoing information is essential for communication with the family to be effective.*[27]

24 Law Commission 2012 Alternative Trial Processes Consultation 3D Specialist Judges retrieved from http://www.lawcom.govt.nz/content/3d-specialist-judges

25 Law Commission 2012 Alternative Trial Processes Consultation 3D Specialist Judges retrieved from http://www.lawcom.govt.nz/content/3d-specialist-judges

26 Law Commission Report 62 Coroners

27 Law Commission Report 62 Coroners

The Commission noted that Coroners often relied on police or funeral directors to provide information to families on coronial process and expressed concern that this often resulted in families receiving conflicting or inadequate information. The Commission stated a view that a co-ordinator located in the coroner's office would be best placed to assist the coroner in providing information to the family as well as in conveying the wishes of the family to the coroner.[28]

Despite the Law Commission's recommendation that "that the family receives accurate information and ongoing advice concerning the coronial process"[29], CASPER regularly receives reports that communication from Coroners Co-ordinators is poor or non-existant. Frequently families are not informed that pre-hearing matters have been set down and find when they call the co-ordinator after lengthy periods of silence, that a date has been set and is only a few days away.

Pre-hearing meetings, hearings and the release of decisions occur with remarkable frequency on the birthday or anniversary of the death of a child who has died from suicide, causing considerable and unnecessary distress to families. Inconsistent and inaccurate advice about Coronial processes is often received from Coroner's Co-ordinators who are not forthcoming in offering families information about their rights and entitlements. No information on applying for assistance with travel costs or witness fees for families attending inquest is provided on the Coronial Services website, nor are we aware of any families being advised that they may apply for it.

CASPER is aware of a number of cases of suspected suicide where bereaved parents have expressed concern about attending, or elected not to attend, an inquest where they have been subject to domestic violence by their deceased child's other parent. Even where current protection orders are in place, Coroners insist invite both parents to attend pre-inquest meetings and inquests, often without notifying the protected person that the respondent will be present. Our recent request to the Coroners Court for information on processes in place to ensure the safety of these women while attending inquests was that Court Security Officers could monitor their physical safety but that no mechanisms existed to protect their emotional safety.

In those whose death of a loved is being heard in criminal courts, families attending inquest do not qualify for the support available from Victim Court Advisers. In 2010, CASPER wrote to the Minister of Justice about our concerns that families attending inquest received no financial support, shared waiting rooms with those they believe caused the death of their loved ones, have no tea or coffee making facilities, no access to parking and no one to show them around the courtroom and that where families are represented by a lawyer, they are without any support during the time they are giving evidence and their lawyer is prohibited from having any contact with them. We received no response on these issues from the Minister.

28 Law Commission Report 62 Coroners

29 Law Commission 2000 NZLC R62 Coroners

We believe that the role of Coroner's Co-Ordinators should be expanded to include the duties of the Victim Court Adviser which include

- advising families about their rights in the court process;
- helping families participate in the court system

We believe the Ministry of Justice should provide appropriate facilities for families attending inquest and that protocols for ensuring the safety of victims of domestic violence in coronial processes be developed.

The legislation governing the conduct of Coroners in Western Australia provides them with powers to ensure that that witnesses are always treated with respect and in accordance with the principles of procedural fairness. CASPER believes a similar provision is required in New Zealand given the numerous reports we receive of families and their dead loved ones being treated with disrespect by Coroners and others in inquiry processes and inquests.[30] We are happy to provide the Ministry with correspondence received by clients on this issue along with contact details for the many CASPER families willing to share their experiences.

Timeliness

In 2011 the Chief Coroner stated at a public lecture that

> *The Ministry and I were somewhat taken aback when it was appreciated when the first ever real national stock take of work in progress was done just prior to the implementation to the Act on July 1, 2007, that there were over 2500 cases in the system.*[31]

Data provided to CASPER by Coronial Services shows that at 30 April 2012 there were 3409 active cases in the system with the oldest of these cases having a date of death of December 2005 and a signficant number with a date of death in 2007. Clearly this 36% increase in outstanding cases shows the new regime which provides for full time coroners has not addressed the issue of timely resolution of cases before the Coroner's Court.

