CORONERS COURT
Te Kōti Kaitirotiro Matewhawhati

Annual Report

2021/2022 and 2022/2023

Te Kōti Kaitirotiro Matewhawhati o Aotearoa
Coroners Court of New Zealand

Aotearoa New Zealand is culturally and ethnically diverse. Different cultures and religions view death in different ways and require different practices to be followed after death. The passage below from the New Zealand Law Commission's 1999 report outlines some of the practices across different cultures and religions when it comes to death.

Cook Islanders believe the deceased should not be interfered with. Traditionally, Fijians view post-mortems as unthinkable and believe that the dead should not be tampered with. Niueans generally consider post-mortems to be a strange practice. Samoans and Tongans regard post-mortems as an indignity to the deceased.

Both Jewish and Islamic beliefs entail the need for a speedy burial of the deceased. Jewish customary law also requires a specially appointed guardian to attend the deceased until burial. The guardian is required to spend the night with the deceased reciting prayers.

Death and dying are a central part of Māori life. The family have an intimate connection with the body of the deceased and are usually closely involved with the preparations leading up to the burial. Respect – in the form of caring for the tūpāpaku, mourning the deceased and speaking to them – is shown because, although the physical remains of a person are lifeless, the spirit continues to live on.

Ki te iwi Māori he tikanga nui tō te mate me te whakahemohemo. He taunga te whānau ki te tūpāpaku, ā, kei reira rātou mō te nuinga o ngā whakaritenga tae noa ki te nehunga. Ko te tiaki I te tūpāpaku, ko te tangi me te tuku kōrero ki a ia – puta ake ai ēnei hei whakaatu, ahakoa kua mate, ora tonu ai te wairua.

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

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FOREWORD

Welcome to the 2021/22 and 2022/23 Report of the Chief Coroner and the Coroners Court of New Zealand

Tēnā koutou katoa,

This Annual Report provides information about the work of the Coroners Court and developments within it over the past two years. It also contains information about the role of the coroner and the drive to ensure that people are at the centre of everything we do. No annual report was produced last year, so consequently, this report covers the 2021/22 and 2022/23 years in the Coroners Court[1].

In May 2022, the previous Chief Coroner, Judge Deborah Marshall, resigned. After having been the Deputy Chief Coroner for some time, I was appointed as the Chief Coroner in November 2022. It is a privilege to lead the coroners and to continue the work of previous chief coroners to improve the way in which the Court serves the community.

I start by acknowledging the deaths, and lives, of all those who have come before the Court in the previous two years. I acknowledge their families and whānau, and offer my condolences.

The Coroners Court exists to serve the community. It is a court that is developing in many ways. Resources are increasing and we are implementing ways to ensure people are at the centre of all our processes.

It is important that those who come into contact with the Coroners Court know what to expect, and can trust that they will be treated with dignity and respect, and their cultural needs will be met to the greatest extent possible. It is important that they, as well as the community generally, understand the role of the coroner and the way in which the Coroners Court operates. It continues to be a priority to provide information in a number of forums and ways, to increase that understanding and the trust that the community has in the court.

During the last two years, the Court has faced challenges, but has also made positive change. The demands on the Court remain substantial. In the last two years, the number of deaths entering the jurisdiction has increased. In addition to the usual work of the Court, we have responded to two mass fatality events: Cyclone Gabrielle that affected much of the country in early 2023, and the Loafers Lodge fire in Wellington in May 2023. The lasting impacts of COVID-19 have affected resources at times.

[1] This covers the financial years from 1 July 2021 to 30 June 2023.

Budget 2022 provided funding to help reduce delays in the Court and improve the coronial process for grieving families and whānau. This funding will enable the appointments of additional relief coroners and the creation of the new roles of associate coroners and clinical advisors.

The additional coroners and the associate coroners will enable the Court to reduce the delays that many families have experienced and the distress those delays have caused. We know families and whānau need answers, and the community needs prompt recommendations to reduce the chances of further tragedies. The Court is working hard to meet those needs.

The appointment of experienced doctors to the new clinical advisor role will assist doctors in hospitals and the community to decide whether they can certify the death of a patient or whether the death is appropriately a Coroners Court matter. I hope this will reduce the number of deaths entering the jurisdiction unnecessarily, so that families and whānau don't face unnecessary delays and processes. The clinical advisors will also provide valuable expert medical advice to coroners to assist with the inquiries.

Unlike other courts, the Coroners Court operates 24 hours a day, seven days a week. Coroners are the judicial officers of the Court, supported and assisted by a number of organisations and individuals. The coronial process is a multi-disciplinary one and a range of people work tirelessly to provide the best service possible to grieving families and whānau.

Coroners are supported by, and work closely with, staff of the Ministry of Justice. We also rely, every day, on the expertise of the pathologists who conduct post-mortem examinations and the mortuary staff who assist them. New Zealand Police staff attend all sudden deaths and investigate on behalf of the coroner. Funeral directors provide transportation services. I acknowledge with thanks the contribution made by all those involved in the work of the Court. It is the collective work of us all that results in answers for families and whānau and helps make the community safer.

One of the ways in which the Court contributes to a safer Aotearoa New Zealand is through coroners' recommendations. This report contains a sample of the kinds of recommendations and comments coroners made during the past two years, with the aim of making the community safer by reducing the chances of further deaths in circumstances similar to those that have come before the Court – an important aspect of a coroner's role. Further examples can be found in our recommendations recap, published on the Ministry of Justice website at Recommendations Recap | Coronial Services of New Zealand (justice.govt.nz).

I hope this report indicates that the Coroners Court is developing in ways that will make a positive difference for those who encounter it, and for society generally.

He aha te mea nui tea o? **He tangata he tangata**, **he tangata**!

Nāku noa,

Judge A Tutton
Chief Coroner

CORONERS COURT OF NEW ZEALAND - TE KŌTI KAITIROTIRO MATEWHAWHATI AOTEAROA

Coroners: the judiciary of the Coroners Court

Coroners, like the judges of other courts, are independent judicial officers, appointed from the legal profession by the Governor-General, on the advice of the Attorney-General after consultation with the Minister of Justice.

Coroners require legal ability, personal qualities (including honesty, integrity, open mindedness, impartiality, empathy and courtesy) and technical skills (such as communication, mental agility and organisational skills), and contribute to ensuring the Court reflects the community it serves.

As at the end of 2022/23, the Coroners Court bench was comprised of 26 coroners, including the Chief Coroner. Coroners are based in nine locations around Aotearoa New Zealand, in Whangārei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch and Dunedin. Coroners are supported in their roles by the Ministry of Justice's Coroners Court staff.

The role of the coroner is to inquire into the cause and circumstances of sudden, unexplained, or unnatural deaths and, where appropriate, to make recommendations designed to reduce the chances of other deaths occurring in similar circumstances.

The coroner has a dual role, both investigative and judicial. The coroner as investigator works to establish the truth – whether someone has died, who that person is, and why, how, when and where they died. A coroner is assigned to investigate each of the deaths accepted into the jurisdiction of the Court, as well as making all the judicial decisions in relation to that investigation and presiding over an inquest if one is held.

"Coroners speak for the dead to protect the living".[2]

[2] The Ontario Coroners Association (Coroners – OPSEU SEFPO).

From a Coroner's Perspective

Coroner Mary-Anne Borrowdale
Wellington Region

I accepted appointment as a coroner for a range of reasons. Becoming a coroner was a career-change for me – one that has been very satisfying and challenging.

Until I became a coroner, I was a litigation lawyer employed within the public service. I was head of the competition and consumer legal teams within the Commerce Commission. I managed a large team of lawyers and supervised the Commission's legal activities. This was a demanding role, but very rewarding. The work was commercially important to New Zealanders, and often very high-profile. Prior to that time, I had worked as a commercial litigator at the Wellington office of Chapman Tripp, and at firms in Queensland and Christchurch.

I am originally from Christchurch, and still have family and strong connections there. It is a privilege to now serve as one of the coroners primarily inquiring into deaths that occur in the South Island, although my chambers are in Wellington.

My first motivation for becoming a coroner was public service. I believe that it is a professional privilege to be able to serve the public interest, by helping to resolve questions that are of high public concern. The work of the coroners is many-faceted. For the loved ones of a deceased, the death being investigated is a personal bereavement and a difficult and emotional time. The coroner's involvement is not always welcome. I enjoy working with the Coroners Court staff of the Ministry of Justice, as well as pathologists and Police, to try to minimise the stress of our investigations, and to provide information about a death which might help with the grieving process.

Like many coroners, I have experienced sudden bereavement, and have had unanswered questions that linger long after the tragic event. While coroners must follow established processes, and may seem formal or remote, we understand the personal impact of early death and are motivated to be of service and help to the bereaved.

In addition, every death represents a chance for the public, and public agencies, corporations and others, to learn from a fatality and to take steps that might prevent a recurrence. It is a vital and important part of the coroner's role to make comments and recommendations that might serve to prevent further deaths. It is frequently challenging to craft recommendations that are clear, relevant and implementable. But making recommendations is a unique feature of the Coroners Court, and it provides a strong sense of purpose to the work that coroners do. Although I had not worked beforehand so closely with Police, or in medical science, it is fascinating to do so. Unfortunately, the causes and circumstances of death are very broad. The investigation skills that I developed in bringing commercial prosecutions are of real assistance to me as a coroner. It is

necessary to plan every investigation, identify sources of reliable information, and ensure that relevant evidence is gathered quickly. This work, when supported by the motivation of public service, is very purposeful.

