National Council of
Women of New Zealand
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Wahine O Aotearoa

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Submission to the Justice and Electoral Select Committee on the Coroners Amendment Bill 239

The National Council of Women of New Zealand ("**NCWNZ**") is an umbrella group representing 288 organisations affiliated at either the national level or to one of our 21 branches. In addition to our organisational membership, about 260 women are individual members of branches. NCWNZ's function is to represent and promote the interests of New Zealand women through research, discussion and action. This submission has been prepared by the NCWNZ Justice and Law Reform Standing Committee and the Parliamentary Watch Committee after consultation with the membership of NCWNZ.

Policy

NCWNZ welcomes the opportunity to submit our members' views on the Coroners Amendment Bill ("**the Bill**"). NCWNZ policy dates back to 1896. That policy is continually reviewed through consultation with our members. We have always lobbied for the rights of women and their families, in particular for those in low paid jobs who are vulnerable.

This submission incorporates our members' personal and professional experience of the coronial process.

General comment about changes to the coronial process

NCWNZ members support the proposals to amend the law to help address some of the sensitive cultural, religious and familial concerns that arise after the death of a loved one and through the coronial process. Members supported the recognition of "interested parties" defined in the Bill to include family members (*Part 1, subpart 1, clause 9, amending section 9 of the Act by inserting a definition of "interested party"; Part 1, subpart 2, clause 16, substituting sections 23 and 24 of the Act*).

Processes for retaining and returning human tissue

There was strong support for the proposals to communicate with families throughout this process. As noted by one branch:

> "Part 1, subpart 2, clause 27, new sections 50(4)(a) to (g) covers the communication processes comprehensively in dealing with the what, why, when and the family rights of the issue of retaining or returning human tissue samples."

Many NCWNZ members recognised the cultural and familial importance of the deceased and the commensurate care that was required in respect of any samples taken; for example:

> "It is vital that the processes for retaining or returning human tissue samples should be improved in the sense of being more sensitive to the needs of families. There should be open discussions between the Coroner and the immediate family, so that there is clarity and understanding of the processes in place. This also gives the family time to ask questions or query about any concerns they have with the processes."

> "Awareness of cultural differences and customs pertaining to human remains and/or body parts needs to be double-checked. Local kaumatua should be consulted. The public hospitals have this link/network."

> "No tissue should be retained after the return of the body without that specific family permission. This must apply to all families not just the ones that the coroner's office thinks might have cultural sensitivities."

Changes to the coronial process for prison deaths

Clause 41 of the Bill replaces section 80, which concerns decisions to hold inquests. Under *new section 80*, the coroner is not required to hold an inquest into every death in official custody or care.

One branch responded to this proposal with the following concern based on professional experience:

> "I have been a nurse in a prison and knew how the prison worked. In fact, I knew the prison staff that testified.

> "I found that the testimony given by prison staff and management was incomplete and left out vital details. The prison version was skewed. The coroner's court could have asked more and deeper questions about the prevailing prison policies and too easily accepted that those were necessary in the name of staff safety. There could have been more of a challenge to the prison whether and how long ago these policies were reviewed and with a fresh eye.

"There could have been more of a challenge to the attitude of the prison staff that the occasional suicide was an unavoidable consequence of a challenging prisoner in custody."

Reporting suicides and exemptions

There are a range of measures in the Bill that are intended to provide a new regime for the reporting (or not) of suicides. We note that the proposals follow a comprehensive review by the Law Commission of New Zealand and that the Government has stated that it has adopted all of the Law Commission's legislative recommendations within the Bill.

Clause 38 (new section 71) establishes new rules about the publication of details of self-inflicted deaths. New section 71(2) provides that, if a death is self-inflicted, or if there is reasonable cause to suspect that the death was self-inflicted, no person may make public—

- the method or any suspected method of the death; or
- the place where the death occurred, if the place suggests the method (or any suspected method) of the death; or
- a description of a death as a suicide.

The restrictions specified in new section 71(2) do not apply to a person who is granted an exemption (under new section 71A) from the restrictions or to certain persons and organisations (for example, the Commissioner of Police) permitted by section 72 to publish particulars of suicide deaths. New section 71(3) clarifies that new section 71(2) does not prevent a person from making public that a death is a suspected suicide, or from making public that a death is a suicide after the coroner has completed a certificate of findings stating that the death is a suicide.

New section 71A provides that the chief coroner may grant an exemption from the restrictions that apply to making public the details of self-inflicted deaths. The chief coroner may grant an exemption only if the chief coroner is satisfied that—

- granting the exemption does not present an undue risk that other people will attempt to copy the behaviour of the dead person concerned; and
- any risk that people will attempt to copy the behaviour of the dead person concerned is outweighed by other considerations that make it desirable, in the public interest, to allow the publication of the details.