30 Peter Dodd, Public Interest Advocacy Centre (PIAC) Western Australia: an opportunity to take the lead on coronial law reform 24 August 2011

31 Speech Notes for Public Lecture NZ Centre for Public Law Wednesday 20 July 12.30 at Victoria University Law School, Government Buildings, 15 Lambton Quay Wednesday, 20 July 2011, 12.30pm REFLECTIONS ON THE FIRST FOUR YEARS OF THE CHIEF CORONER UNDER THE CORONERS ACT 2006

The views of CASPER families on the optimal timeframe in which investigations into their loved ones deaths are investigated by Coroners varies. While some families find delays of 2-3 years increase their distress, a larger number of the families we work with are concerned that early hearing of their cases provides them with insufficient time to regain their functioning following the trauma of the sudden and often violent suicide of their loved one and prepare for inquest.

Many families, whose inquests have been scheduled within a few months or a year of the death, either declined to attend or were unable to participate in the inquest to the extent they wanted answered because shock and trauma were too fresh for them at the time the hearing was scheduled. One of the characteristics of suicide is that it frequently occurs in the home and that as a consequence, family are generally first on the scene. The trauma experienced by families of finding the body of their child, spouse or parent following what is often a very violent death renders many incapable of even basic functioning for a long period of time.

The delays of concern most frequently conveyed to us, are those which families often experience in receiving findings many months after the inquest has been completed.

Consistency, Quality and Accountability

During debate on the new legislation, Courts Minister Rick Barker stated

> *There will be fewer coroners in the new system, but they will be well trained and work closely together to deliver a consistent, high-quality standard of practice. At present, most coroners deal with only a small number of cases a year. Moving to a system of largely full-time positions will enable coroners to develop greater expertise, and will improve the timeliness of inquests and the release of coronial findings. Full-time coroners will also have more time to undertake public education and develop closer relationships with other investigating authorities*

There are a number of signals that Minister Barker's vision has not been realised. These include the concerns about timeliness, consistency, implementation of recommendations and inter-agency boundary issues which underpin this reivew, the backlog of cases and the comments of the Chief Coroner on "resistance to changing old practices both by some Coroners and other stakeholders such as Police and Pathologists.[32]"

The Law Commission's review of the Coroner's Court proposed a range of roles for the Chief Coroner including

- monitoring consistency and investigatory standards

32 Judge Neil Maclean **Chief Coroner of New Zealand Asia Pacific Coroners' Society 2012 Conference** An Inquisitorial Cuckoo in an Adversarial Nest: Five Years of Coronial Reform in New Zealand

- ensuring that coroners are properly trained
- maintaining an overview of patterns of sudden deaths and their fundamental causes and considering whether additional inquiries are required; and
- reporting regularly to the Ministers of Justice and Health with particular emphasis on patterns of circumstances leading to death or risk of death and the steps needed for their prevention or reduction.[33]

In the absence of the provision of an annual report from the Office of the Chief Coroner, it is impossible for the public to know what work has been done in these areas.

Practice Notes, Guidelines and Protocols

Section 7(h) of the Coroners Act empowers the Chief Coroner "to help to inform and achieve consistency in coronial decision-making and other coronial conduct by issuing practice notes" The Law Commission proposed that the role of pathologists and police are appropriate subject matter for guidelines or protocols to be developed by the Chief Coroner.

We agree that development of such guidelines and protocols is essential to ensure consistency and to address the current issues in relation to the processes employed by Coroners, Pathologists and Police.

We are however advised by the Ministry of Justice that the Chief Coroner has issued no practice notes, despite his publicly expressed concerns about the reluctance of Coroners, pathologists and police to adopt modern practices and the review of media guidelines on suicide concluding that

> *Rather than amending the Coroners Act to allow for more open reporting the Committee has discussed with the Chief Coroner the possibility of him issuing a practice note on this matter.*[34]

We consider there are a number of issues on which the Chief Coroner could promote best practice and consistency through the issuing of Practice Notes, guidelines and protocols.