Finally, I knew several coroners before I became one myself. They were intellectually capable, great communicators, empathetic people and skilled lawyers. I believed that by joining the coroners bench I would be working alongside judicial officers of real ability, and so it has proved to be. The coroners all share a deep commitment to improve health outcomes for New Zealanders, through the work that we do.

From a Coroner's Perspective...continued

Coroner Louella Dunn

Hamilton Region

I was born in Greymouth and moved to Christchurch when I was 4 years of age. I grew up in Christchurch and completed my LLB at Canterbury University. When I finished my degree, I had no idea what area of law I wanted to practise and just felt despondent that the fun times at university had actually come to an end.

I was offered a graduate position at the Hamilton Crown Solicitors firm. I became a partner of the firm in 1997 and was Acting Crown Solicitor at the time I accepted the position of Relief Coroner.

Over my 30 years at the Crown, I prosecuted literally hundreds of back-to-back trials – sexual violations, family violence, fraud, multi-accused drug trials and murders. I also represented other agencies – Waikato Regional Council, Historic Places Trust, Community Corrections, and various government departments. I represented a number of overseas countries seeking extradition and was appointed to an expert extradition panel by the Crown Law Office. I enjoyed working with the Police while appreciating the independence that a Crown prosecutor brings to the criminal justice system.

The criminal law provided me with an invaluable insight into how people's lives can unravel and how they end up before the courts. I met countless victims of crime and perpetrators of crime. Many of these men and women have limited options in their life choices primarily due to poverty, abuse and addiction issues. I consider I was very

I am very proud to be able to work as a coroner

privileged during my criminal career to be able to support victims and advocate on their behalf. Constant advocacy, however, takes a toll, and I made the decision that I needed a change from that adversarial role. I believed the Coroners Court inquisitorial role would be a welcome change and I consider I made the right decision. I was appointed a relief coroner just before the first lockdown in 2020.

My working life has always been busy – running a firm of lawyers and staff with a constant trial schedule while raising two children and doing various stints on school Boards of Trustees. I was Chair of St Johns College Board of Trustees and enjoyed working in the education sector. I found time for overseas travel (however, I could always do with more time for that) and I love walking my loyal dog, Maadi.

I appreciate nature and recognise that my mental health requires me to be outside and physical as much as I can. Fortunately, the Waikato and Bay of Plenty have excellent walking tracks and cycleways. I love of all forms of biking – mountain biking, for a period road racing (although that was some time ago now!) and just riding my bike whenever I can. I recently finished the Alpz to Ocean and Timber Trail and plan to complete more of the great cycle tracks available in NZ.

I am very proud to be able to work as a coroner. My previous work as a prosecutor has hopefully equipped me in my role to provide empathy and support to those grieving. The Coroners Court system is often misunderstood by the families that require the most support. I believe my role is a humble one and hope that I can provide families with answers and a sense of closure.

I appreciate that my role has provided me independence and flexible working hours, something that I value and juggle with given the heavy workload. The Coroners Court bench has been incredibly welcoming and supportive and, in my time, working as a coroner there have been a number of significant and beneficial changes implemented.

I look forward to continuing this journey.

MANAGER JUSTICE SERVICES

Profile on Debbie Gell – Manager Justice Services, Coroners Court

As manager of support services for the Coroners Court, I see myself as a small but important cog in a big wheel. I lead 97 staff across New Zealand who work to ensure the smooth running of the Coroners Court. Their roles are varied, and our team includes case managers, administrators, and legal support who assist individual coroners, the National Initial Investigation Office that operates 24 hours per day, every day of the year, and the Office of the Chief Coroner.

My role can be challenging, and no two days are the same. Tasks can be as varied and significant as supporting coroners in the response to major incidents such as the fire at Wellington's Loafer's Lodge, supporting a Select Committee process related to new legislation and managing logistics for large and complex inquests. Other requests can be more detailed but just as important. I have been known to do late-night trips to K-Mart to source blankets for people to use during an inquest. At the forefront of my mind every day is my passion to help others and provide service to people and the community.

I came to the Coroners Court after managing quality and risk in one of the former District Health Boards, and the delivery of domestic health services within the New Zealand Defence Force. My time managing health care services was frantic, but it prepared me well for my current role. As did my study - I hold a Masters of Nursing and I have a LLB from Victoria University of Wellington. While I haven't practised law, it's given me an important understanding of the legal system which complements the knowledge and experience I gained in nursing and health care, that above all, empathy, care and respect are everything.

THE DUTY CORONER STAGE

If someone dies suddenly, their death is generally referred to the coroner. The duty coroner is responsible for making the initial judicial decisions in the investigation into the cause and circumstances of death. All coroners are regularly rostered to work as the national duty coroner.

The duty coroner makes all the judicial decisions relating to the deaths reported: whether or not to accept jurisdiction, whether a post-mortem examination is required and, if so, the type of examination, whether the identification of the deceased has been established, and when the body/tūpāpaku can be released to the family/whānau.

The National Initial Investigation Office (NIIO), an office staffed by Ministry of Justice, supports the duty coroner. NIIO is the initial point of contact for families and whānau when deaths are referred to the coroner.

The Duty Coroner and NIIO provide a 24-hour service

NIIO is an office staffed by the Ministry of Justice, comprised of 19 staff members that provides a 24-hour service, supporting the duty coroner.

NIIO coordinates the first stages of the Coroners Court process by delivering support services such as:

- responding to the initial reporting of a death by a doctor, hospital, or the Police
- arranging for the collection, holding, viewing, and transporting of a body, as well as the coordination of a post-mortem, if directed by a coroner
- actioning the directions of the duty coroner
- releasing the deceased's body to their family.

NIIO staff liaise with families and whānau to explain the process and update them, and all others involved in the process. Just as the judges of other courts, the duty coroner does not usually liaise directly with families/whānau – NIIO is the point of contact for families/whānau and the staff of other agencies.

Always with the families and whānau in mind, NIIO staff work to minimise the impact of the process by providing an effective, efficient service, and ensuring the duty coroner has appropriate information to make informed and timely decisions.

Number of deaths reported

The number of deaths reported to the coroner **increased** during the two-year period covered in this report. On average, **100 deaths were reported each week during the two-year period**.

There are two types of cases that progress through NIIO. Advice cases are those that have been reported to the coroner, but the duty coroner has decided that they do not need to enter the Court; for example, natural causes deaths which the attending doctor is willing to certify, and which the duty coroner considers do not need to enter the Court.

If the duty coroner accepts jurisdiction in relation to a death, the matter enters the Coroners Court, and a coroner will make decisions about the appropriate way to progress it.

Table 1 shows the number of deaths reported to the duty coroner for the last five financial years:

Table 1: The number of deaths reported, between 1 July 2017 and 30 June 2023, by case type

	2022/23*	2021/22*	2020/21*	2019/20*	2018/19*	2017/18*
Deaths reported where coroners accepted jurisdiction	3,829	3,734	3,599	3,608	3,800	3,582
Deaths reported where a doctor issued a death certificate	1,583	1,519	1,388	1,597	1,745	2,005
Total deaths reported	**5,412**	**5,253**	**4,987**	**5,205**	**5,545**	**5,587**

**The financial year is from 1 July to 30 June. Numbers are based on the Coroners Court Case Management System as at 4 July 2023. Since this is an operational system, numbers for the 2020/21 financial year have been updated since published in previous annual reports.*

JURISDICTION OF THE CORONER

Coroners have jurisdiction under the Coroners Act 2006 (the Act) to investigate unexpected, unexplained, or unnatural deaths, and to make recommendations or comments that may prevent further deaths in similar circumstances.

Unlike other courts, the Coroners Court process is inquisitorial. Coroners investigate the cause and circumstances of death, taking into account the concerns of family and whānau and other interested parties. Coroners have a statutory obligation to establish, where possible, the identity, causes and circumstances of reportable deaths, and, where appropriate, to make specific recommendations and comments to help reduce preventable deaths.

Reportable deaths

Unlike any other court in Aotearoa New Zealand, the Coroners Court operates 24 hours a day, seven days a week. In the 2021/22 financial year there were **5,253 deaths reported to the duty coroner** and **coroners accepted jurisdiction in relation to around 3,700 of these deaths**.

In the 2022/23 financial year there were **5412 deaths reported to the duty coroner** and **coroners accepted jurisdiction in relation to around 3,800 of these deaths.**

The Act states that a death must be reported if:

- the body is in Aotearoa New Zealand
- the death appears to have been without known cause, or self-inflicted, unnatural, or violent
- the death occurred during, or appears to have been the result of, a medical procedure and was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and was medically unexpected
- the death of a woman occurred while giving birth or the death appears to be a result of the pregnancy or birth
- the death occurred in official custody or care
- the death is one in relation to which no doctor has given a death certificate.

About 5,400 deaths are reported to the coroner every year, and coroners accept jurisdiction for around 3,800 of these deaths.

CORONERS COURT INVESTIGATIONS AND COURT OPERATIONS

Process overview

Once a death has been reported, the duty coroner decides whether to accept the death into the jurisdiction, or to decline jurisdiction because the matter does not need to enter the Coroners Court.

