



**Shining a light on whānau
experiences of Coroners'
investigations of suspected
self-inflicted deaths**

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1. Whānau Voice – Opening Comments

Maranga mai, maranga mai! Maranga ki te tangi o te manu e rere nei, tui, tui, tui, tuia. Tuia i runga, tuia i raro, tuia i roto, tuia i waho, tuia i te here tangata. Ka rongo te pō, ka rongo te ao. Ko te tangi o te rauika wairua ka rere. Ko te tangi o te rauika kikokiko, ka rere. Tukua te taonga ki te atea, tukua te koha e takoto rā. Te takoha aroha, takoha wairua, takoha o te whānau pani e hora nei. Ka ea, ka ea, ka ea e!

Let us rise, let us rise! To the cry of the bird that wails. Bind us together from above, below, within, and beyond. From within the dark to the world of light. As the spiritual world descends and the physical realms gather, we lay down our taonga as a koha with love and in the spirit of bereaved families. Our duty is complete.

Bereavement by suicide has permanently altered our lives. As well as confronting a traumatic death, many of us have experienced a coronial system that has exacerbated our trauma. Bereaved whānau have been calling for change for some time.

Driving us all has been the silent voices of our loved ones – the desire to honour you all gives us strength and your wairua is woven into this taonga.

This review of the Coronial Investigations Process relating to self-inflicted death has been welcomed by us all. Thank you to the Office of Suicide Prevention for picking up the wero of putting whānau front and centre of this review. Whānau need to play a pivotal role in future coronial inquiries to ensure equity and inclusion. The investigations we so desire are something all New Zealanders deserve.

We have shared our experiences and recommendations with you and these are recorded in this report. It lays out the stark challenges that whānau face following a suicide and the system changes required.

We are proud of our involvement and the strong connection and collaboration we have forged with other whānau and agencies through this review. Our grief has given us the strength and passion to undertake this difficult task. The recommendations we offer give us hope of a more compassionate coronial process in the future.

We thank KPMG for collating our experiences with aroha and shepherding our words into the well-crafted report that follows. It marks the beginning of the change we have long sought.

Ki te kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati.

When we stand alone, we are vulnerable, but together we are unbreakable.



2. Foreword: Matthew Tukaki Director, Suicide Prevention Office

When I reflect on the mahi we need to do in the area of suicide prevention it would be easy to be overwhelmed by the tasks at hand. It would be easy also just to focus on the things we need to change from a systems or process perspective but, in all reality, those things only exist because of the very people-centred stories and experiences that sit at the heart of why a report like this is so important.

Every story, every lived experience and every voice of those still with us and those who have passed on are why we do what we do.

This report and its recommendations are a culmination of those many voices that speak from the very people-centred approach that we need to enshrine if we are to make a difference. I want to thank all of those involved from the Design Group and mihi to our whānau and communities across the nation who have helped to bring this together.

This report will form one of the key pou/pillars of our journey towards making that difference and will join with the very real need to be inclusive of other organisations and entities involved in the pursuit of suicide prevention and the next stage of the work programme of the Suicide Prevention Office as the Coronial Investigation Process continues. Joining both these strands of work together sees us all paddling our waka in the same direction.

**Anake, kihai koe e hoe te waka
Ki te mahia te neketanga o te
moana, he maha nga Kaihoe.
*You do not paddle the waka
alone, it takes many paddlers
to make the waters shift.***

Again, I want to especially thank all of those involved for their passion, their mahi and their clear focus on seeing real and meaningful change occur.

**Tawhiti rawa tōu haerenga ake
te kore haere tonu. *We have
come too far not to go further.
We have done too much not to
do more.***

Matthew Tukaki



3. Foreword: Carla na Nagara Steering Group Chair

Tēnā koutou, tālofa lava, ni sa bula vanaka, kia orana, fakaalofa lahi atu, mālō e lelei, warm Pacific greetings to you all.

I have not suffered the particular trauma and grief of losing someone I love to suicide, and I am under no illusion as to my good fortune in this regard. The insight I have into the devastation self-inflicted death causes has been informed by my experiences as a coroner and as the inaugural director of the Suicide Prevention Office, and I wish to pay tribute to those who have been bereaved in this most dreadful of circumstances. Words simply cannot capture the depth and breadth either of your loss, nor of my sympathy and compassion for you all.

In my work as a coroner over a 12 year period, I gained some insight into how disempowering and alienating the traditional approach to investigating suspected self-inflicted deaths was for whānau and families. Within the limits of that role I tried to modify aspects of the inquiry processes that I was responsible for, in order to support whānau and families to be more meaningfully engaged. However, it is only by hearing from those whānau and families who have lost loved ones to self-inflicted death that effective change can be made.

It was a privilege to support this work, and to have been permitted to sit alongside those who had lost loved ones to self-inflicted death, and whose lives had then been so negatively impacted by the system I had been an integral part of.

I learnt a lot about my blind spots and biases as a coroner, and I am left with a profound respect for the grace, dignity and optimism of those who shared their experiences without bitterness, and in the expectation that it will contribute to the improvement of a system they variously experienced as brutal, silencing, traumatic and the antithesis of supportive and caring.

I am certain no one who works in or alongside the coronial system means to do harm to those whose lives intersect with it due to the unexpected death – or self-inflicted death – of a loved one. What this work helps to illuminate is where and how harm is unwittingly being done, as well as proposing ideas for solutions.

In providing clearly articulated ideas for how the system might be improved across a range of touch points, this seminal piece of work is an important first step on a journey to ensure that whānau and families who are bereaved by suicide are appropriately supported by the coronial system, and able to participate meaningfully and on equal footing in coronial inquiries.

I wish to thank sincerely those bereaved by suicide who so courageously and graciously gave their time and energy to this work, and to commend to those to whom proposed change in the words of Maya Angelou: “Do the best you can until you know better. Then, when you know better, do better.”

Mauri ora

Carla na Nagara

4. Acknowledgements: Rachel Scott KPMG Hauora & Govt Consulting Lead Partner

This review report is borne out of a significant collaborative effort between and with whānau with lived experience. Their loved ones and their stories are at the very heart of this mahi. To respect and preserve the integrity of the stories shared, concerns, aspirations and ideas, every attempt has been made to ensure that they are captured through lived experience voices. KPMG are honoured to have been kaitiaki of these stories, this precious taonga, during our journey together in this work.

KPMG were engaged by the Suicide Prevention Office within the Ministry of Health to provide support throughout the review process from its inception to the report completion, including providing project management support, facilitating workshops with the Design Group to bring forth whānau-led insights and solutions, providing secretariat support to the Review Steering Group, and drafting this report to provide a platform for change. It has been a privilege to be invited in and entrusted with this vital mahi.

KPMG would like to thank the Design Group, made up of whānau with lived experience, for their willingness to actively participate in the Coronial Investigations review process. We acknowledge their strength and dignity in sharing the traumatic experiences endured by their whānau and communities.

It was a privilege to witness the resoluteness of the Design Group in seeking out impactful solutions to ensure that future whānau have a more compassionate experience. This work reflects the Design Group's courage, tenacity and aroha for their loved ones, whānau, families, and communities.

We would also like to thank and acknowledge the support and mahi of Carla na Nagara for her thoughtful Chairing of the Steering Group. Her expertise and knowledge of the Coronial Investigation Process was invaluable in supporting the Design Group in their considerations and recommendations.