Developments in the understanding of the role of genetics, toxins and disease in suicide and a lack of consistency and best practice in suspected suicide autopsies, mean guidance around post-mortems should be developed by the Chief Coroner. We note that best practice standards in post mortem examinations of suspected cardiac, SUDI and other deaths have been developed but that none have been developed for suicide. Those protocols currently in existance for other causes of sudden and unexpected death require that pathologists:

33 Law Commission 2000 NZLC *R 62* Coroners

34 Ministerial Committee on Suicide Prevention Report to the Prime Minister, Rt Hon John Key Review of the restrictions on the media reporting of suicide 4 November 2010

1, Examine all cases of sudden unexpected or unexplained death in the young (particularly in the

age group of 0-40 yrs)

2. Investigate the possibility of familial disease

3. Educate, inform and communicate with the family in an open and timely manner.

4. Save DNA or other tissue to allow greater diagnostic accuracy either currently or in the future.

5. Preserve data and tissue to facilitate the prospect of future clinical diagnosis and research into causes of sudden death in accordance with local legal, ethical and cultural frameworks

6. Use a multidisciplinary approach, which utilises the requisite specialist skills of allied clinical

and scientific disciplines, to evaluate all available information likely to identify the underlying

factor(s) responsible for the sudden and unexpected death.

7. Record sufficient diagnostic data from which the incidence of sudden death and related health trends can be determined.[35]

The protocols require consistency and a team approach to post mortem examinations, laboratories with molecular genetics, toxicology and metabolic expertise, detailed antecedent clinical history and relevant family history be obtained, establishment of early ongoing family liaison until a cause of death is ascertained, skilled macroscopic and microscopic examination of the organs and the brain, collection and retention of adequate histological material, collection of tissue or blood suitable for DNA extraction and results clearly documented, described and annotated in a standard fashion to allow epidemiological data gathering.[36]

35 Post-mortem in sudden unexpected death in the young: Guidelines on autopsy practice Prepared by the members of Trans-Tasman Response AGAinst sudden Death in the Young (TRAGADY) Endorsed by the Royal College of Pathologists of Australasia May 27t 2008 Officially Endorsed by the National Heart Foundation of New Zealand August 25th 2008

36 Post-mortem in sudden unexpected death in the young: Guidelines on autopsy practice Prepared by the members of Trans-Tasman Response AGAinst sudden Death in the Young (TRAGADY) Endorsed by the Royal College of Pathologists of Australasia May 27t 2008 Officially Endorsed by the National Heart Foundation of New Zealand August 25th 2008

In 2011 CASPER approached the Royal College of Pathologists of Australasia to request the development of guidelines or protocols for the investigation of suspected suicides and outlined our concerns about current practice. In response the College advised:

> *The concerns and issues raised by CASPER (Community Action on Suicide Prevention Education & Research) are noted by the Forensic Pathology Advisory Committee of The Royal College of Pathologists of Australasia. Within the Coronial system forensic pathologists have the role of performing an examination of the deceased primarily to determine the cause of death, but it is the Coroners who determine manner of death and how a case is investigated to reach that determination. Therefore, any discussion of guidelines for investigation of apparent suicide requires the Coroners to be included. Thus, a broad consultative approach by an appropriately formulated body involving all interested parties (which would include College representation) is suggested before any guidelines are proposed.*[37]

The scope and consistency of data currently gathered in post mortem examinations of suspected suicide victims would, in our view, benefit from the Chief Coroner working with the Royal College of Australasia and families bereaved by suicide to develop guidelines on investigation of suspected suicide.

We are concerned that the Law Commission's view that there is need for a review of the training and support which police officers who work within the coronial system receive, has not been implemented. We consider this a matter of urgency and again believe that given investigations are undertaken on behalf of the Coroner, this is a matter which should be led by the Chief Coroner.