If a coroner accepts jurisdiction, they decide whether a post-mortem examination is needed and, if so, which type of examination. Those decisions often include consultation with pathologists (doctors who have completed specialist training and qualifications as pathologists) and Police. Coroners often direct pathologists to perform a preliminary inspection before making further decisions about post-mortems. A preliminary inspection can only be conducted by a pathologist, in a mortuary facility. In many locations, a body/tūpāpaku will need to be transported some distance to the nearest mortuary facility. NIIO arranges that transportation.

A preliminary inspection consists of an external visual examination of the body and/or the use of medical imaging. Such an examination allows pathologists to advise coroners about whether they consider a post-mortem examination is needed and can help to avoid unnecessary post-mortems. If a post-mortem is needed, the coroner will consider the advice of the pathologist and Police, the views of the family/whānau (where next of kin has a right to object (but not refuse) a post-mortem examination under the Act) and the public interest , and decide whether a full internal and external examination of the body is needed, or whether a lesser examination will enable the cause of death to be determined. The pathologist generally tries to perform the post-mortem as soon as possible (usually the next working day), but in some cases it can take longer.

The duty coroner must also determine who has died, by considering the evidence of identification provided by Police. Often that is simple, because a family member, or someone who has known the person who has died for a reasonable time, can identify the body. In some circumstances, however, visual identification is not appropriate or reliable, and identification can be more complicated and take longer.

Once any post-mortem examination has been completed and the duty coroner is satisfied that the person who has died has been identified, the duty coroner will authorise release of the body.

A coroner will then be assigned to investigate and make decisions about the death. The coroner assigned will decide whether to direct further investigations, wait for the results of further investigations already under way, put the investigation on hold (where there are other

processes occurring such as a criminal prosecution), or make their final findings about the death.

Most matters are dealt with “on the papers”, which means there is no court hearing. In some cases, however, the coroner will decide that an inquest is required. An inquest is a public court hearing, in which family/whānau and other interested parties can participate. Members of the public and media representatives are entitled to attend. The media can report on the hearing. The inquest forms part of a coroner’s inquiry into the cause and circumstances of death, and informs comments and recommendations made to prevent future deaths occurring in similar circumstances.

At the conclusion of a Coroners Court investigation, the coroner issues a written decision, called findings. In some cases, the coroner might make recommendations or comments to help prevent similar deaths in the future.

Case Progression

National Initial Investigation Office

When a person is reported as deceased, NIIO collects, collates, and records the initial information and evidence, and provides it to the duty coroner to inform decisions about jurisdiction, post-mortems, and identification. The NIIO staff liaise with families of the deceased to inform them about the processes and update them as decisions are made.

NIIO staff are responsible for the movement of the deceased’s body, and liaison with Police, pathologists and others, to facilitate directions made by the duty coroner.

Once the duty coroner has authorised the release of the deceased’s body, the case is assigned to a coroner based in one of the nine regional locations, known as the responsible coroner. From that point on, the contact point for the family/whānau is the case manager who supports the relevant responsible coroner.

The responsibilities of the staff at NIIO cover from the time a death is reported until the time the duty coroner has authorised release of the deceased’s body.

Location of coroners

Coroners and their support staff are based in nine regional centres:

- Whangārei
- Auckland
- Hamilton
- Rotorua
- Hastings
- Palmerston North
- Wellington
- Christchurch
- Dunedin.

Coroners Court staff

Coroners are supported by the Ministry of Justice’s Coroners Court staff, comprised of case managers and administrators across the regional locations.

Case managers and administrators work directly with coroners to progress their inquiries by enabling the effective and efficient progression of a case to its final

hearing or inquest. As the main point of contact for families and whānau, stakeholders and interested parties, case managers ensure they are kept informed about the inquiry and prepare the files and documentation for the coroner to consider.

Coronial Information

Upon a case being completed, the Coronial Information team (part of the Office of the Chief Coroner) is tasked with the archiving, management, and release of information on closed Coroners Court files.

Requests for information from closed files come from family members, members of the public, media, government organisations and research groups. These requests include Coroners Act 2006 and Official Information Act 1982 requests. The Coronial Information team is comprised of a senior information advisor, four information advisors, and an administration support officer.

Between 1 July 2021 and 30 June 2023, the Coronial Information team dealt with 4557 requests for information and files.

Legal and Research Team

Coroners are further supported by a team of legal and research counsel/advisors. These are lawyers or law graduates who conduct legal research, provide legal opinions, assist with drafting of coronial findings and with preparation and the conduct of inquests. They also prepare summaries of recommendations. The legal and research team is based in Auckland, Wellington, and Christchurch.

Findings

An inquiry is a legal investigation into a death; it is not a trial. The role of a coroner is not to determine civil, criminal, or disciplinary liability. Rather, it is to establish the cause and circumstances of a death and identify any lessons that can be learned to prevent similar future deaths. In some cases, such as death from natural causes, a coroner may make a finding without opening an inquiry.

Coroners' findings can also contain recommendations or comments made by the coroner to help reduce the chances of further deaths occurring in similar circumstances.

The Act requires that recommendations or comments are:

- linked to the factors that contributed to the death
- based on evidence considered during the inquiry
- accompanied by an explanation about how the recommendations or comments, if drawn to public attention, may reduce the chances of similar deaths occurring.

Coroners must also notify any person or organisation when recommendations or comments have been directed to them and allow them time to respond.

RECOMMENDATIONS AND COMMENTS MADE

The Office of the Chief Coroner maintains a public register of coroners' recommendations and comments. This register is publicly available on the Coronial Services of New Zealand website (Coronial Services | Coronial Services of New Zealand (justice.govt.nz)) and the New Zealand Legal Information Institute website (New Zealand Legal Information Institute (NZLII)). In some cases, such as deaths by suicide, publication restrictions prevent the recommendations being published.

The following are examples of recommendations or comments made, and responses received by coroners, during the last two financial years.

Othman Mohammed Bsaiso

Date of death: **26/11/2017**

Date of findings: **10/12/2021**

Coroner Katharine Greig

CIRCUMSTANCES

Othman Mohammed Bsaiso, aged 18 months, died on 26 November 2017 at Epsom, Auckland as a result of drowning in a swimming pool on a residential property that was rented to his family.

The Bsaiso family had lived in the property in Epsom, which they rented, approximately two and a half years (since May 2015). At the rear of the house was a swimming pool, which the family did not use.

The pool area could be accessed from a deck, for which there were two entrances from the house. The pool was separated from the deck by a metal fence and gate. The gate had a pool lock and would automatically shut after being opened. The pool could also be accessed from a wooden gate on the side of the house, which was down a path next to the driveway.

On the evening of 26 November 2017, Othman was found floating face down in the swimming pool. He was unconscious and unresponsive and unable to be revived. Othman got into the swimming pool area through a wooden gate beside the house that had not closed properly.

Under the Building Act 2004, and previously the Fencing of Swimming Pools Act 1987, residential pools are required to have "physical barriers that restrict access to the pool by unsupervised children under 5 years of age". As of 1 January 2017, territorial authorities are required to inspect residential pools every three years to ensure compliance with the law.

An inspector for Auckland Council reported that the pool had last been inspected in 2015 and was due to be inspected in 2018. In the 2015 inspection, the barriers to the pool were compliant with the legislative requirements.

Following Othman's death, the pool area was inspected, and it was found the

barriers to the pool were not compliant in the following ways:

- the wooden gate failed to self-latch upon closing
- the gap underneath the metal gate from the deck to the pool area was greater than 100mm
- horizontal rails on an adjoining boundary fence were less than 900mm apart.

These issues had not been discovered by the property manager during routine property inspections. It was not clear to the landlords, property managers, or the Bsaiso family where the responsibility lay for ensuring safety and compliance with the legislation. As a result of this lack of knowledge, the wooden gate was no longer compliant with the Building Act 2004 as it did not self-latch.

The coroner consulted with the Ministry of Business Innovation and Employment (MBIE), Auckland Council, and the Real Estate Institute of New Zealand (REINZ) about what could be done to prevent deaths in similar circumstances. The actions taken by MBIE were incorporated into the formal recommendations.

Auckland Council advised the coroner that its website contains a page on pool fencing, including a Pool Safety Area Checklist, with links to videos for in-ground, above-ground, and small heated pools (Pool area safety checklist (aucklandcouncil.govt.nz)).

Auckland Council also carries out an annual campaign between December and February to remind Aucklanders to be vigilant around pools by closely monitoring young children and ensuring that pool barriers are secure. The campaign is also designed to reach people who may have pools that the council is unaware of, such as portable/inflatable pools, or pools built without a building consent.

Auckland Council also considered the potential role it could play in highlighting the responsibilities of landlords and tenants relating to pool safety, and the council's legislative obligations. Auckland Council identified the following areas where it could emphasise the obligations of landlords and tenants.

- Updating the relevant page(s) on its website to highlight the fact that both owners and occupiers are responsible for complying with pool fencing laws, and that tenants should advise their landlord if there are maintenance issues.

- Including a link to the updated webpage in the Notice of Pool Barrier Inspection and developing a flyer to be included with the Notice, summarising the key pool safety messages (including responsibilities of owners and occupiers).

- Undertaking a project by the Auckland Council's Proactive Compliance team to identify properties on the swimming pool register that are bought and sold each month, and to send a letter advising new owners of the pool fencing safety rules and their responsibilities. This is to help educate owners who have never owned a swimming pool, and alert owners that intend to rent the property of their specific obligations.

- Actively working with REINZ to assist with pool safety education for its property managers (at least in the Auckland region). This assistance is likely to take the form of a video or webinar.