Thanks also to the Suicide Prevention Office for the opportunity, support throughout the process, and the trust placed in us for this important mahi.

And finally, to our kaumatua, our community leaders, KPMG whānau, and everyone who offered support throughout this journey – this was an incredibly challenging piece of work, and we are grateful for the unwavering support you provided throughout.

Ngā manaakitanga

Rachel Scott

5. Key insights and recommendations on a page

The figure below summarises the key insights from the Design Group, 'How Might We' statements and recommendations captured through high-level ideas canvas. Further details can be found in the Executive Summary and throughout the report that follows.

Shining a light on whānau experiences of Coroners' investigations of suspected death by suicide

Personal and Agency Sessions

Insights from the voices of whānau

1. The journey is different for everyone, and everyone has different needs in navigating through the haze
2. The environment should promote inquisitory behaviour and drive restorative outcomes.
3. Whānau want to be active participants in the journey.
4. Te Tiriti o Waitangi, cultural and community lens anchor partnership and interactions throughout the journey.
5. Stories are a reflection of a person's life, it needs to be accurate and honourable.
6. The journey starts long before the coroner and continues well beyond coronial findings.

'How Might We' statements

We should focus our efforts to:

- Create a supportive and compassionate coronial system that puts whānau front and centre in a way that is culturally safe and spiritually responsive.
- Amplify whānau voice and perspectives to create inclusive care and support systems that meet the emotional, financial, and other needs of whānau.
- Enable whānau to sit at decision-making tables as equals in environments that are inclusive and power neutral.
- Awhi whānau to navigate the coronial system and its communications to ensure whānau are well-informed and engaged to enable whānau confidence, dignity and trust in it.
- Ensure the sacredness of our loved ones and their mana, mauri and tapu is upheld, treasured and respected.

High level ideas canvas

OUR RECOMMENDATIONS:

Induction & Opportunities for Continuous Learning

- Recruitment and Training
- Monitoring of Continuous Learning
- Cultural Awareness & Te Tiriti o Waitangi
- Trauma, Drivers & Behaviours
- Standards & Guidelines

Coronial Liaison Services

- Online Portal
- Whānau Liaison
- Emotional Support Service
- Free Access to Legal Support Services & Expert Witnesses

Safe Options for Inquests

Build and Maintain Cultural and Community Connectedness

- Kaumātua
- Spiritual & Community Leaders
- Establish Pou Tikanga
- Regional Whānau Network



6. Executive Summary

6.1 Where we started

The Coronial Investigations Review (*for suspected self-inflicted deaths*) was an action item of *Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand*, released in 2019. This followed the recommendation from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* that a review of the process by which suspected self-inflicted deaths are investigated by coroners be conducted in collaboration with whānau and families who had been bereaved by suicide.

Further information on the purpose, scope and aim of this review are set out in the full Steering Group Terms of Reference in [page 49](#).

6.2 How we approached the review

In working with whānau and communities with lived experience, an understanding of current state challenges was built. These challenges informed a set of future state recommendations. The design approach that was used sought to retain whānau as the first and last voice throughout.

In line with this approach, this report reflects the views of the Design Group and represents perspectives of those with lived experience. It does not necessarily represent the views of the Ministry of Health or wider government.

6.3 Where did we land?

6.3.1 Identifying our current challenges (key insights)

Through the voice of those with lived experience five key insights were developed. These insights inform challenges and frustrations experienced by whānau.

- The journey is different for everyone, and everyone has different needs in navigating through the haze.
- The environment should promote inquisitory behaviour and drive restorative outcomes.
- Whānau want to be active participants in the journey.
- Cultural and community lenses and Te Tiriti o Waitangi anchor partnership and interactions throughout the journey.
- Stories are a reflection of a person's life; they need to be accurate and honoured.

6.3.2 Prioritising our focus (key problems and opportunities)

Building on the five key insights, the Design Group, made up of whānau with lived experience identified and prioritised the key challenges to address.

The challenges are described by the following 'How Might We' statements:

- A. How might we create a supportive and compassionate coronial system that puts whānau front and centre in a way that is culturally safe and spiritually responsive?
- B. How might we amplify whānau voice and perspectives to create inclusive care and support systems that meet the emotional, financial, and other needs of whānau?
- C. How might we enable whānau to sit at decision-making tables as equals in environments that are inclusive and power neutral?
- D. How might we awahi whānau to navigate the coronial system and its communications to ensure whānau are well-informed and engaged to enable whānau confidence, dignity and trust in it?
- E. How might we ensure the sacredness of our loved ones and their mana, mauri and tapu is upheld, treasured and respected?

6. Executive Summary (continued)

6.3 Where did we land? (continued)

6.3.3 Focusing on where we can create the most impact (key recommendations)

The Design Group of whānau with lived experience began with a long list of bold and unconstrained potential opportunities for improvements to address the five 'How Might We' statements (the long list of potential solutions can be found from [page 44](#)).

The long list of ideas were themed, challenged, scoped and prioritised resulting in key recommendations. These recommendations were designed to be actionable:

1. **Induction & opportunities for continuous learning:** Selecting coroners and other coronial services workers with the right skills and providing on-going training and performance monitoring.
2. **Coronial Liaison Services:** Providing holistic support to whānau and enabling them to engage in the process, such as emotional, legal and navigation support through online and in-person services.

3. **Safer options for inquests:** Supporting whānau with spiritually and culturally safe venues that support healing.
4. **Build and maintain cultural and community connectedness:** Establishing processes for whānau, cultural leadership oversight and support through the investigation processes.

Further detail on the recommendations is found from [page 22](#) of this report.

6.4 What should we keep in mind?

The recommendations provided largely do not require legislative change. Instead, they are related to 'how' coronial investigations are carried out.

The recommendations apply to a range of stakeholders and agencies, but primarily to:

- Coronial Services New Zealand;
- New Zealand Police; and
- Ministry of Justice.

Significant collaborative improvements can be made through targeted efforts and actions, starting with those identified above.

It is acknowledged that a wider Coronial Work Programme is underway by the Ministry of Justice, separate to this Coronial Investigations Review. The outputs of the Coronial Work Programme were not known throughout the duration of this review.

The recommendations contained within this report could be used to inform the Coronial Work Programme and other on-going efforts of the Ministry of Justice.

6.5 The way forward

Getting this right means taking time to consider the recommendations to form the way forward. To progress, key stakeholder engagement and implementation planning will be undertaken.

7. Shining a light on whānau experiences of Coroners' investigations of suspected self-inflicted deaths

This report supports the key action 'Review the coronial investigative process' within **Action area 8: Postvention – Supporting individuals, whānau and families, and communities after a suicide** of *Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand (He Tapu te Oranga)*.

The narrative for Action area 8 in He Tapu te Oranga notes the review should provide opportunities for the voices of whānau, families and communities to have their say on what a system that validates the impact of self-inflicted deaths and supports healing looks like.

The scope included, but is not limited to:

- Response to a suspected self-inflicted death by Police and the coronial service.
- Immediate support offered to whānau.
- Investigative processes following a suspected self-inflicted death.
- The way recommendations are released to reduce risks of future self-inflicted deaths.

A high-level overview of the current state of the coronial investigative process for suspected self-inflicted deaths can be found in [page 42](#).

7.1 What was the genesis of this review?

7.1.1 He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction

The purpose of the 2018 Government Inquiry into Mental Health and Addiction included to:

- hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction and what needs to change;
- report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems; and

- recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

The Inquiry resulted in the publication of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* in November 2018.