When someone dies in an apparent suicide, the police investigate the death on behalf of the Coroner. Our experience, and our discussions with Police, indicate that they have no specific training on investigating suicide and do not conduct thorough investigations.

We are told by police that the presence of common suicide tools such as a noose or hose pipe from an exhaust to the interior of a car, mean a view is formed immediately that the death was a suicide and the police see no need for in-depth evidence gathering or investigation.

The Coroner's Act is clear that only the Coroner can determine whether a death was a suicide and that this is not a determination the police should make. Their job is to assist the Coroner in ruling out other causes of death including homicide, assisted suicide or accidental death. Further their role is to assist the Coroner in ascertaining the circumstances leading to the suicide.

37 Correspondence from Dr Debra Graves, CEO, Royal College Pathologists of Australasia Dec 2011

We believe Coroners need to establish best practice standards for suspected suicide investigations and be pro-active in ensuring Police provide them with complete investigation files which reflect thorough investigations. It is our view that Coroners need to challenge the police practice of investigations being informed by a view of the cause of death established by police at the scene. We submit that Coroners need to be more pro-active in requiring Police to undertake further investigations where files are incomplete or there is evidence that relevant lines of inquiry have not been pursued.

The Law Commission commented that

> *It has been the experience of paediatricians that there is inadequate effort in the investigation of deaths in childhood in collecting 'at the scene' information and little careful taking of a medical history and in particular the environmental issues that might illuminate the preventable aspects of any death. Such an analysis can only be done by a multi-disciplinary team.*[38]

The Commission further reports that

> *Similarly, in the context of investigations into road fatalities, Drs John and Margaret Bailey submitted that the current coronial system includes little investigation of human factors: The medical cause of the death is examined in great detail, but what led to that death is not covered adequately. Even when an inquest is held, some coroners' reports consist simply of witness reports plus a brief police report, with no or hardly any interpretation by the coroner. Recent police reports look in detail at factors such as estimation of speed, roading, weather and so on, but with little investigation of human factors. The latter are considered by international researchers and ourselves to be much more important in causing accidents than the former factors.*

This mirrors the experience of CASPER who in reviewing the investigations undertaken by the police in respect of suicide victims repeatedly find evidence destroyed or not collected, inadequate interviewing of key informants including those first on the scene and family members, failure to collect and preserve exhibits and refusal to gather medical evidence, phone and computer records despite families offering this evidence to the police. We are happy to provide documentary evidence of these events to the Ministry of Justice.

In its submission to the Law Commission, the Ministry of Health suggested that consideration be given to whether some type of auxiliary investigative body attached should be attached to each coroner's

38 Law Commission 2000 NZLC *R 62* Coroners

office. They suggested that the need for such a body arises from the reliance of coroners on police to gather information often results in a limited investigation due to police resource constraints.[39]

We note the comments of the Public Interest Advocacy Centre in their submission on reform of the NSW Coroners Act that in discussing the limitations of police investigations. In discussing a case in which the Coroner found the death was primarily the failure of a health service to provide care, but where the police investigation did not include any inquiries into the healthcare provided to the victim. They comment

> *The police are not experts in health care matters. Had there been a specialist health care related investigation team in NSW, they would have at least been able to advise the police and the Coroner that there were questions to ask about [the deceased's] health care.*[40]

Our experience is that the police avoid investigation into the role of health care professionals into suicide deaths and that Coroners, who are also not experts in suicide or health care issues, would benefit from the availability of a multidisciplinary team to assist in identifying potential lines of enquiry, conducting investigations and providing expert reports.

While we acknowledge that such a body would involve additional cost we consider that the potential for proper investigation to contribute to reduction in the economic cost of suicide and the benefits of an independent investigation, mean such a body could ultimately reduce both the social and financial costs of suicide.

We agree with the authors of the Irish review of coronial systems that

> *In the allocation of scarce resources, society perhaps has not always fully appreciated that the Coroner performs a public service by making enquiries into sudden and unexplained deaths independently of the medical profession, the Gardaí,(police) the State or any parties who might for whatever reason have an interest in the outcome of death investigation.*[41]

We submit that the benefits of independent investigators apparent in workplace and air traffic deaths would also be realised in investigations into suspected suicides.