REINZ is a membership organisation that represents more than 16,000 real estate

professionals nationwide and is involved in all facets of real estate including residential property leasing and management. While REINZ is not an industry regulator, it has a Residential Property Management Code of Practice. The code is explicit that properties are to be managed in accordance with relevant statutes, the tenancy agreement and a written management authority with the landlord that outlines all responsibilities, fees, and charges to the landlord. Clause 6.2 of the code makes specific reference to swimming pool fences and gates – setting out the requirement that a property manager should make a tenant aware of the need to notify the agency member or landlord, as soon as possible after discovery, of any damage to the premises or the need for any repairs, including, but not limited to, swimming pools and their fences and gates (if any).

REINZ advised the coroner that it has begun work on a framework to raise awareness around pool safety in rented properties. In addition to working with Auckland Council, as mentioned above, REINZ has identified the following actions it can take.

- REINZ will write a pool clause and promote its use in all property management authorities. For example, the owner of the property will need to confirm and provide evidence to the property manager that their pool has been inspected by the local authority in the last three years and is currently compliant. REINZ needs to keep in mind that each business will ultimately have its own internal policies, however, feedback received is that many are looking for guidance on this very topic.

- REINZ will also write a clause for tenancy agreements. For example, identifying if there is a pool, and whether it is classed as either a spa, or a pool. The clause will also state the spa/pool complies with the relevant building code and the date it was last inspected. As well as the clause, there will be a general information sheet for the tenant on their responsibilities as the occupier of the property.

- REINZ has also tabled an educational webinar that it plans to work on in conjunction with the Auckland Council for owners/landlords and tenants.

- REINZ will promote this material via its regional networks, to disseminate it to its 16,000 real estate members.

RECOMMENDATIONS MADE BY CORONER GREIG

Pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendations:

To the Chief Executive Ministry of Business, Innovation and Employment Hīkina Whakatutuki:

- That the tenancy agreement builder on the Tenancy Services website be updated to include a new optional clause relating to pool safety and maintenance.
- That MBIE's Tenancy Compliance and Investigations Team (TCIT) investigates and addresses any gaps within its operating procedures in relation to pool maintenance and safety. For example, to allow TCIT to address any shortcomings discovered in the practices of property managers around

swimming pool fencing, TCIT includes questions regarding pool safety compliance in its detailed assessment process of property managers.

- To highlight the importance of pool maintenance for tenants and landlords, that MBIE:
    - adds content to Tenancy Services to ensure all parties are aware of their responsibilities for pool safety
    - ensures its service centre staff are equipped with information if customers call to ask who in the tenancy relationship is responsible for meeting requirements for pool fencing
    - shares information on pool maintenance and safety obligations with key stakeholders, including property manager organisations
    - includes information in its Tenancy Matters newsletter including regular reminders.

- That MBIE's Building Assurance Team develops and sends a communication, attaching MBIE's guidance, to all Territorial Authorities reminding them to check that their public information on pool barriers is adequate and up to date.

- The above recommendations arise out of consultation with MBIE, with most being the result of proactive suggestions from MBIE as to how it could assist, across its organisation, to address the issues identified in these findings in an effort to prevent deaths in similar circumstances in future. MBIE's willing engagement and assistance during this inquiry has been constructive and most helpful.

To the Chief Executive Auckland Council Te Kaunihera o Tāmaki Makaurau:

- I recommend that Auckland Council complete all the proactive steps it has indicated the Council is currently putting in place, and that it continues to monitor whether there are further ways the Council can draw attention to the issues highlighted in these findings.

- Again, I note the willing engagement and assistance of Auckland Council. The steps it is putting in place are designed to enhance pool safety and to try and help prevent deaths in similar circumstances in future.

To the Chief Executive Real Estate Institute of New Zealand

- All the steps REINZ has identified it could do are helpful and positive initiatives designed to raise awareness of the obligations of property owners and tenants for swimming pool safety responsibilities in order to try and prevent deaths in circumstances similar to Othman's in future. I commend REINZ for the work it has begun and recommend that it completes and implements the initiatives it has identified.

- I note that REINZ has helpfully and proactively engaged in identifying a variety of steps the organisation can take to help to prevent deaths in circumstances similar to Othman's in future. I hope other property managers also follow suit.

Section 74 non-publication orders

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Othman entered into evidence, in the interests of personal privacy and decency.

Ann Dornan

Date of death: **28/9/2019**

Date of findings: **15/9/2021**

Coroner Bruce Hesketh

Circumstances

Ann Dornan, aged 78, died on 28 September 2019 at Whanganui Hospital of acute left subdural haematoma.

On 9 July 2019, Mrs Dornan collapsed and was taken to Tauranga Hospital (she was transferred to Waikato and then to Whanganui Hospital for further treatment over the coming days). A CT scan revealed a large subarachnoid haemorrhage from an aneurysm (stroke). Mrs Dornan underwent endovascular stent-assisted coiling of the left posterior communicating artery aneurysm. She went to rehabilitation and following improvement was discharged on 26 August 2019.

On 16 September 2019, Mrs Dornan was re-admitted to Whanganui Hospital after presenting to the emergency department with stroke-related symptoms. An MRI scan revealed a right cerebral infarction. Mrs Dornan remained in hospital for treatment. She was in a “high watch” room (which requires staff to check on patients every 15 minutes) and was given a “stroke bed” which is alarmed and has sides that lock into place to prevent falling out.

Mrs Dornan continued to show signs of physical recovery. However, she had poor insight about her new impairments, including belief that she was able to independently do things that she could not e.g., stand and walk. On 28 September 2019, Mrs Dornan had an unwitnessed fall from her bed. The bed rail was found in the down position. Her condition deteriorated and she died the same day.

The Whanganui District Health Board commissioned a report into Mrs Dornan’s fall following her death. It found that there was no documentation of Mrs Dornan being checked on every 15 minutes. It also found general issues with Mrs Dornan’s hospital notes and that there were issues experienced by staff and patients relating to the stroke bed alarms.

Comments of Coroner Hesketh

- Medical staff are often very busy on Wards in hospitals around the country. Staff work different shifts as health is not a 9-5 profession. Medical staff are often confronted with challenging situations and people. The DHBs create policy and procedure to ensure patients are cared for to the highest standards possible. In most cases these standards are met, and medical professionals work tirelessly to ensure they deliver their best abilities, often in challenging and busy periods.

- The recording of clinical notes is an important procedural requirement to ensure both present and oncoming staff are kept up to date with relevant information about patients. Given Mrs Dornan’s medical condition it is concerning that no record was made of her being seen to lower the bed rail as later alleged.

- That is not only from the perspective of there being no record of an event that has subsequently become subject to an internal investigation but also from the need that other staff should have been aware of her actions as further monitoring would have been required.

- I also comment on the Falls Report section on bed alarms. The report authors discovered that staff had expressed their concern in the past about the bed alarms not always working. Staff had reported these faults; however, it appears from the report the staff concerns had not been addressed. Furthermore, some bed alarms appeared to be faulty as they continually "beeped" leading to staff developing a syndrome they referred to as "bed fatigue". They became so used to the noise that they ignored it until the patients complained.

Recommendations of Coroner Hesketh

- I recommend the Whanganui DHB produce guidelines for "high watch" patients to ensure they are observed at 15-minute intervals and a record of those observations is kept.

- I recommend ward staff be reminded of, or if necessary, receive further training around the importance of the need for attention to detail when recording patient's clinical notes. Matters that are relevant to the care plan of a patient should be recorded.

- I recommend Whanganui DHB attend to fixing any defective bed alarms so that staff will have confidence in knowing when a bed alarm activates it is a genuine incident.

- These recommendations are made in accordance with section 57A of the Coroners Act 2006. I notified Whanganui DHB of my comments and recommendations.

Responses

In accordance with section 57B of the Coroners Act, Whanganui DHB were provided with the opportunity to consider and respond to the proposed recommendations.

The Clinical Quality and Risk Advisor provided the below.

- The DHB discussed the provisional finding and recommendations and are fully supportive of these.

- Since Mrs Dornan's death the DHB have the stroke beds serviced and the alarms checked regularly. Staff have been formally reminded to document all matters regarding a patient irrespective of their source, that is from visitors and other patients as well as from direct observation and contact.

- The DHB are currently reviewing their observation procedure to ensure "high watch" is well defined and there is a recording sheet to support the required 15-minute observations.

Section 74 non-publication orders

- An order under section 74 of the Coroners Act 2006 prohibits the making public any of the photographs of Mrs Dornan entered into evidence, in the interests of personal privacy and decency.

CORONERS' COMMUNITY OUTREACH

The Coroners Court serves, and engages with, the community. Coroners regularly present to external audiences around the country on the role of the coroner and various aspects of the operation of the Coroners Court. This is part of ongoing education about the Coroners Court and the ways coroners engage with different systems.

Over the last two years, coroners have presented to a range of audiences including those shown in the table below.