The scope of this report relates to recommendation 33 of that report – to **direct** the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating suspected self-inflicted deaths, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.

7. Shining a light on whānau experiences of Coroners' investigations of suspected self-inflicted deaths (continued)

7.1 What was the genesis of this review? (continued)

This recommendation is carried through into Every Life Matters – *He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand (He Tapu te Oranga)*.

Importantly, He Tapu te Oranga is based on equity. This review of systems and processes that are triggered by a suspected self-inflicted death, focusing on but not limited to the coronial processes, recognises the standing of Māori as the tāngata whenua of Aotearoa and as Te Tiriti o Waitangi partners of the Crown.

7.1.2 Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029

He Tapu te Oranga describes what we aim to achieve for suicide prevention over the next 10 years. The framework consists of:

- a **vision** setting the long-term aspiration for the strategy and suicide prevention in Aotearoa New Zealand
- **outcomes** sought through the strategy to support the vision
- **focus areas** which describe key actions needed to support the vision
- **collective ownership** and shared ways of working that must underpin delivery of the vision.

It is acknowledged that while every unexpected death has an impact on whānau, the impact of loss by self-inflicted death is intensified by unique issues. These include stigma, isolation, mental distress and barriers to support, leaving families vulnerable to long-term health problems; whānau disruption; breakdown of relationships; financial difficulty; shame; self-blame; and a heightened risk of self-inflicted death.

A suspected self-inflicted death triggers various legal procedures and processes, including coroners' investigations. However, whānau and families are often left unsupported, and without the adequate cultural/pastoral support or the resources required to fully engage with the processes and voice their needs.

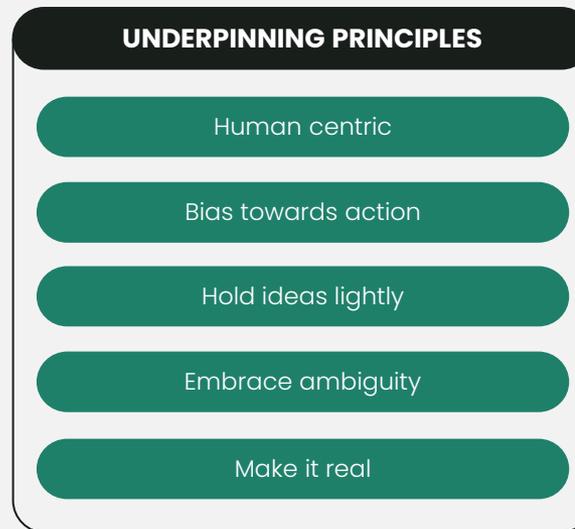
8. Bringing voice of lived experience to the centre of solution design

The aim of all recommendations was to improve current systems and investigative processes following suspected self-inflicted deaths to:

- Support and resource healing for bereaved whānau and communities following the loss of a loved one to a suspected self-inflicted death.
- Support and resource equitable and safe whānau engagement in all investigations subsequent to the loss of a loved one to a suspected self-inflicted death.
- Provide opportunities for bereaved whānau, families and communities to understand the causes and drivers of their loved one's death.
- Contribute to the timely release of information and rate of implementation of recommendations which aim to reduce the risk of future deaths in similar circumstances.
- Embrace a human-centric, non-transactional approach to legal processes.

The methodology used to create the recommendations within this report were guided by Service Design and Design Thinking tools. These are centred on close engagement with end-users of a service to understand their experiences, challenge assumptions, redefine problems and co-create innovative solutions that address the underlying needs of end-users.

Turning principles into action



Develop a **shared agreement** of the prioritised current state challenges that we will look to solve.

Collectively design a list of bold and innovative solutions that solve the current state challenges.

Prioritise and enhance ideas to promote sustainable long-term change.

Produce **actionable solutions** by drawing on the feedback and experiences of all individuals.

8. Bringing voice of lived experience to the centre of solution design (continued)

The methodology applied in the development of the recommendations as described in the diagram below.

	DEFINE	UNDERSTAND	DESIGN	PROTOTYPE	RECOMMENDATIONS
	What will be the approach for the review, who needs to be involved at each stage and how will they be engaged?	What does the current process look like for whānau that experience it, where are the pain points and what could it improve?	What recommendations do whānau want to be implemented? Which of these should we prioritise?	How can we make the recommendations actionable to maximise the likelihood that they will be implemented?	What are the next steps for the review to carry the recommendations forward into implementation?
Who was involved?	<ul style="list-style-type: none"> Steering Group. 	<ul style="list-style-type: none"> Design Group (<i>whānau with lived experience of bereavement by suicide</i>). Government and non-Government agencies, and stakeholder groups. 	<ul style="list-style-type: none"> Design Group (<i>whānau with lived experience of bereavement by suicide</i>). 	<ul style="list-style-type: none"> Design Group (<i>whānau with lived experience of bereavement by suicide</i>). 	<ul style="list-style-type: none"> Suicide Prevention Office. Design Group (<i>whānau with lived experience of bereavement by suicide</i>). Government and non-Government agencies.
What was the approach?	<ul style="list-style-type: none"> Fortnightly Steering Group meetings. 	<p>Design Group:</p> <ul style="list-style-type: none"> One on one personal sessions In-person design workshops (days 1 and 2). <p>Agencies and stakeholder groups:</p> <ul style="list-style-type: none"> Interviews and group workshops. 	<ul style="list-style-type: none"> In-person design workshops (days 3 and 4). 	<ul style="list-style-type: none"> On-going virtual workshops. 	<ul style="list-style-type: none"> Report of findings provided to the Suicide Prevention Office. On-going engagement between the Suicide Prevention Office, Design Group and agencies to agree and action the next steps for the recommendations.

9. Reflecting on personal journeys for each whānau in findings

9.1 Insights from the voices of whānau

Design Group participants were invited to share their personal stories through personal sessions. Empathy interview techniques were employed to build trust and honour the personal stories shared.

The insights derived from the personal sessions illuminated the current state experiences and frustrations, as well as motivations and desires for change.

9.1.1 The journey is different for everyone, and everyone has different needs in navigating through the haze

Whānau have a range of practical and emotional needs and these needs are different for all whānau and all individuals. At a time of emotional distress, the system becomes increasingly challenging to navigate.

What we heard



"It is all overwhelming when you don't know what's going on"

"They weren't trained in grief counselling"

"They only supported 'direct whānau'... there was no support available for wider communities"

"First-responders should do suicide prevention training and trauma training, so they have the knowledge on how to deal with the family sensitively that is going through the shame, blame, stigma and trauma – ideally within the various cultural contexts"

"I became concerned about the well-being of first responders [when they arrived on the scene]"

"I had no idea what to expect [from the outset]"

"Group support is great but it isn't for me"

"When I sought support, they only wanted to prescribe medication"

"No one told me what to prepare for the hearing"

"Everyone is reactive"

"I felt so alone"

9. Reflecting on personal journeys (continued)

9.1 Insights from the voices of whānau (continued)

9.1.2 The environment should promote inquisitory behaviour and drive restorative outcomes

The physical setting and the way in which processes are conducted are led by the law. There is an absence of whānau identity and environmental appropriateness. Families feel as if they are on trial.