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39 Law Commission 2000 NZLC *R 62* Coroners

40 Peter Dodd, Public Interest Advocacy Committee **Western Australia: an opportunity to take** the lead on coronial law reform **24 August 2011**

41 Department of Justice, Equality & Law Reform, 2000 Review of the Coroner's Service: Report of the working Group retrieved from http://www.justice.ie/en/JELR/ReviewCoronerService.pdf/Files/ReviewCoronerService.pdf

Sociological Autopsy

> *When hundreds of people die slowly, alone and at home, unprotected by friends and family and unassisted by the state, it is a sign of social breakdown in which communities, neighbourhoods, governmental agencies and the media charged with signalling warnings are all implicated.*[42]

The psychological autopsy method was designed to assist Coroners to determine intent in equivocal cases. As initially conceptualised, it was a broad gathering of information about the circumstances leading to a sudden deathy with a view to determining whether a death was a suicide and what lead the deceased to the desire to die.

As utilised in New Zealand Coroners Courts however, it is a mental health assessment on a dead person used to determine that the cause of suicide was mental illness, rather than the action or inaction of another person. Suicide experts Owens and Lambert explain:

> *Suicide research has relied heavily on the psychological autopsy method, which uses interviews with the bereaved to ascertain the mental health status of the deceased prior to death. The resulting data are typically interpreted within a clinical diagnostic framework, which reinforces psychiatric assumptions concerning the ubiquity of mental illness amongst those who take their own lives.*[43]

Psychological autopsies focus narrowly on the individual level factors using psychiatric conceptions of individual deficits have served to medicalise suicide and reduce social and environmental factors impacting on the deceased as mere triggers of pathology. Given that psychiatry defines disorders as including sadness, irritability, alcohol abuse, relationship difficulties, over-activity, underactivity, shopping too much, sexual infidelity, use of technology, outbursts of anger and failing to take prescribed medication as mental disorders, it is not surprising that psychological autopsies find mental disorders in almost 100% of cases.

It is this method which has led to research findings that over 90% of suicide victims are mentally ill. The approach has been widely criticised for lack of reliability and validity. The Coroners Act charges

42 Klinenberg, E. 2002 Heat Wave: A Social Autopsy of Disaster in Chicago. University of Chicago Press, Chicago.

43 Owens, C, Lambert, H 2012 Mad, Bad or Heroic? Gender, Identity and Accountability in Lay Portrayals of Suicide in LateTwentieth-Century England. Journal of Culture, Medicine & Psychiatry, 36:348-371

Coroners with the broad task of finding the causes and circumstances leading to suicide, not the narrow task of identifying individual deficits in the deceased. In our view, the Court is charged with conducting a sociological autopsy not a posthumous mental illness examination.

While a finding that someone was mentally ill and that this caused them to take their life, such an assessment can not be said to represent fact given the absence of biological tests for mental illness and the inherent flaws in conducting psychiatric assessments on people who are dead. Psychological autopsies do little to unravel the social factors contributing to suicide and measures required to prevent further suicides. They do much to obscure the real causes of suicide and perpetuate myths about suicide. They do much to frustrate and distress families who know that suicide is a behaviour not an illness, that their loved ones were not mentally ill and that ascribing all suicides to 'depression' does not represent a proper investigation of the causes of suicide.

As the Law Commission pointed out

> *Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context, it has progressively become evident that the fundamental causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by coroners.*[44]

We agree with the Law Commission that the Chief Coroner [is] well placed to oversee the system as a whole and assess how it should be further developed and has the potential to play an important part in achieving an expanded focus to the investigation of deaths.[45] We submit that the medicalisation of suicide and use of clinically focused psychological autopsy methods represents a narrowing rather than broadening of death investigation and ask the Chief Coroner to commission research on sociological autopsy processes.

