FAQs – Coroners Amendment Bill

PART 1 – Questions about what the Bill does

Why is the Coroners Act being changed?

Our conversations with key players have told us the coronial system has worked well since the 2006 Act was passed but that there are still opportunities to make subtle changes to the system, particularly in the way coroners make their recommendations and in the time it takes to hear cases.

What will change?

The changes will speed up the coronial decision-making process, better define which cases need to be reported to the coroner or investigated by other authorities to reduce duplication, and clarify rules around coroners' recommendation-making powers to better prevent future deaths.

How will changing the law improve how the coronial system works in practice?

Many of the changes are small, but together will help to improve public safety, reduce unnecessary deaths and speed up the coronial process to make things easier on grieving families.

The Bill will clarify several aspects of the legislation to make it easier for individuals and organisations involved in the coronial system to work together effectively.

The changes will also give the Chief Coroner better tools to take a strong leadership role and encourage coroners to produce consistent and timely findings.

Why are you making changes to coroners' recommendation-making powers?

Coroners' recommendations are an important way to learn from a death and hopefully prevent similar deaths in the future. However, there are concerns that the way that some recommendations are reached is preventing them from delivering their full potential.

Focussing recommendations on what we can learn from that death in particular, and improving the way coroners engage with groups that have an interest in the death will create the best possible recommendations, which public policy makers can then consider.

How will changes to coroners' recommendations improve public safety?

Coroners' recommendations are sometimes criticised for not being relevant to the particular death they are investigating, or not taking expert evidence into account.

The proposed changes will focus the recommendations on the facts and circumstances of the death in front of the coroner, and involve individuals and organisations such as government departments at an earlier stage. This will ensure the relevant people contribute to the evidence and help develop robust, workable recommendations.

Why aren't responses to coroners' recommendations mandatory?

Mandatory responses to coroners' recommendations would require a significant amount of time and resources, particularly from small organisations. Many organisations already respond voluntarily to coroners' recommendations.

The Government considers it is more beneficial to involve relevant individuals and organisations early on in the process to ensure that the coroner's recommendations are useful. Good recommendations speak for themselves.

How do you propose speeding up the coronial process?

The role of Chief Coroner will be strengthened to be able to spread workloads more evenly among coroners and designate coroners to deal with certain types of death.

The Chief Coroner will also be able to issue procedural guidance through practice notes to significantly improve the timeliness and consistency of coronial processes. These practice notes are helpful for such things as the use of pre-inquest hearings, suitable expert witnesses and ways to share information between witnesses.

What are the benefits for families?

Coroners' cases involving an inquest or hearing on the papers take over 400 days to complete on average, and over 700 days if coroners have to wait for another investigation to be completed. This is too long for families already grieving over the unexpected death of a family member.

Speeding up the process will help families have early answers to their questions and assist them to move forward with their lives.

What changes are being made to reduce duplication between coroners and other investigating agencies?

The Act lists 13 authorities with statutory investigatory responsibilities, for instance the Transport Accident Investigation Commission, that may overlap with coroners in certain circumstances, in addition to Royal Commissions and Commissions of Inquiry. The relationship between coroners and these authorities is not always clear in legislation and has resulted in some uncertainty about the respective roles.

The changes will give the Chief Coroner an oversight role to avoid duplication of investigations and the ability to order than an inquiry not be opened.

PART 2 – Questions about changes to suicide reporting

What are the current restrictions on reporting suicide?

If a death appears to have been self-inflicted, unless the coroner agrees, no one can make public any information on how the death occurred until the coroner's inquiry is completed.

If a coroner decides a death was a suicide, the only information that can be made public is the person's name, address, occupation and the fact that the coroner found the death to be self-inflicted.

A coroner can allow additional information to be made public, but only if it is "unlikely to be detrimental to public safety."

These restrictions are set out in the Coroners Act 2006.

Why are the restrictions in place?

Research shows a link between media reporting and copycat suicides. Some evidence also suggests that media reporting may have a role in triggering suicide clusters and may encourage people to see suicide as an appropriate option if they are suffering a life stress.

Restrictions on reporting are intended to help reduce these risks and to prevent suicides by people who are already vulnerable and might be negatively influenced.

Does the current law apply to social media?

Yes. The current law applies to anyone who makes public the details of a suicide death.

The definition of "make public" includes broadcasting, publishing in newspapers and magazines, making sound or visual recordings and posting information on internet sites that are generally accessible to the public.

What law changes to suicide reporting restrictions did the Law Commission propose?