What we heard

"The Police presence made me feel that I was in trouble. That I was to blame"

"When I encountered parts of the process, it was like being in a battle or being patronised"

"Most delays come from waiting for the right information"

"It shouldn't be a blaming process"

"It shouldn't be purely a legal process - we could answer those questions, the lawyers couldn't. It felt like a court case"

"I was too scared to go near the courtroom"

"We were squished onto a single bench... we also couldn't read our files"

"They said they contacted us but never did"

"[During breaks in proceedings] there was no place to rest for lunch"

"It was a legal argument not a human one"

"It seems like their [healthcare professionals and institutions] legal support is funded from a bottomless pit"

"It was supposed to be inquisitory, but it felt adversarial"

9. Reflecting on personal journeys (continued)

9.1 Insights from the voices of whānau (continued)

9.1.3 Whānau want to be active participants in the journey

There are barriers to active participation for whānau. Whānau are treated as 'interested parties', without dignity and suffer from power imbalances at all stages.

What we heard

"We had to self-fund expenses for the inquest"

"[Proceedings and the Report] was full of legal jargon"

"We were treated like naughty children"

"We have to enter their world"

"You need to tell your story or somebody else will"

"We had to speak to 9 lawyers before one would take the case"

"Whānau need to be empowered and enabled to participate with dignity and resourcing"

"Delays come from whānau not knowing how to participate"

"[I] was too scared to ask questions"

9. Reflecting on personal journeys (continued)

9.1 Insights from the voices of whānau (continued)

9.1.4 Te Tiriti o Waitangi, cultural and community lens anchor partnership and interactions throughout the journey

The largely monocultural lens drives interactions, missing the required cultural nuances. Te Tiriti o Waitangi does not actively feature in the Act.

What we heard

“There is a need for a team in the Police that can translate the system [in a way that works] for Māori. It is important they [the Police]:

*Understand culture,
Understand legislation,
Can hold the system and whānau to account”*

“Whānau accept barriers when they feel they’ve been listened to”

“It seems like an archaic and monocultural system - no consideration for what is right for our needs, serves their purposes”

“We would have wanted some sort of spiritual element conducted at the time of death. It would have been good if the Police could offer this”

“The Police wouldn’t work with us to return the belongings”

“Need to respect bodily autonomy of how the person identified [gender identities] ... not necessarily just how their family saw them [biologically]”

“It felt like they [healthcare professionals and institutions] just wanted to give us a bit of money so we would go”

“Agencies stick together... they are scared of the bereaved”

“They [agencies] wouldn’t provide the subsidy without the death certificate”

“They [coroner’s office] called me on my loved one’s birthday”

“There was no empathy from admin staff at the coroner’s office”

9. Reflecting on personal journeys (continued)

9.1 Insights from the voices of whānau (continued)

9.1.5 Stories are a reflection of a person's life, it needs to be accurate and honourable

Whānau are often in a position where they are presented with incorrect information, or information that does not provide whakapapa and context for a complete understanding of their loved one. Stories are treated as case files and every recollection reports on the story differently.

What we heard

"[The gender identity of] bodies were documented as their birth gender over identity [chosen by the deceased]"

"Coroners treat the body as binary with no respect for how they identified"

"Whānau don't always accept the [gender] identity of the person that died"

"The findings were the same as the DHB report... I don't understand why it took 3 years"

"The story was completely misrepresented"

"There is a need for more whakapapa or context for the circumstances [that lead to a person's death]"

"[The report came with a] "With compliments from the coroner" slip"

"There is no partnership between us all. It is an us vs them"

"It felt like she was another number at the hospital"

"The most traumatic details of a loved one's death"

"They spelt my daughter's name wrong"

9. Reflecting on personal journeys (continued)

9.1 Insights from the voices of whānau (continued)

9.1.6 The journey starts long before the coroner and continues well beyond coronial findings

After the loss of a loved one, whānau experience many things, the coronial process is but one part of a life-long journey.

What we heard

“We would want accountability so that no one else goes through what we did”

“The grief never leaves you [it continues beyond the coronial process]. The delays in the process made it feel like a punishment”

“Closure [can] come from the acknowledgement of a wrong”

“We were handed from agency to agency”

“No one follows-up after the findings”

“Closure [can] come from accepting and taking accountability of recommendations being implemented”

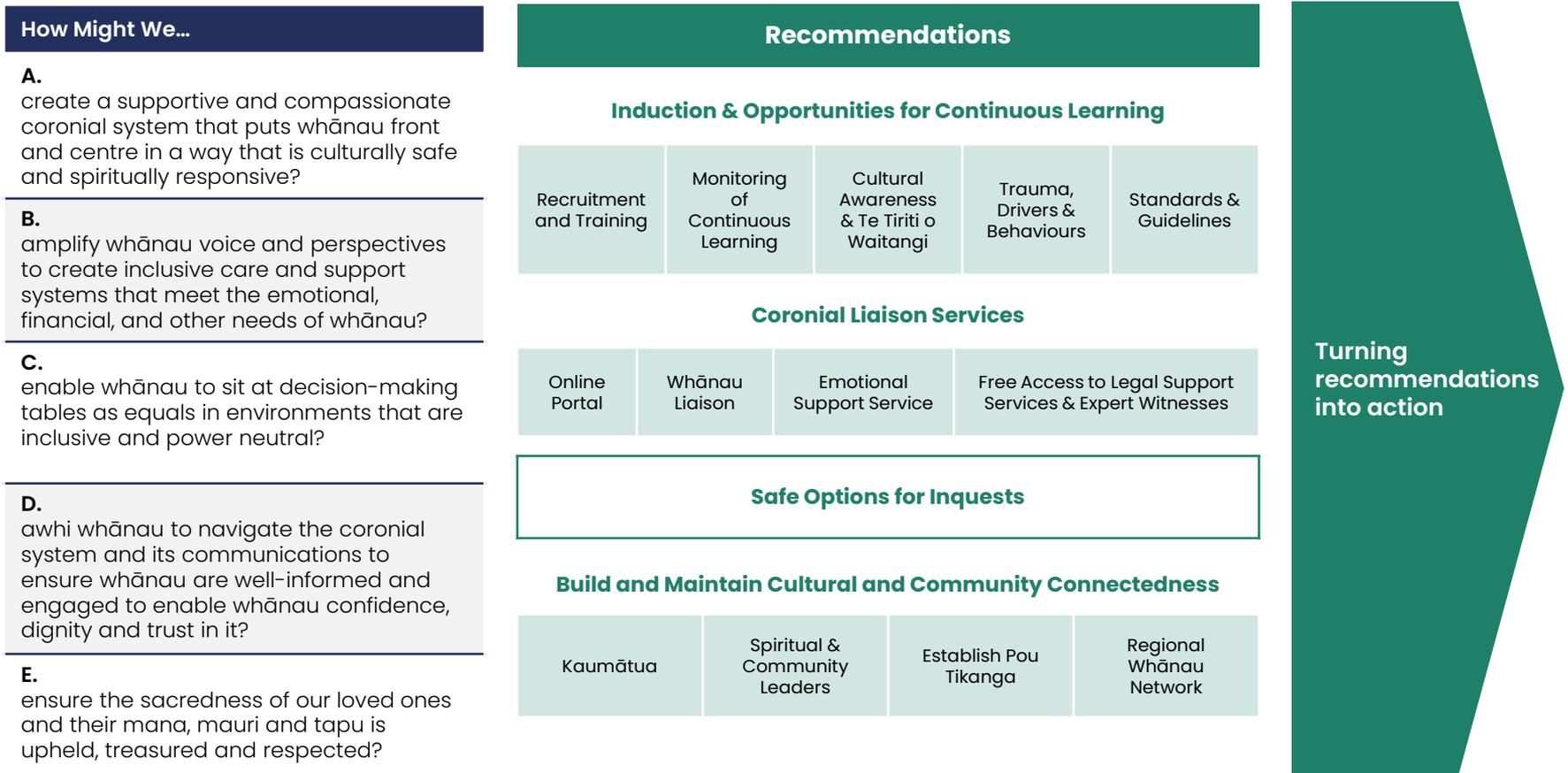
“We never heard from the coroner [while our case was with the coroner]”

“There was so much uncertainty and anxiety while waiting for answers”

9. Reflecting on personal journeys (continued)

9.2. Pathway to short-listing recommendations

The diagram below describes the journey taken to develop recommendations, with the next steps intended to be how the recommendations are turned into action. The development of 'How Might We' statements are described in detail in [page 21](#) and recommendations are described in detail in from [page 22](#).