Accountability for Action or Inaction

A key aspect which affects the perception of value of Coronial processes for families of suicide victims is the inability of Coroners to hold accountable any individual or organisation who contributed to the suicide of their loved one.

44 Law Commission 2000 NZLC *R 62* Coroners

45 Law Commission 2000 NZLC *R 62* Coroners

The Coroners Act acknowledges that the action or inaction of other people may contribute to sudden and unexpected deaths. It requires that Coroners consider this factor in deciding whether to direct a post mortem but prohibits Coroners holding accountable those who cause or contribute to suicide deaths. It allows Coroners only to make recommendations, few of which are implemented, and implementation of which cannot be enforced. It provides for name suppression for those professionals who give evidence in inquests. As such, it provides no deterrent to the negligence, poor practice and systemic failure that are often causal or contributory factors in suicide deaths.

Given families have no other options for either compensation or accountability, they feel let down by death investigations in the Coroners Court which do not involve the deterrent effect of penalties for those who have statutory or professional duties of care and fail to properly execute them.

As former Health & Disability Commissioner Ron Patterson explains

> *The Court of Appeal in Green v Matheson firmly shut the door on claims for compensatory damages arising from the way in which a patient had been dealt with by the health system: "whether the failures alleged be insufficient or wrong treatment, failure to inform, misdiagnosis, misrepresentation ... or administrative shortcomings", they amount to "medical misadventure" which triggers a statutory bar. Claims for exemplary or punitive damages are available, but it is not clear that even gross negligence by a health provider will lead to such an award; the only successful claim to date involved sexual abuse of a patient by a psychiatrist. The net result is that doctors and other health professionals are the fortunate beneficiaries of a system that looks to the state to compensate victims of medical negligence; they are not even required to contribute to the cost of state funding for the medical misadventure account*[46]

Opportunities for compensation of course, have been removed from families bereaved by suicide as a result of changes to the Accident Compensation Act. In addition, a recent decision of the new Health & Disability Commissioner indicates that the final remaining avenue for accountability, the HDC, is closing for families given his decision to refuse to investigate a complaint on the grounds that an inquest had already been held. This removed any opportunity for the family to have breaches of the Patient Code of Rights identified and the actions of the doctor involved in their son's suicide to be brought to the attention of the Medical Council.

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46 Ron Paterson Health and Disability Commissioner Patients rights in New Zealand: a tool for quality improvement? Paper delivered to 3rd National Health Care Complaints Conference Melbourne March 2001 http://www.hdc.org.nz/education/presentations/patients-rights-in-new-zealand-a-tool-for-quality-improvement

The investment families make in participating in inquests, their desire to ensure professionals are deterred from action or inaction which leads to suicide and the fact that the Coroners court is effectively 'toothless', lowers confidence in the system.

The confidence of court users is likely to be one of the best tools for the achievement of what David Baragwanath, president of the Law Commission sees as the necessity for Coroners "to capture the imagination and secure the confidence of the people of New Zealand that your work matters and warrants their support.[47] A system which does not provide deterrence, accountability or recompense for loss does not inspire confidence in its ability to prevent recurrence of adverse events. It is unlikely to be promoted or endorsed in the community by those who use it.

47 David Baragwanath How we got here: Law Commission Report 62 and the Coroners Act 2006" Coroners Orientation Programme 18 June 2007, Wellington

Media Reporting of Suicide

Restrictions on media reporting of suicide were tightened in the new Coroners Act 2006. This act requires that prior to a Coroner's findings, only the name and age of the deceased may be made public. After a Coroner's findings (if any) have been released, only the name, address and occupation of the person concerned and the fact that the Coroner found the death to be a suicide can be made public without a Coroner's permission. Families of those who have died by suicide are subject to the restriction that any person making public any other information without a Coroner's permission is committing an offence and could be fined in accordance with section 139(a) of the Coroners Act 2006."[48]

CASPER's views on the harm caused by restricting publication of information on individual suicides both to the public and to families bereaved by suicide are well documented. Unlike families of murder victims, our efforts to use our loved ones stories to prevent further deaths are punishable by fines of $1,000.