Sector	**Audience**
Government agency	New Zealand Police
Health professionals	Bay of Plenty Child and Youth Mortality Review Group
	Starship Hospital
	NZ Society of Forensic Odontology
	GPs Rotorua
Universities and Polytechnics	University of Auckland
	Otago Polytechnic
	Papamoa University of the Third Age
Legal profession	Ngāti Hine Legal Clinic
Bereavement care services	Communio
	Funeral Directors Association of NZ
Community groups	Omanu Rebus Club
	Omokoroa Peninsula
	Metlifecare Retirement Village
	Wellington Central Probus/Rotary Club
	Kapiti Probus/Rotary Club
Business networks	Tauranga Businesswomen's Network

PERFORMANCE MEASURES 2021/22

5,253

Deaths were reported to the National Initial Investigation Office

3,734

Cases were accepted into the Coroners Court

Compared to 2020/21, this is an increase of

266 cases reported*

In 2021/22, coroners closed 3,094 cases

Closing a Coroners Court case took an average of

510 Days

This is an increase of 13 days when compared with **2020/21**

** Numbers are based on the Coroners Court Case Management System as at 4 July 2023. Since this is an operational system, numbers for 2020/21 have been updated since published in previous annual reports.*

PERFORMANCE MEASURES 2022/23

5,412

Deaths were reported to the National Initial Investigation Office

3,829

Cases were accepted into the Coroners Court

Compared to 2021/22, this is an increase of

159 cases reported*

In 2022/23, coroners closed 3,342 cases

Closing a Coroners Court case took an average of

510 Days

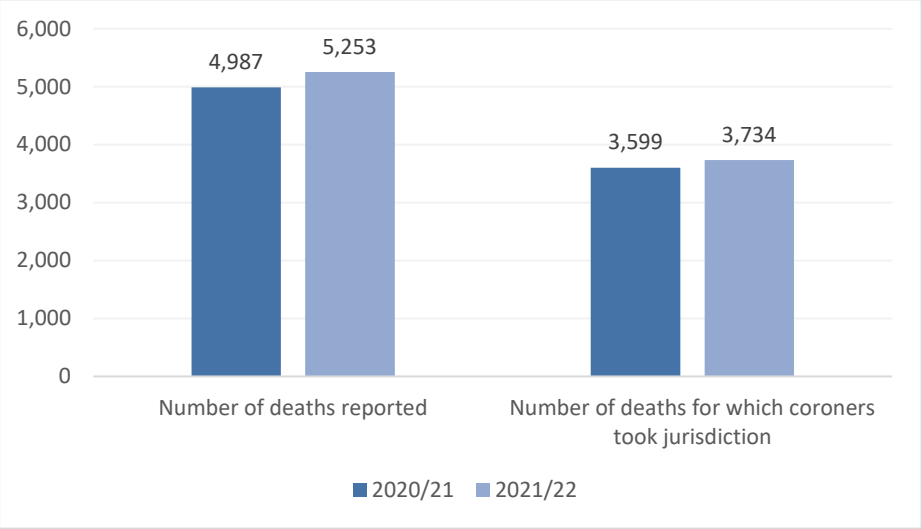
No change in the number of days compared with **2021/22**

** Numbers are based on the Coroners Court Case Management System as at 4 July 2023. Since this is an operational system, numbers for 2020/21 have been updated since published in previous annual reports.*

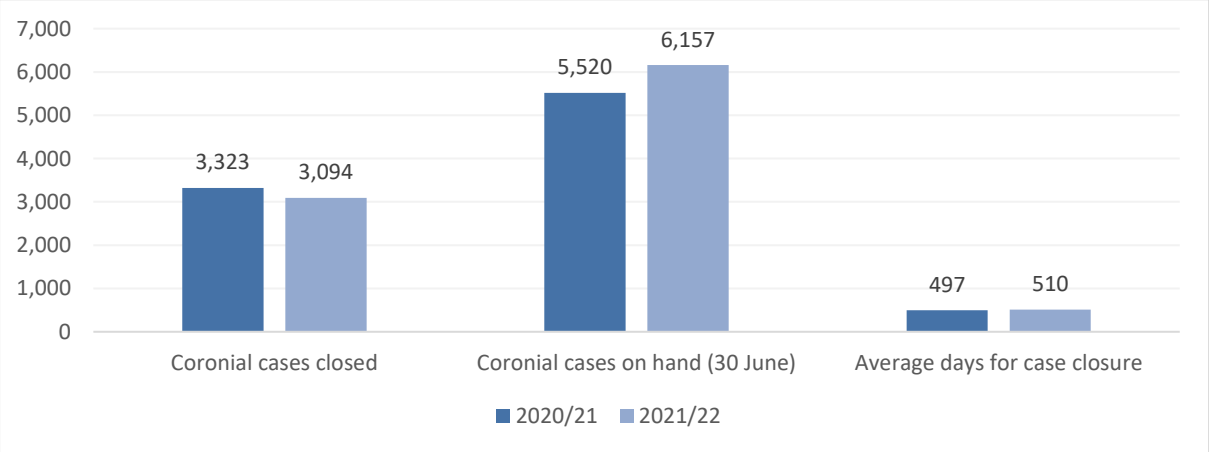
Year in review: 2021/22

During the 2021/22 year, 5,253 deaths were reported to the National Initial Investigation Office. Of these, coroners took jurisdiction over 3,734 deaths.

As at 30 June 2022, coroners were investigating 6,157 deaths. In 2021/22, coroners closed 3,094 cases. This is 229 fewer cases than in 2020/21*. On average, it took 510 days to close a Coroners Court case. This is an increase of 13 days when compared with 2020/21.



The number of Coroners Court deaths increased compared to the previous year



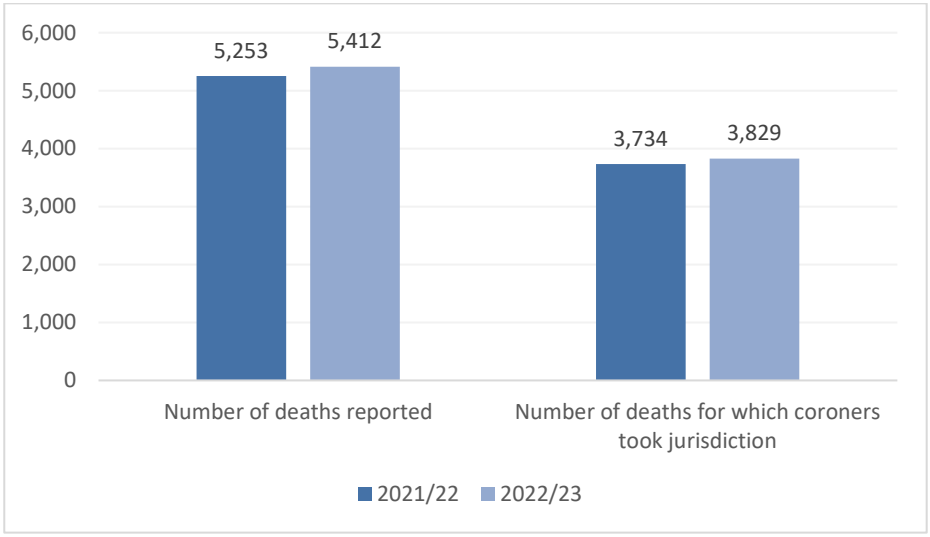
Year in review	2020-21*	2021-22*	CHANGE	% CHANGE
Number of deaths reported	**4,987**	**5,253**	**266**	**5%**
Number of deaths coroners took jurisdiction over	**3,599**	**3,734**	**135**	**4%**
Coroners Court cases closed	**3,323**	**3,094**	**-229**	**-7%**
Coroners Court cases on hand (30 June)	**5,520**	**6,157**	**637**	**12%**
Average days for case closure	**497**	**510**	**13**	**3%**

** Numbers are based on the Coroners Court Case Management System as at 4 July 2023. Since this is an operational system, numbers for 2020/21 have been updated since published in previous annual reports.*

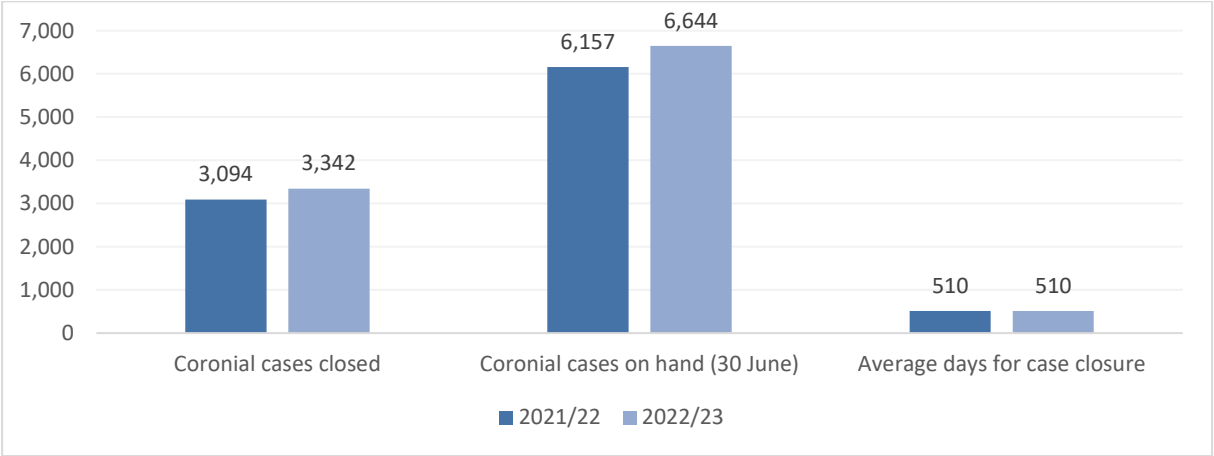
Year in review: 2022/23

During the 2022/23 year, 5,412 deaths were reported to the National Initial Investigation Office. Of these, coroners took jurisdiction over 3,829 deaths.