9. Reflecting on personal journeys (continued)

9.3 To know where we are going, we needed 'How Might We' problem statements

'How Might We' statements identify the specific challenges to be addressed. These statements were developed with the Design Group and informed by insights from the voices of whānau.



There is no part of the Coronial system that is dedicated to supporting the family [and] that is a real indictment of the system.

How Might We...

A. Create a supportive and compassionate coronial system that puts whānau front and centre in a way that is culturally safe and spiritually responsive?

How Might We...

B. Amplify whānau voice and perspectives to create inclusive care and support systems that meet the emotional, financial, and other needs of whānau?

How Might We...

C. Enable whānau to sit at decision-making tables as equals in environments that are inclusive and power neutral?

How Might We...

D. Awahi whānau to navigate the coronial system and its communications to ensure whānau are well-informed and engaged to enable whānau confidence, dignity and trust in it?

How Might We...

E. Ensure the sacredness of our loved ones and their mana, mauri and tapu is upheld, treasured and respected?

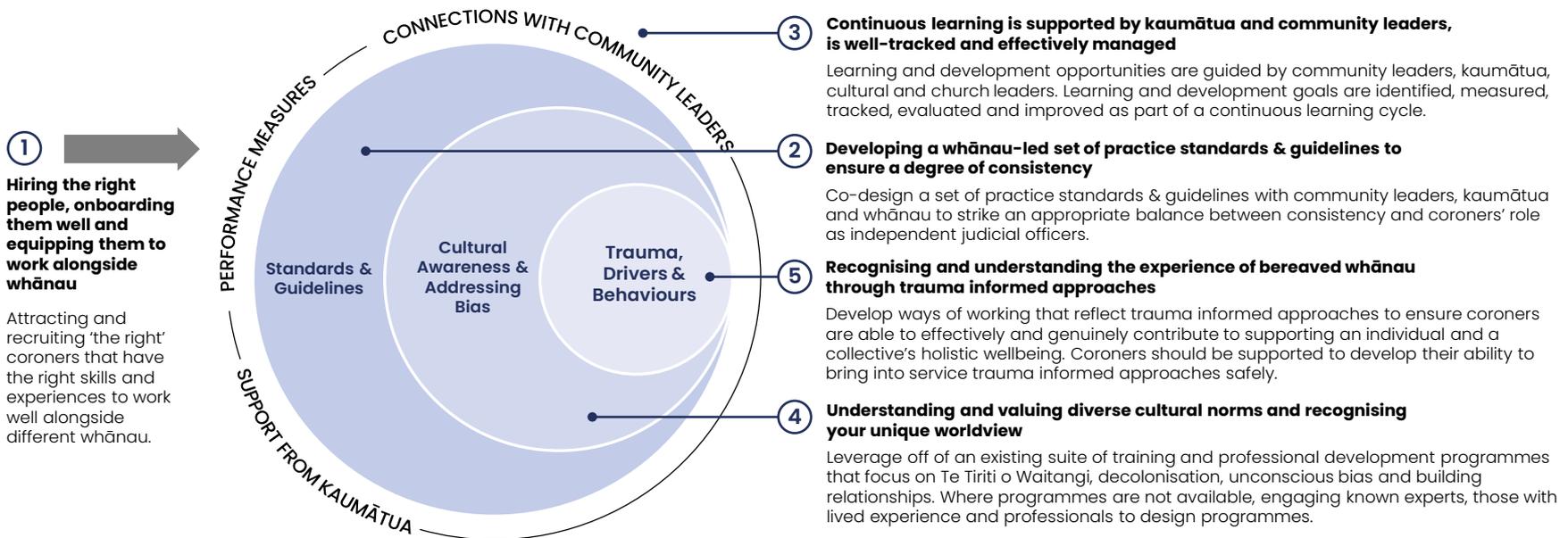
9. Reflecting on personal journeys (continued)

9.4 The formation and development of recommendations

The following section provides an 'ideas canvas' (overview) to be used to 'pitch' a proposed solution, followed by detailed recommendations (recommendations).

9.4.1. Induction & Opportunities for Continuous Learning – Overview

This solution provides comprehensive whānau-informed learning and development opportunities, so that coroners and other points of continued contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.



9. Reflecting on personal journeys (continued)

9.4.1. Induction & Opportunities for Continuous Learning – Recommendations

These recommendations provide comprehensive whānau-informed learning and development opportunities, so that coroners and other points of continuous for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 1	Key recommended actions	Urgency for action
<p>“Hiring the right people, onboarding them well and equipping them to work alongside whānau”</p> <p>Attracting and recruiting ‘the right’ coroners who have the right skills and experiences to work well alongside different whānau.</p>	<ul style="list-style-type: none"> A. Explore options to have a team of coroners that specialise in suspected self-inflicted deaths; build their understanding of the whānau experience; embed on-going learnings in the processes. B. Develop a capability matrix alongside whānau to determine the core competencies and attributes required by coroners to engage with and support whānau in their roles. C. Update job descriptions of coroners to reflect the relevant core empathy competencies and attributes required. D. Undertake a gap analysis to understand the development needs of existing coroners based on the core competencies and attributes reflected in the capability matrix and upskill them in the outstanding areas. E. Ensure all new coroners recruited meet the capabilities aligned with the capability matrix and are inducted in a way that empowers them to deliver their role. F. Involve whānau in the recruitment of new coroners to ensure they meet the core competencies and attributes required. G. Develop a new recruitment, induction, retention and education programme for coroners that focusses on whānau-centric approaches to the legal processes and tikanga. H. Continue to work with whānau to review and update the job descriptions of coroners. I. Ensure whānau are aware of the training Police and others (to be identified) have received in engaging with whānau. J. Ensure that Police attending the scene of death are aware of all the information required for the preliminary finding to reduce the need to request further information from whānau. 	<p>Short-term (0 months – 12 months)</p>

9. Reflecting on personal journeys (continued)

9.4.1. Induction & Opportunities for Continuous Learning – Recommendations (continued)

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 2	Key recommended actions	Urgency for action
<p>“Continuous learning is supported by kaumātua and community leaders, is well-tracked and effectively managed”</p> <p>Learning and development opportunities are guided by community leaders, kaumātua, cultural and church leaders. Learning and development goals are identified, measured, tracked, evaluated and improved as part of a continuous learning cycle.</p>	<ul style="list-style-type: none"> A. Complete an initial stock-take of all learning and development programmes that are available. Establish and implement a core set of national performance measures for all coroners, with specific metrics targeting cultural competency and anti-racism. B. Conduct regular individual performance appraisals used to assess progress made by coroners against the core set of national performance standards and to identify further development opportunities. C. Develop learning opportunities and plans for each coroner dependent on their individual development areas and monitor progress against set development plans. D. Hold debriefs with whānau following the release of their case findings to share their experience through the process, assess the success of the coroner against the national performance standards and provide feedback for future improvements. 	<p>Short-term (0 months – 12 months)</p>