Self-inflicted death is a contentious and sensitive area. NCWNZ members recognised the grief that this type of death caused to families and the particular sensitivities surrounding suicide in some cultures. We note that New Zealand has a high rate of youth suicide compared to other developed nations, although understand that this has fallen in recent years based on figures

released by the Chief Coroner.[1] Alongside this, there is a growing voice for decriminalising euthanasia[2].

Given the complexity of the issue, it is important that the media acts responsibly with the information in individual cases to help ensure that there is an informed, but mature and nuanced, debate about suicide and the extent to which it is occurring in New Zealand.

The majority of NCWNZ members felt that the Bill struck the right balance. In particular:

- only releasing information about the fact that it was suicide – not the method or location;
- the importance of not releasing information that might lead to "copycat" behaviour;
- the need to ensure that other identifying features, such as the deceased's former occupation or address, are withheld; and
- the introduction of a new advisory panel of media and mental health experts to provide advice to the Chief Coroner (Part 2, Subpart 1, Clause 38, substituting Sections 70 and 71 and inserting New Section 71A into the Act; Subpart 2, Clause 52, inserting New Section 116A into the Act). There was a recommendation that there must be specific representation of Māori and Māori youth, given the prevalence of suicide within those groups.

One group affiliated to NCWNZ recommended that "the chief coroner seek advice from panel members with expertise in tikanga Māori, especially in the instance that Tūpāpaku is Māori."

Statutory timeframes and oversight

Introducing timeframes and monitoring the progress of coronial inquiries is an important change proposed by the Bill. *Clause 45* replaces section 94(1) to require a certificate of findings to be completed and signed as soon as is reasonably practicable and clause 46 inserts new section 94A in the Act and would require the chief coroner to monitor inquiries that are not completed within one year. This sits alongside new functions for the chief coroner, including "facilitating the orderly and efficient management of the [coronial] system", to be introduced by clause 6 (new section 7(1)).

There was widespread support amongst the NCWNZ membership for improvements to the system to ensure that the process was efficient, timely and responsive to the needs of families of the deceased. This has both emotional and practical purposes:

[1] http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11311656 (last accessed 13/03/2015).
[2] http://www.listener.co.nz/current-affairs/health-current-affairs/dying-wishes/ (last accessed 13/03/2015) also reflected in a recent private member's bill.

> "The feeling from the group is that there is too long a gap before the findings are released. We are astounded about the 700 days. Estates need to be wound up and families need resolution."

> "Coroner's inquests should be completed within one year unless there is good reason. Grief is only prolonged for the nearest and dearest if the issue is allowed to drag on."

> "… we are aware that coroners' inquests are still taking over a year to get heard in the coroners' courts. This does not assist the whānau to move forward and each step of the process, whānau will relive the hurt and mamae they felt as losing their whānau member."

> "The timeframes in new section 81(1)(b) provide at least 10 working days for interested parties to attend a coronial court hearing and new section 94 requires to the Chief Coroner to monitor that inquiries are provided within a year. Within our limited experience of the coronial court, their timeframes seem reasonable."

While there are some benefits to be gained through having a clear expectation and practice oversight, more than one branch recognised that the current delays were a symptom of under-resourcing. Comments included:

> "Coroner's inquests years after the death are a sign of under resourcing of the Coroner's Court. A family should not have to cope with a rerun of the events surrounding a death. This results in re-traumatising. The evidence, unless it is objective to the person, is tainted by poor memory or recasting memories; more palatable versions of events."

> "In our area there is no coroner / pathologist. Therefore, the processes are delayed as they have to be referred to Nelson. We understand that the body is released to the family when the pathologists have finished their investigations."

> "More coroners are needed. Does Government funding cap the number at 20? When can negotiation take place to increase the number of coroners, when an incident like the Christchurch occurs? It must ensure that repetition of inquiry does not occur."

Introducing timeframes without also increasing resourcing or the number of coroners will increase the workload of coroners and potentially lead to poorer outcomes or decisions. There may be some gains through the Chief Coroner having a leadership role and providing greater oversight over the coronial service. Appropriate training and professional development should also be included as part of the non-legislative mechanisms to improve the service.

Other comments

One group affiliated to NCWNZ raised concerns about the fact that there was no mention of Sudden Infant Death Syndrome (cot death) within the Bill.

Summary

While our members were in favour of the changes to the coronial process proposed in the Bill, members did stress the importance of adequate resources to support the changes.

We request the opportunity appear before the Select Committee to make an oral submission on the Bill.

Rae Duff
National President

Eva Hartshorn-Sanders
Convener
Justice and Law Reform Standing Committee