The Law Commission made several recommendations to amend the Coroners Act to clarify and improve the law governing suicide reporting. Rather than the current broad restrictions, its proposals focus on limiting the types of details that are most likely to cause harm. For example, the Commission recommended:

- preventing anyone from making public how a person committed suicide (including where it happened, if the site suggests the method), unless the Chief Coroner grants an exemption

- allowing the Chief Coroner to only grant an exemption if they are satisfied that the risk of copycat suicidal behaviour is small and outweighed by the public interest.

- preventing anyone from describing a death as suicide unless the Chief Coroner has granted an exemption, or a coroner made a finding that the death is suicide

- allowing a death to be reported as a suspected suicide before a coroner's inquiry is completed, if the facts support that conclusion.

What will the penalties be for breaching the restrictions?

The maximum fine will be increased to $20,000 for a body corporate or $5,000 for anyone else. The current fines are up to $5,000 for a body corporate and $1,000 for anyone else.

However, it is likely that fines would be used only in the most serious cases (for example, if someone deliberately breached the Act on several occasions). In less serious cases, people might be asked to remove details that breach the Coroners Act, or be given a warning by the Police.

Is the Government accepting all the Law Commission's recommendations?

Yes. The Commission made 17 recommendations. The Government fully accepts 14 proposals for changing the Coroners Act, and generally accepts 3 recommendations about developing reporting standards.

For example, the Law Commission proposed that the Minister of Health:

- prepare a set of standards for suicide reporting, in consultation with representatives of the media and mental health interests. The proposed new standards would apply to anyone publicly reporting on a suicide death, including mainstream media, blogs and social media.

- implement an ongoing programme to promote and support the implementation of the standards, and evaluate their success in achieving the goal of low-risk suicide reporting.

The Government has already committed to improving information for media as part of the New Zealand Suicide Prevention Action Plan 2013–2016, using existing guidance. It will monitor how the legislative changes are working and consider whether new reporting standards are needed as part of a planned review of the action plan and the New Zealand Suicide Prevention Strategy when they come up for renewal in 2016.

More information can be found at: http://www.justice.govt.nz/publications/global-publications/s/suicide-reporting-recommendations-and-government-response

What are the goals of the New Zealand Suicide Prevention Strategy?

The New Zealand Suicide Prevention Strategy 2006–2016 (launched in June 2006) provides a framework for New Zealand's suicide prevention efforts over a 10 year period. Its overarching aim is to reduce the rate of suicidal behaviour and its effects on the lives of New Zealanders, while taking into account that suicide affects certain groups more than others.

The strategy has seven goals:

1. promote mental health and well-being, and prevent mental health problems
2. improve the care of people who are experiencing mental disorders associated with suicidal behaviour
3. improve the care of people who make non-fatal suicide attempts
4. reduce access to the means of suicide
5. promote the safe reporting and portrayal of suicidal behaviour by the media
6. support families/whānau, friends and others affected by a suicide or suicide attempt
7. expand the evidence about the rates, causes and effective interventions

More information is available at http://www.health.govt.nz/publication/new-zealand-suicide-prevention-strategy-2006-2016

What is the Suicide Prevention Action Plan?

The New Zealand Suicide Prevention Action Plan 2013–2016 outlines a programme of actions that the Government will implement over the next few years. It is a cross-government initiative bringing together the work of eight agencies. It builds on the previous action plan covering 2008–2012. Both action plans reflect the goals of the New Zealand Suicide Prevention Strategy 2006–2016.

The Action Plan includes actions designed to:

- address the impact of suicide on families, whānau and communities by strengthening support for family, whānau and communities
- build the evidence base, specifically around what works for Māori and Pasifika
- extend existing services, specifically addressing geographical gaps in the coverage of services
- strengthen suicide prevention targeted to high risk populations who are in contact with agencies.

More information about the Suicide Prevention Action Plan is available at: http://www.health.govt.nz/publication/new-zealand-suicide-prevention-action-plan-2013-2016

What guidance is available to the media on reporting suicide?

Guidelines for journalists are available at www.health.govt.nz/publication/reporting-suicide-resource-media.

They describe issues relating to suicide reporting, suggest areas that journalists should think carefully about, and identify sources of information that journalists may find useful.

The guidelines were developed by key stakeholders including representatives of the news media and mental health professionals. They have been adopted by the Newspaper Publishers' Association and the Media Freedom Committee.

What is the Government doing to address serious bullying behaviour that may provoke a person to take their own life?

The Harmful Digital Communications Bill, which is currently before Parliament, includes a new offence of incitement to commit suicide (where the person does not attempt to take their own life), punishable by up to three years imprisonment.

Currently, it is only an offence to aid, abet or incite suicide if a person attempts or commits suicide.

The new offence recognises the distress such provocation can cause and sends a message that the potential consequences of this kind of harassment are too serious to ignore.