9. Reflecting on personal journeys (continued)

9.4.1. Induction & Opportunities for Continuous Learning – Recommendations (continued)

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 3	Key recommended actions	Urgency for action
<p>“Understanding and valuing diverse cultural norms and recognising your unique worldview”</p> <p>Development of programmes that focus on Te Tiriti o Waitangi, decolonisation, unconscious bias and building relationships based on an existing suite of training and professional materials. Where programmes are not available, engaging known experts, those with lived experience and professionals to design programmes.</p>	<ul style="list-style-type: none"> A. Complete an initial stock-take of all learning and development programmes that are available nationally to be adopted or adapted to contain the appropriate content. B. Compile a full suite of learning and development programmes for coroners to upskill in the capabilities aligned with their roles and the capability matrix. C. Ensure the suite of training programmes facilitates upskilling through all modalities (e.g., virtual and in-person; written and video). D. Inform whānau and community leaders, kaumātua, cultural and church leaders about the programmes and resources available and how they are used where whānau are not directly involved in the design and delivery. 	<p>Short-term (0 months – 12 months)</p>
Recommendation 4	Key recommended actions	Urgency for action
<p>“Recognising and understanding the experience of bereaved whānau through trauma informed approaches”</p> <p>Develop ways of working that reflect trauma informed approaches to ensure coroners can effectively and genuinely contribute to supporting an individual and a collective’s holistic wellbeing. Coroners should be supported to develop their ability to bring into service trauma informed approaches safely.</p>	<ul style="list-style-type: none"> A. Train all coroners, coronial services staff (e.g., Counsel to Assist) and Police in suspected self-inflicted deaths training, including training in the principles of trauma informed care. B. Integrate principles of trauma informed care into Coronial policies and procedures. 	<p>Short-term (0 months – 12 months)</p>

9. Reflecting on personal journeys (continued)

9.4.1. Induction & Opportunities for Continuous Learning – Recommendations (continued)

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 5	Key recommended actions	Urgency for action
<p>“Developing a whānau-led set of practice standards and guidelines to ensure a degree of consistency”</p> <p>Co-design a set of practice standards and guidelines with community leaders, kaumātua and whānau to strike an appropriate balance between consistency and coroners’ role as independent judicial officers.</p>	<ul style="list-style-type: none"> A. Collaborate with whānau to design a consistent set of processes and procedures to enable a whānau-centric system. B. Ensure tikanga best practice as agreed with individual whānau is incorporated across all guidelines, such as: <ul style="list-style-type: none"> 1. at the time and scene of death 2. notification to whānau 3. removal and transporting of the body 4. enacting of rituals; viewing of the body 5. guardianship of the body; manaaki at mortuaries (including the coordination of information dissemination and making sure whānau are housed appropriately) 6. clearing the scene 7. access to Pou Tikanga/kaumātua/Police Iwi Liaison Officers; and 8. returning the body and the deceased’s property to the whānau. C. Utilise restorative approaches to inform the basis of core components of all processes and procedures developed. D. Monitor and evaluate the adoption of whānau-centric processes and procedures. Means of monitoring and evaluation should be designed with whānau. 	<p>Medium-term (12 months – 24 months)</p>

9. Reflecting on personal journeys (continued)

9.4.2. Coronial Liaison Services – Overview

This solution provides an end-to-end holistic service that is interactive and supports active communication, so that whānau are well-informed throughout the coronial process and empowered to actively communicate at all stages of the coronial process.

#6: Online Portal (staged release)

- Development of an interactive end-to-end portal to keep whānau up to date on **key information** including, **who, what, where, when** and roles at **each stage of the coronial process**.
- Whānau are given access to **fulsome information** to cater to a range of learning styles, to ensure equitable access to information.
- Whānau are able to make notes, upload and request information via the Portal.
- Whānau are able to **ask questions** at each stage of the process through the portal, including contact information for relevant individuals at all stages.
- Whānau are able to **track the status** of recommendations after a report has been issued.

#7: Whānau Liaison

Whānau are provided (or able to request) an individual to work alongside them as a liaison from the time of discovery until a negotiated period after the release of recommendations. Ultimately, the liaison will be able to **support whānau** during times of distress in a **cultural and spiritual safe** manner, making sure whānau are the **first voice**.

Critical skills of whānau liaison include:

- Ability to coordinate across core sections of the coronial process.
- Ability to coordinate access to specialist services.
- Experience working with bereaved whānau, is sensitive and aware.
- Clinical expertise and experience in clinical safety.
- Ability to coordinate access to financial support available.
- Understanding of the Coronial system; the roles of various agencies; and information that whānau have access to.

#8: Emotional Support Services

Whānau are able to access relevant and on-going support services that meet their unique needs. Including but not limited to:

- Equitable access to counselling services (e.g. as homicide related support).
- Increase to the availability of existing support services.
- Diversity of support services available for example, psycho-social, online and rongoā based services.
- Opportunity for tailored right-time and right-place services.
- Extended access of existing support services to all members of the whānau and community.

#9: Free Access to Legal Support Services & Expert Witnesses

- Whānau are able to access equitable legal resources to ensure they are fairly represented, at least until a time where inquests are treated as non-adversarial.
- Whānau legal support is equivalent to the legal support afforded to all interested parties.

9. Reflecting on personal journeys (continued)

9.4.2. Coronial Liaison Services – Recommendations

These recommendations seek to create an end-to-end holistic service that is interactive and supports active communication, so that whānau are well-informed throughout the coronial process and empowered to actively communicate at all stages of the coronial process.

Recommendation 6	Key recommended actions	Urgency for action
Online Portal (staged release)	<p>A. Develop an interactive end-to-end portal that keeps whānau up to date on key information at each stage of the coronial process. The portal should include:</p> <ol style="list-style-type: none"> 1. A written and video user manual to provide a walk-through on how to use the portal. 2. An overview of the coronial process with anticipated timelines and the requirements of whānau at each stage. 3. Personalised information on who the coroner for the case is and a written and video biography to build a personal connection. 4. A centrally accessible repository for whānau to share videos of how to navigate the coronial process with other whānau. 5. General information about the coronial process (e.g., process maps and video walk-throughs) which are publicly available on the website. <p>B. Give whānau access to fulsome information to cater to a range of learning styles, to ensure equitable access to information.</p> <ol style="list-style-type: none"> 1. Ensure all information, manuals and bios are provided in written, video, visual and audio format. 2. Ensure all information is written in 'layman's terms', available in different languages and disability enabled. 3. Enable whānau without access to their own technology with mechanisms to access the portal (e.g., provided a device to use or given access to publicly available spaces with the technology required for accessing the portal). <p>C. Allow whānau to make notes, upload and request information via the Portal.</p> <ol style="list-style-type: none"> 1. The coronial reports and other important information sent to whānau are automatically stored in their portal. Whānau are able to upload their own files, images and reports to their portal for storing important information. 2. A personal log-in is required to access personal information (e.g., case reports) in relation to the case. 3. Each whānau member is provided their own personal log-in. Files uploaded are private to each member's log-in by default, and with the option to share with other whānau members. <p>D. Enable whānau to ask questions at each stage of the process through the portal, including contact information for relevant individuals at all stages.</p> <ol style="list-style-type: none"> 1. A help function is accessible through a range of channels (video calls; email; chat functions). <p>E. Provide a way for whānau to track the status of recommendations after a report has been issued and receive notifications at each key stage.</p> <ol style="list-style-type: none"> 1. An interactive process map illustrates the status of each whānau case on the portal. 2. Notifications are sent to whānau when a new file is being uploaded to their portal so that they are aware in advance of the new information. 	<p>Medium-term (12 months – 24 months)</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>The following additional features were also recommended to be included as part of the online portal:</p> <ul style="list-style-type: none"> • A frequently asked questions (FAQ) section for common queries regarding the coronial process and support services available. • An outline of the services and helplines of the suicide bereavement, grief and trauma support services available by region. • Access to psycho-education materials. • Directories to suicide bereavement support groups by region. </div>