As at 30 June 2023, coroners were investigating 6,644 deaths. In 2022/23, coroners closed 3,342 cases. This is 487 more cases than in 2021/22*. On average, it took 510 days to close a Coroners Court case. This is no change in the number of days when compared with 2021/22.



The number of Coroners Court deaths increased compared to the previous year



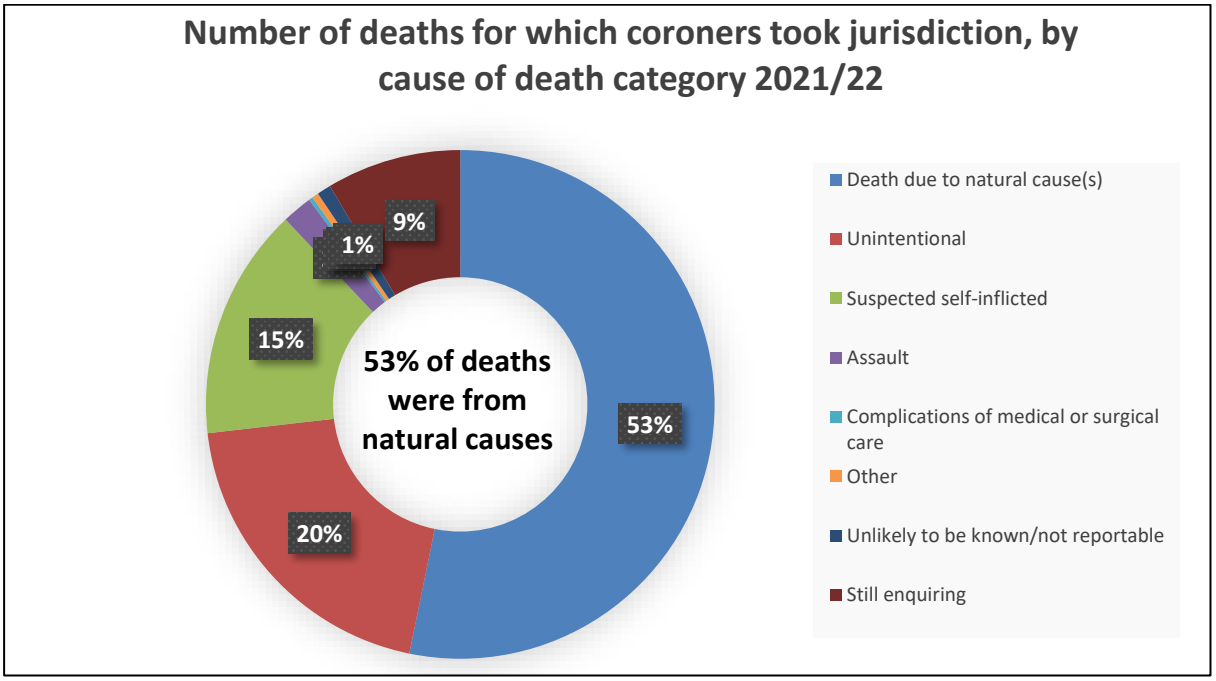
Year in review	2021-22*	2022-23*	CHANGE	% CHANGE
Number of deaths reported	**5,253**	**5,412**	**159**	**3%**
Number of deaths coroners took jurisdiction over	**3,734**	**3,829**	**95**	**3%**
Coroners Court cases closed	**3,094**	**3,342**	**248**	**8%**
Coroners Court cases on hand (30 June)	**6,157**	**6,644**	**487**	**8%**
Average days for case closure	**510**	**510**	**0**	**0%**

** Numbers are based on the Coroners Court Case Management System as at 4 July 2023.*

National statistics 2021/22

In 2021/22, coroners took jurisdiction over 3734* deaths. Of these, most deaths were due to natural causes, followed by unintentional deaths and then suspected self-inflicted deaths.

Cause of death category	Total
Death due to natural cause(s)	1987
Unintentional	746
Transport	327
Drowning/water	70
Fire/burn	13
Other	336
Suspected self-inflicted	551
Assault	72
Complications of medical or surgical care	9
Other	16
Unlikely to be known/not reportable	33
Still enquiring	320
Total	**3734**

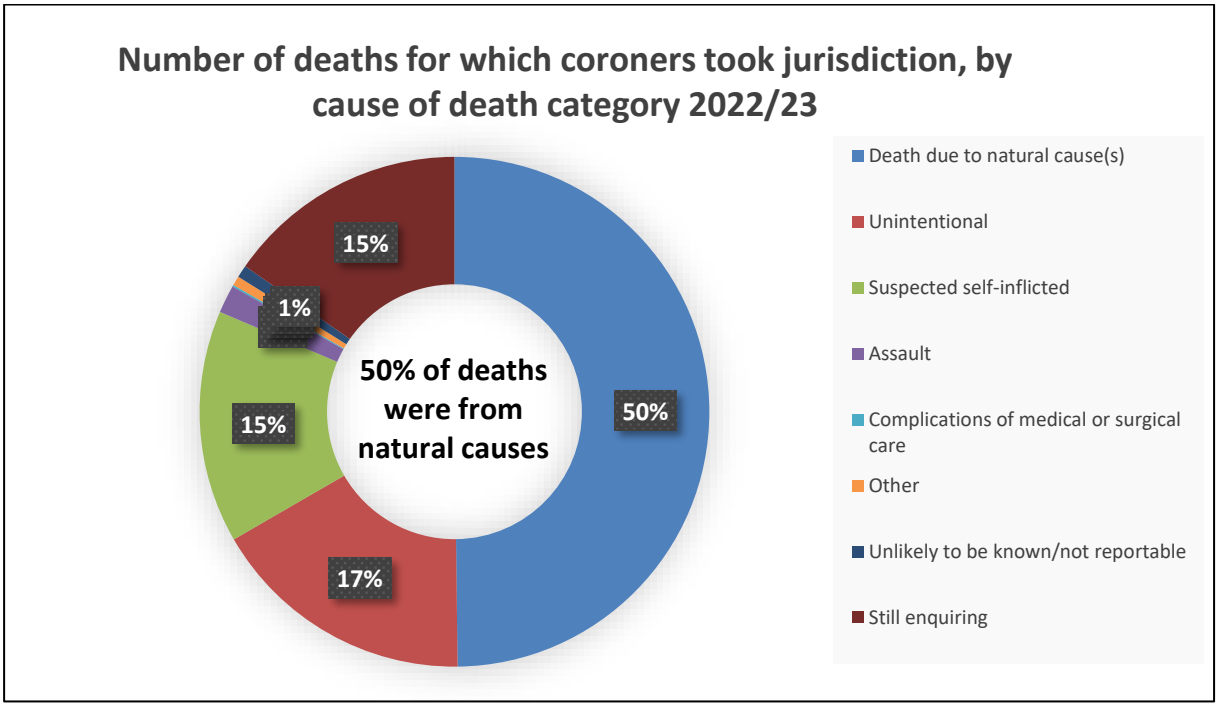


Causes of death are dependent on the way in which information is received and recorded by the coroner. For this reason, they cannot be easily summarised in a table, except at a high level. Where the death was categorised as 'Unintentional' and there are multiple causes of death, only one is counted. The prioritisation order used for counting is: 'Drowning/Water', 'Fire/Burn', 'Transport', 'Other'. Categories are based on information reported at the notification of the death unless closed in the same financial year, where at closure information is used instead.

National statistics 2022/23

In 2022/23, coroners took jurisdiction over 3829* deaths. Of these, most deaths were due to natural causes, followed by unintentional deaths and then deaths where the cause of death category was recorded as “still enquiring.”

Cause of death category	Total
Death due to natural cause(s)	1907
Unintentional	645
Transport	318
Drowning/water	87
Fire/burn	12
Other	228
Suspected self-inflicted	565
Assault	68
Complications of medical or surgical care	4
Other	23
Unlikely to be known/not reportable	30
Still enquiring	587
Total	**3829**



Causes of death are dependent on the way in which information is received and recorded by the coroner. For this reason, they cannot be easily summarised in a table, except at a high level. Where the death was categorised as 'Unintentional' and there are multiple causes of death, only one is counted. The prioritisation order used for counting is: 'Drowning/Water', 'Fire/Burn', 'Transport', 'Other'. Categories are based on information reported at the notification of the death unless closed in the same financial year, where at closure information is used instead.

Suicide reporting

Between 1 July 2021 and 30 June 2022, approximately 551 New Zealanders intentionally took their lives. Last year, the suicide rate decreased from 11.9 deaths per 100,000 people to 10.5 deaths per 100,000 people.

Between 1 July 2022 and 30 June 2023, approximately 565 New Zealanders intentionally took their lives. This year, the suicide rate increased from 10.5 deaths per 100,000 people to 10.6 deaths per 100,000 people.

As part of the collective effort to reduce Aotearoa New Zealand's rate of suicide, the Chief Coroner releases the national provisional suicide statistics each year. This release of national suspected suicide statistics each year is to help suicide prevention efforts and initiatives undertaken by other agencies.

This includes the work of the Suicide Prevention Office (SPO), which was established in November 2019 to provide kaitiakitanga (leadership and stewardship) for suicide prevention efforts and postvention work across the country. The Office of the Chief Coroner works alongside the SPO to support these efforts.