Rather than repeat our documented views in this submission, we attach the CASPER submission made to the working party who developed guidelines on media reporting of suicide. We note that following the publication of the new guidelines, our view and concerns remain unchanged.

We however wish to support the comments of the Chief Coroner that restrictions on media reporting of suicides do not reflect the wishes of families bereaved by suicide. Arguments supporting restrictions on the basis of protecting the privacy of families ignore the reality reflected in the following quotes from Judge McLean:

> *Parents also wanted the stories of their children who committed suicide told so lessons could be learnt and other parents didn't have to go through the same anguish. I am sensing people saying, please don't clam this up ... we want to know.*
>
> *What I'm picking up increasingly now is, families are asking for that. In the past they've been saying – please, this is a personal private tragedy, please don't publish anything, could you even restrict publication of the name. That's starting to change.*
>
> *"They will often say we don't want this to ever happen to other parents in a comparable situation."*[49]

We endorse the comments of Judge MacLean that

48 WHEN SOMEONE DIES A GUIDE TO THE CORONIAL SERVICES OF NEW ZEALAND DEC 2010

49 THE CHIEF CORONER AND SUICIDE REPORTING SPINZ 27 MAY 2011 HTTP://WWW.SPINZ.ORG.NZ/PAGE/157-MAY-2011+IMPROVING-SUICIDE-REPORTING-THE-CHIEF-CORONERS-VIEW

intense police and media scrutiny on drink-driving, dangerous driving and speeding had helped to reduce the road toll and it was "worth a try" to be more open about suicide, "because the current system isn't making any difference" [50]

We note that the Chief Coroner himself has recently authorised the media to report that the deaths of two people in Manurewa on 9 November 2012 are being investigated as a murder / suicide.

We are concerned and frustrated that despite the fact that there is widespread dissatisfaction and dissension on the issue of media reporting of suicide, neither legislative amendment nor the issuing of a practice note, which was promoted by the Minister as an alternative to such amendment, has occurred.

Review of Coroners Decisions

Under the Coroners Act 2006, a review of Coroners decisions can only be achieved through an application to the High Court. We consider that recourse only to judicial review in the High Court, puts families under significant financial pressure and agree with the authors of the Irish review of Coroners Courts that

Without prejudice to the role of judicial review for all parties in all aspects of the coroner system, an application for a review should be provided to the Attorney General in relation to a specified range of situations arising from a decision by a coroner.

The Irish review team acknowledged that coroners "make crucial decisions which may have a significant effect on the relatives, both at the time of a death investigation and for some time afterwards" and that

A coroner can be the subject of judicial review but this review is usually confined to matters of procedure only. Furthermore, judicial review can be expensive from the relative's point of view and is not particularly user-friendly for reviews not pertaining to a point of law.

50 EVAN HARDING FAIRFAX MEDIA 08/06/2012 CORONER WANTS MORE OPEN SUICIDE REPORTING HTTP://WWW.STUFF.CO.NZ/NATIONAL/7062995/CORONER-WANTS-MORE-OPEN-SUICIDE-REPORTING

In New Zealand, an application may be made to the Solicitor General to open an inquest where a Coroner has not done so or conduct a fresh inquest because of fraud, rejection of evidence, irregularity of proceedings, or discovery of new facts, or for any other sufficient reason.

The Irish review recommended that such applications also apply where

- a coroner concluded that death was due to natural causes and issues a certificate to the Registrar of Births and Deaths following the reporting of a death
- a coroner decided not to proceed with a post mortem
- disagreement exists over a coroner's procedural handling of a first inquest
- relatives or other interested parties were not satisfied with the verdict at a first inquest
- a coroner himself wishes to initiate a review.

It recommended that applications for review be referred to a Review Board who would advise the Attorney General whether an inquest or new inquest should be undertaken.

We submit that a board be established to review New Zealand Coroners decisions in the interests of public confidence and consistency.