9. Reflecting on personal journeys (continued)

9.4.2. Coronial Liaison Services – Recommendations (continued)

These recommendations seek to create an end-to-end holistic service that is interactive and supports active communication, so that whānau are well-informed throughout the coronial process and empowered to actively communicate at all stages of the coronial process.

Recommendation 7	Key recommended actions	Urgency for action
<p>Whānau Liaison</p> <p>Whānau are provided (or able to request) an individual to work alongside them as a liaison from the time of discovery until a negotiated period after the release of recommendations. Ultimately, the liaison will be able to support whānau during times of distress in a culturally and spiritually safe manner, making sure whānau are the first voice.</p>	<p>A. Include the following in the role of the whānau liaison officer:</p> <ol style="list-style-type: none"> 1. Connecting with whānau immediately at point of discovery to explain the process. 2. Explaining the online portal to whānau and providing support to access it. 3. Supporting whānau in asking questions by informing them of their rights, assuring them no question is too small, and providing examples of questions other whānau have asked that may be useful and relevant. 4. Ensuring whānau are aware of what information is made public and what remains private. 5. Outlining the legal processes to whānau and helping them to understand the boundaries, limitations and reasoning for these processes. 6. Explaining to whānau why personal belongings are being taken. 7. Informing whānau of the purpose of the statements taken by Police or other agencies and when and how they will be used. 8. Explaining what is compulsory to provide in the initial Police statement to whānau. 9. Advising whānau of their right to object to an autopsy. 10. Asking whānau what members they would like involved in the process and communications. 11. Communicating with all whānau members that would like to be engaged in the process, beyond immediate whānau. 12. Providing notification in advance to whānau that findings/reports are being released. 13. Informing Suicide Prevention Coordinators of findings being released to whānau in their locality. 14. Inviting and working with whānau to put forward recommendations to the coroner. <p>B. Ensure the whānau liaison office fulfils the following additional roles:</p> <ol style="list-style-type: none"> 1. Allowing whānau to choose their liaison and provide them with written and video biographies of the whānau liaisons are available. 2. Allowing whānau to change their liaison throughout the process. 3. Ensuring diversity and cultural awareness across the whānau liaison team. 	<p>Short-term (<i>0 months – 12 months</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.2. Coronial Liaison Services – Recommendations (continued)

These recommendations seek to create an end-to-end holistic service that is interactive and supports active communication, so that whānau are well-informed throughout the coronial process and empowered to actively communicate at all stages of the coronial process.

Recommendation 8	Key recommended actions	Urgency for action
<p>“Emotional Support Services”</p> <p>Whānau are able to access relevant and on-going support services that meet their unique needs.</p>	<ul style="list-style-type: none"> A. Increase the availability of existing (e.g., Aoake te Rā) and new services to provide whānau unlimited support in response to their needs, for as long as they need. B. Provide equitable access to counselling services to those receiving counselling for other events. (e.g., as homicide related support). C. Facilitate accessibility and funding available to a diverse range of support services (e.g., peer-support, online and rongoā based services). D. Provide targeted support in the immediate period prior to and following the release of the coroner’s findings. E. Provide access to a diverse range of tailored, right-time and right-place support services, such as psycho-social (e.g., Eye Movement Desensitisation and Reprocessing). F. Provide funding to whānau to access services which are not publicly available. G. Extend access of existing support services to all members of the whānau and impacted community. H. Ensure that the providers of support services have sufficient levels of experience and are trauma informed trained. 	<p>Short-term (0 months – 12 months)</p>
Recommendation 9	Key recommended actions	Urgency for action
<p>Free Access to Legal Support Services & Expert Witnesses</p>	<ul style="list-style-type: none"> A. Whānau are able to access equitable legal resources to ensure they are fairly represented, at least until a time where inquests are treated as non-adversarial. <ul style="list-style-type: none"> 1. Provide free lawyers to whānau for the duration of the process. 2. Provide whānau free access to expert witnesses. 3. Implement a set of process and education programmes to ensure that coroners enable whānau to be heard and reduce the number of legal representatives required. 4. Train coroners in embracing a restorative culture throughout inquests. B. Whānau legal support is equivalent to the legal support afforded to all interested parties. <ul style="list-style-type: none"> 1. Ensure that lawyers provided to whānau have been through the Coronial court previously. 2. Ensure the lawyers provided to whānau are of the same calibre and experience as those representing other interested parties. 3. Appoint legal representation to all interested parties (whānau and other) to ensure the level of representation is equal in quantity and capability. 	<p>Short-term (0 months – 12 months)</p> <hr/> <p>Key considerations</p> <ul style="list-style-type: none"> • Should lawyers be involved in the process if it is inquisitorial? • Can we reduce the total number of lawyers involved to reduce the power imbalance e.g., a limit placed on the maximum number of lawyers able to be involved by each party in the process?

9. Reflecting on personal journeys (continued)

9.4.3. Safer Options for Inquests – Overview

This solution provides an alternative to selecting safe, power neutral venues to hold inquests, so that whānau, coroners and interested parties are able to engage with one another in a physical setting that brings everyone together.



#10: Whānau are supported to access safer physical settings

Alternative physical setting options are communicated to whānau early and they are supported to access alternatives to meet their unique needs.

#11: Define what would make a physical setting 'safer' from the perspective of each party

Coroners, whānau and interested parties co-create a high-level list of criteria that determines what makes a physical setting 'safer' to meet the diverse needs of communities.

#12: Coroners develop a base list of safer options to host inquests in partnership with Māori and other communities

Criteria used to define a 'safer' physical setting is used to create a base list of safer options to host inquests.

#13: Community leaders and kaumātua verify the base list of safer options

Coroners engage with community leaders and kaumātua on an on-going basis to ensure that the venues collated on the base list remain safe for whānau.

#14: Two-way dialogue is used to add venues to the base list

There is an avenue available to whānau to add venues to the base list, with the caveat that it meets criteria set.