Data on suspected intentionally self-inflicted deaths reported by the Chief Coroner is available alongside Ministry of Health data on confirmed suicides via an interactive web tool providing a single comprehensive source of information on deaths by suicide in Aotearoa New Zealand.

It is important to note that the Chief Coroner's data is provisional. It includes all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally coded as suicides may not be determined to be suicides. Similarly, some deaths initially not coded as suicide may later be determined to be suicides.

In Aotearoa New Zealand, the legal position is that a person dies by suicide if the coroner determines that the evidence before them establishes that the death was self-inflicted and that the deceased intended to take their own life knowing the probable consequence of their actions. The coroner must be satisfied there is clear evidence inferring an intention to end one's life.

This data is provided by the Chief Coroner to Te Whatu Ora for inclusion in the 'Suicide web tool'. The web tool contains annual suspected suicides reported to the coroner for each year of 1 July to 30 June from 2008 to 2023.

Suspected self-inflicted death statistics

Please note when reading the data on suspected self-inflicted deaths that, when calculating rates for groups where numbers are very low, small changes in the numbers of suicide deaths across years can result in large changes in the corresponding rates. Rates that are based on such small numbers may not be reliable and can show large changes over time that may not accurately represent underlying trends. Because of issues with particularly small counts, rates are not calculated for groups with fewer than six suspected self-inflicted deaths in any given year.

Information about the estimated population of New Zealand can be found at Estimated population of NZ | Stats NZ. The per 100,000 population rates for the male and female groups have been calculated using the male and female populations respectively, taken from Stats NZ's national population estimates as published at the end of each financial year.

In addition, all statistics included here are based on the manner in which information was recorded in the Coroners Court Case Management System (CMS) on 12 July 2023. CMS is an operational system; therefore, numbers are subject to change in future publications.

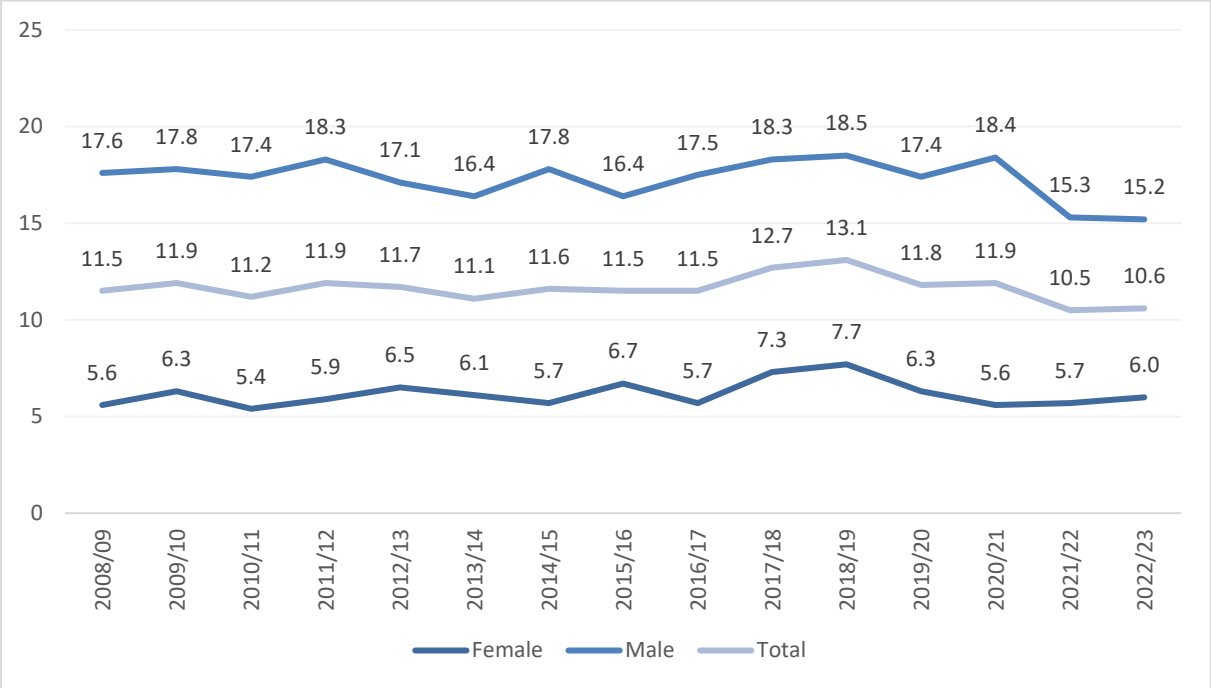
Suspected self-inflicted deaths between 1 July 2008 and 30 June 2023, by sex, for the rate per 100,000 people

Table 2: Numbers and rates of suspected self-inflicted deaths, by sex

Year*	Men		Women		Total	
	Number	Rate	Number	Rate	**Number**	**Rate**
2008/09	383	17.6	125	5.6	**508**	**11.5**
2009/10	385	17.8	144	6.3	**529**	**11.9**
2010/11	384	17.4	122	5.4	**506**	**11.2**
2011/12	396	18.3	134	5.9	**530**	**11.9**
2012/13	381	17.1	150	6.5	**531**	**11.7**
2013/14	383	16.4	143	6.1	**526**	**11.1**
2014/15	420	17.8	133	5.7	**553**	**11.6**
2015/16	400	16.4	162	6.7	**562**	**11.5**
2016/17	437	17.5	142	5.7	**579**	**11.5**
2017/18	471	18.3	190	7.3	**661**	**12.7**
2018/19	476	18.5	188	7.7	**664**	**13.1**
2019/20	462	17.4	168	6.3	**630**	**11.8**
2020/21	485	18.4	141	5.6	**626**	**11.9**
2021/22	**407**	**15.3**	**144**	**5.7**	**551**	**10.5**
2022/23	**411**	**15.2**	**154**	**6.0**	**565**	**10.6**

** Numbers are based on the Coroners Court Case Management System as at 12 July 2023. Since this is an operational system, numbers may differ from those published in previous annual reports.*

Figure 1: Rates of suspected self-inflicted deaths by sex

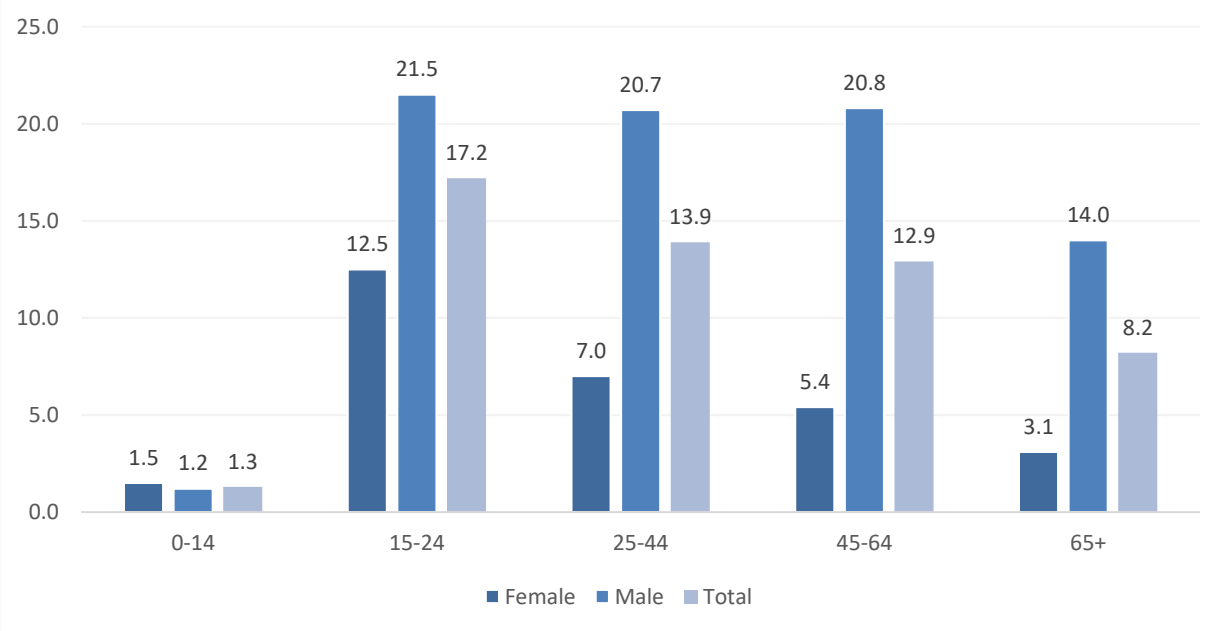


Suspected self-inflicted deaths between 1 July 2021 and 30 June 2022, by sex and age, for the rate per 100,000 people

Table 3: Numbers and rates of suspected self-inflicted deaths, by sex and age (2021/22)

Age group	Men		Women		Total	
	Number	Rate	Number	Rate	Number	Rate
0-14	6	1.2	7	1.5	**13**	**1.3**
15-24	71	21.5	39	12.5	**110**	**17.2**
25-44	146	20.7	49	7.0	**195**	**13.9**
45-64	129	20.8	35	5.4	**164**	**12.9**
65+	55	14.0	14	3.1	**69**	**8.2**
All ages	**407**	**15.3**	**144**	**5.7**	**551**	**10.5**

Figure 2: Provisional suicide rates by sex and age (2021/22)