It is one of a range of measures in the Bill to address damaging online communications and ensure perpetrators are held to account for their actions.

Is it okay to talk about suicide?

Yes, it is. However, it is important to be mindful of how we talk about suicide, as certain ways of discussing it are more helpful than others.

In particular, useful conversations may include information about mental health problems; how and where to get support and services in the community; where to find online information and support; and personal stories of hope and healing.

Such information can help people feel more supported and can encourage them to seek help.

Where can people get support and help?

Below is a list of some of the services available which offer support, information and help. All services are available 24 hours a day, seven days a week unless otherwise specified.

- Depression Helpline (8 am to 12 midnight) – 0800 111 757
- Healthline – 0800 611 116
- Kidsline (aimed at children up to 14 years of age; 4 pm to 6 pm weekdays) – 0800 54 37 54 (0800 kidsline)
- Lifeline – 0800 543 354 or (09) 5222 999 within Auckland
- Samaritans – visit the website www.samaritans.org.nz, or call 0800 726 666 (for callers from the Lower North Island, Christchurch and West Coast only) or (04) 473 9739 from all regions
- Skylight (aimed at supporting people facing tough times of change, loss, trauma and grief) – visit the website www.skylight.org.nz or call 0800 299 100 (9 am to 5 pm weekdays; facility to leave a message outside these hours)
- Suicide Crisis Helpline (aimed at those in distress, or those who are concerned about the wellbeing of someone else; 12 noon to 12 midnight) – 0508 828 865 (0508 TAUTOKO)
- Suicide Prevention Information New Zealand – www.spinz.org.nz
- Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz
- What's Up (for 5–18 year olds; 1 pm to 11 pm) – 0800 942 8787
- www.depression.org.nz
- www.thelowdown.co.nz – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight).

PART 3 – Questions about the coronial system and the Coroners Act Review

What cases go to a coroner?

Deaths that must be referred to the coroner include those that are without known cause, suicides, unnatural or violent, deaths for which no doctor's certificate is given, and deaths during medical treatment or while in official custody or care. In 2012/13, 5,512 deaths were reported to the coroner (around 18% of all deaths), coroners took jurisdiction of 3,098 cases, 1,326 inquiries were opened and 198 public coronial inquests were held.

What is the coroner's role?

The coroner's role is to establish, so far as possible, the cause and circumstances of death in cases of sudden or unexplained deaths and deaths in other special circumstances. The coroner, as an independent judicial officer, acts on behalf of the State to inquire into such deaths.

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What is a coroner's inquiry?

Coroners open inquiries so they can find out more about who the person was, where, when and how they died.

A coroner can open an inquiry straightaway or after a few weeks. Sometimes the coroner asks for another kind of investigation, perhaps medical (such as a post mortem or doctor's report) or occupational safety and health, to help them decide whether to hold an inquiry.

Coroners don't inquire into all these deaths as sometimes the post mortem shows it was a natural death and there were no suspicious circumstances.

Sometimes the coroner puts the inquiry on hold (adjourns) until other investigations are finished, such as a police prosecution or an investigation by the Department of Labour or the Health and Disability Commissioner.

What is a coroner's inquest?

An inquest is a public hearing where the coroner publicly looks at all the evidence about the death. It is usually held in a courtroom, but sometimes in another place approved by the coroner, like a conference room at a hotel. It is called a coroners court when the Coroner is holding an inquest.

It is a special type of court hearing and follows an inquisitorial process. The coroner asks experts and witnesses to give evidence in court about what happened. An inquest is not a trial. It's about finding out what happened and how to stop other people dying in a similar way. It's not about blaming anyone for what happened.

It isn't as formal as a criminal court hearing and there isn't a jury. Anyone can come to an inquest, including the media. However, sometimes the Coroner decides to keep people out of the inquest or part of it.

How many coroners are there?

Coronial services are currently provided by a Chief Coroner and 16 permanent coroners. The Ministry of Justice provides support staff – called the Coronial Services Unit.

What is the Chief Coroner's role?

The Chief Coroner's main function is to oversee the coronial system and ensure that coronial inquiries are conducted orderly and expeditiously. The Chief assigns areas of work to coroners and encourages consistency between coroners. The Chief also has a public education role and provides a central point of contact for members of the public and other investigative authorities.

Who was involved in the review?

It was a targeted review that focused on seeking submissions from key stakeholders on where they saw the current Coroners Act could be improved.

The Ministry wrote to approximately 168 key stakeholders seeking feedback on the current system and received 49 submissions from government agencies, professional stakeholder groups, iwi authorities and some interested members of the public.

Information about the review was also available on the Ministry of Justice website.

How can the public be involved?

Anyone interested in the Bill can make a submission when the Bill is considered at select committee.