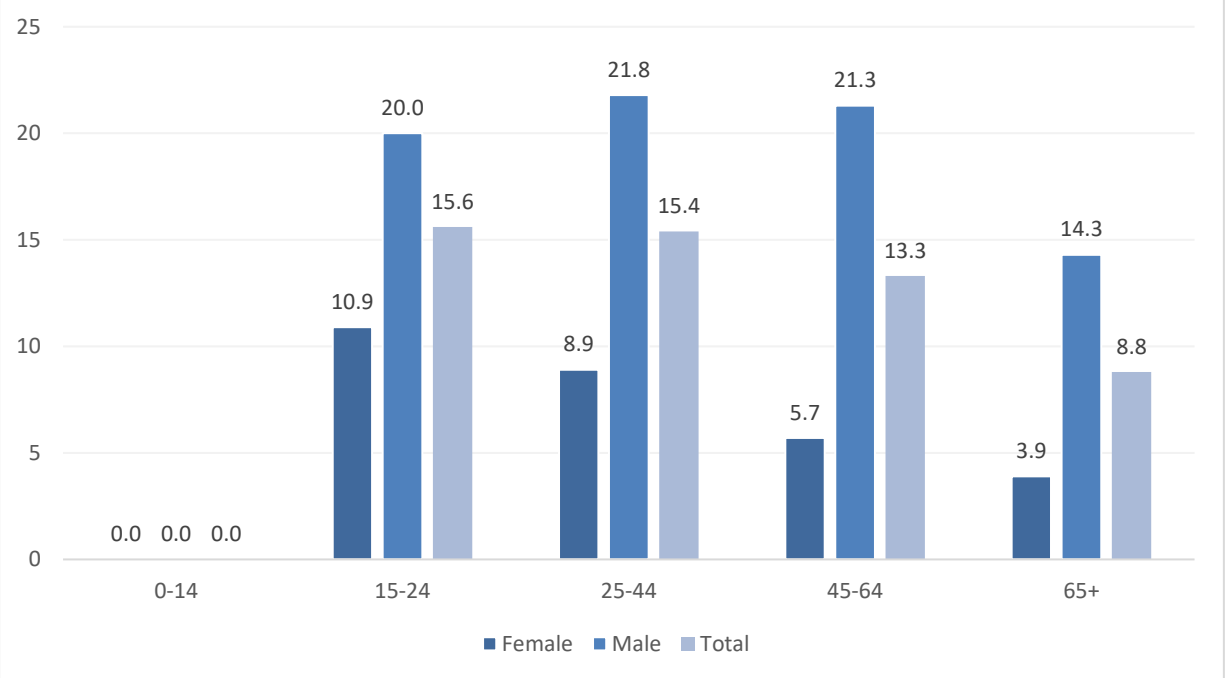


Suspected self-inflicted deaths between 1 July 2022 and 30 June 2023, by sex and age, for the rate per 100,000 people

Table 3: Numbers and rates of suspected self-inflicted deaths, by sex and age (2022/23)

Age group	Men		Women		Total	
	Number	Rate	Number	Rate	Number	Rate
0-14	1	0.0	2	0.0	**3**	**0.0**
15-24	66	20.0	34	10.9	**100**	**15.6**
25-44	154	21.8	63	8.9	**217**	**15.4**
45-64	132	21.3	37	5.7	**169**	**13.3**
65+	58	14.3	18	3.9	**76**	**8.8**
All ages	**411**	**15.2**	**154**	**6.0**	**565**	**10.6**

Figure 2: Rates of suspected self-inflicted deaths by sex and age (2022/23)

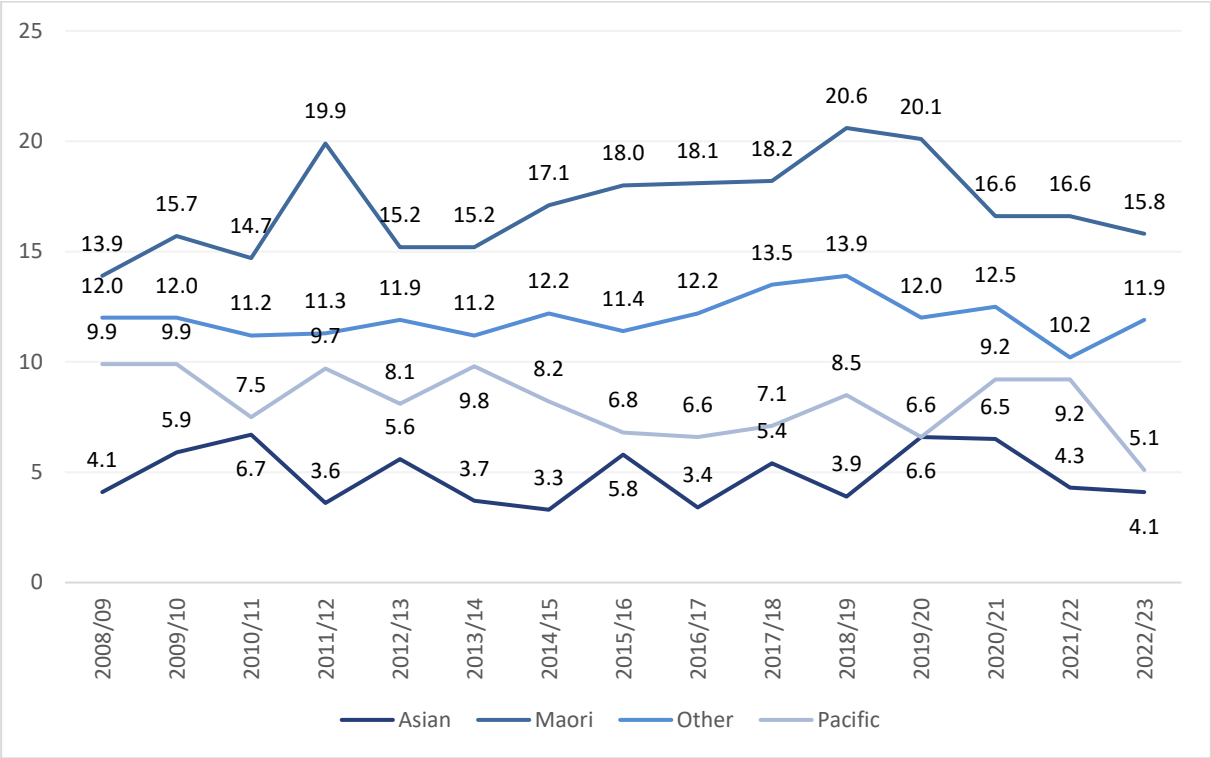


Suspected self-inflicted deaths between 1 July 2008 and 30 June 2023, by ethnic group, for the rate per 100,000 people

Table 4: Numbers and rates of suspected self-inflicted deaths by ethnic group

Year	Asian		Māori		Pacific		Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2008/09	17	4.1	89	13.9	27	9.9	375	12.0
2009/10	29	5.9	99	15.7	27	9.9	374	12.0
2010/11	30	6.7	97	14.7	21	7.5	358	11.2
2011/12	20	3.6	133	19.9	28	9.7	349	11.3
2012/13	30	5.6	101	15.2	24	8.1	376	11.9
2013/14	23	3.7	102	15.2	30	9.8	371	11.2
2014/15	20	3.3	118	17.1	25	8.2	390	12.2
2015/16	40	5.8	130	18.0	21	6.8	371	11.4
2016/17	25	3.4	135	18.1	21	6.6	398	12.2
2017/18	41	5.4	141	18.2	23	7.1	456	13.5
2018/19	31	3.9	166	20.6	29	8.5	438	13.9
2019/20	53	6.6	163	20.1	24	6.6	390	12.0
2020/21	52	6.5	136	16.6	34	9.2	404	12.5
2021/22	**34**	**4.3**	**143**	**16.6**	**34**	**9.2**	**340**	**10.2**
2022/23	**33**	**4.1**	**136**	**15.8**	**19**	**5.1**	**377**	**11.9**

Figure 3: Rates of suspected self-inflicted deaths by ethnic group



For more information and more data, visit https://minhealthnz.shinyapps.io/suicide-web-tool

CORONERS AS AT 30 JUNE 2023

Office of the Chief Coroner
Chief Coroner, Judge Anna Tutton

Whangārei
Coroner Tania Tetitaha
Coroner Alison Mills

Auckland
Coroner Tracey Fitzgibbon
Coroner Alexander Ho
Coroner Erin Woolley
Coroner Janet Anderson
Coroner Ian Telford
Relief Coroner Meenal Duggal

Hamilton
Coroner Matthew Bates
Coroner Michael Robb
Relief Coroner Louella Dunn

Rotorua
Coroner Donna Llewell
Coroner Bruce Hesketh

Hastings
Coroner Heidi Wrigley

Palmerston North
Coroner Robin Kay
Relief Coroner Ruth Thomas

Wellington
Coroner Brigitte Windley
Coroner Katharine Greig
Coroner Mary-Anne Borrowdale
Coroner Peter Ryan
Relief Coroner Mark Wilton

Christchurch
Coroner Marcus Elliott
Coroner Sue Johnson
Coroner Alexandra Cunninghame

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Coroner Heather McKenzie

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CORONERS COURT
Te Kōti Kaitirotiro Matewhawhati

MINISTRY OF JUSTICE
Tāhū o te Ture

Te Kāwanatanga o Aotearoa
New Zealand Government