9. Reflecting on personal journeys (continued)

9.4.3. Safer Options for Inquests – Recommendations

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 10	Key recommended actions	Urgency for action
<p>“Whānau are supported to access safer physical settings”</p> <p>Alternative physical setting options for inquests are communicated to whānau early and they are supported to access alternatives to meet their unique needs.</p>	<ul style="list-style-type: none"> A. Implement procedures to ensure that coroners engage with whānau to determine what a safe place means to them and make arrangements to meet those needs. B. Make spaces available at venues for advocates to attend. C. Consider ways to reduce power imbalances at venues (e.g., seating is arranged in circles; coroners do not sit at benches above parties). D. Engage whānau in the layout of the venue to ensure it promotes safety on an individual basis. E. Notify whānau in advance of their inquest date (to support in planning) and provided the opportunity to request new dates. 	<p>Short-term (<i>start the process now with intent to build a list ready in 6 months time at the local district, regional, and national level</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.3. Safer Options for Inquests – Recommendations (continued)

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 11	Key recommended actions	Urgency for action
<p>“Define what would make a physical setting ‘safer’ from the perspective of each party”</p> <p>Coroners, whānau and interested parties co-create a high-level list of criteria that determines what makes a physical setting ‘safer’ to meet the diverse needs of communities.</p>	<ul style="list-style-type: none"> A. Account for the needs and resources available in each locality/region in the national criteria developed for selecting venues. B. Ensure that the criteria developed considers Tikanga and kawa for the safety of all whānau. C. Ensure that all physical spaces: <ul style="list-style-type: none"> 1. Are accessible for all whānau (e.g., disability suitable). 2. Are comfortable (e.g., warm temperature and furniture that is comfortable for whānau). 3. Have access to refreshments (e.g., tea, coffee and water). 4. Only include security when required assessed on a case-by-case basis. 5. Have a place set up for time away and healing. 6. Facilitate the option for sessions to be recorded or transcribed. D. Ensure the settings of the venues: <ul style="list-style-type: none"> 1. Promote equal ‘power’ to all parties (and are not intimidating for whānau). 2. Enable whānau to be heard and tell their stories. 3. Respect the stories of whānau and value the truth of the stories to them. 	<p>Short-term (<i>0 months – 12 months</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.3. Safer Options for Inquests – Recommendations (continued)

These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 12	Key recommended actions	Urgency for action
<p>“Coroners develop a base list of safer options to host inquests in partnership with Māori and other communities”</p> <p>Criteria used to define a ‘safer’ physical setting is used to create a base list of safer options to host inquests.</p>	<ul style="list-style-type: none"> A. Ensure the base list includes venues that are geographically close and accessible to all regions. B. Provide funding for travel, accommodation and other expenses is provided to whānau where venues are not easily accessible. C. Ensure the base list of venues is accessible on the online ‘Coronial Liaison Service’ portal. D. Setup a ‘mobile inquest station’ to be available as a venue in remote areas to overcome travel and other practical barriers in accessing venues on the base-list. 	<p>Short-term (<i>0 months – 12 months</i>)</p>
Recommendation 13	Key recommended actions	Urgency for action
<p>“Community leaders and kaumātua verify the base list of safer options”</p> <p>Coroners engage with community leaders and kaumātua on an on-going basis to ensure that the venues collated on the base list remain safe for whānau.</p>	<ul style="list-style-type: none"> A. Create a national list of the groups, individuals and roles within communities that must be consulted each time the base list is added to and reviewed in an on-going way. 	<p>Short-term (<i>0 months – 12 months</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.3. Safer Options for Inquests – Recommendations (continued)

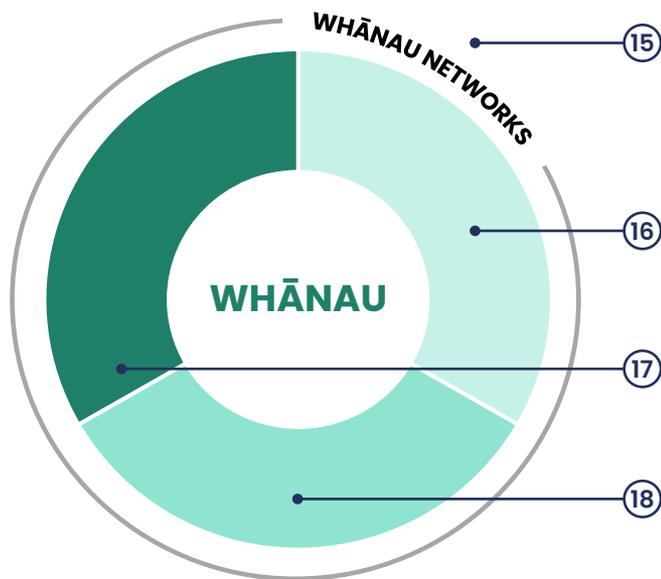
These recommendations seek to create comprehensive and whānau informed learning and development opportunities, so that coroners and other points of contact for whānau are able to access learning that is practical, actionable and relevant to their mahi and how they work with whānau.

Recommendation 14	Key recommended actions	Urgency for action
<p>“Two-way dialogue is used to add venues to the base list”</p> <p>There is an avenue available to whānau to add venues to the base list, with the caveat that it meets criteria set.</p>	<ul style="list-style-type: none"> A. Review the base list every 6 months. B. Involve and partner with whānau to review and continuously update the base list of venues. 	<p>Short-term (<i>0 months – 12 months</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.4. Build and Maintain Cultural and Community Connectedness – Overview

This solution builds a network of support systems accessible to coroners, so that coroners are well-connected and supported to make decisions collaboratively with whānau in a way that is spiritually and culturally safe for all parties.



Whānau Networks

15 Whānau are empowered to create regional whānau networks and have identified community champions to work alongside kaumātua, spiritual and community leaders, and the Chief Coroner's Pou Tikanga. Whānau networks are whānau led. Whānau networks are a collaboration point for future planning and implementation to reduce "talking about us, without us".

Recruitment and appointment of a Pou Tikanga to support coroners to make culturally appropriate decisions

16 The Chief Coroner is guided by a Pou Tikanga to make strategic decisions that uphold Te Tiriti o Waitangi, to ensure the cultural safety of the coronial profession as a whole and to support pathway development to attract Māori coroners into the workforce. The Pou Tikanga is available to support all coroners in their everyday work where a regionally based kaumātua may not be the most appropriate.

Note – appointment of a Pou Tikanga and their role should support the coronial system as a whole, opposed to limited by suspected self-inflicted deaths.

Creation and maintenance of a network of kaumātua at a regional level

17 Coroners are connected to kaumātua regionally to provide local support to ensure they are able to make informed and appropriate decisions. These relationships also support the cultural safety of coroners and whānau.

Creation and maintenance of a network of Spiritual & Community Leaders to support decision making

18 Coroners form deep and meaningful relationships with spiritual and community leaders to ensure they are able to make informed and appropriate decisions based on sound and relevant advice to meet the diverse needs of whānau. Coroners actively maintain these relationships.

9. Reflecting on personal journeys (continued)

9.4.4. Build and Maintain Cultural and Community Connectedness – Recommendations

These recommendations seek to build a network of support systems accessible to coroners, so that coroners are well-connected and supported to make decisions collaboratively with whānau in a way that is spiritually and culturally safe for all parties.

Recommendation 15	Key recommended actions	Urgency for action
<p>“Whānau Networks”</p> <p>Whānau are empowered to create regional whānau networks and have identified community champions to work alongside kaumātua, spiritual and community leaders, and the Chief Coroner’s Pou Tikanga. Whānau networks are whānau led. Whānau networks are a collaboration point for future planning and implementation to reduce “talking about us, without us”.</p>	<p>Whānau networks are self-created and self-determined according to the make-up and structure necessary to meet needs of whānau. Whānau networks can be as narrow or expansive as whānau require, with whomever whānau invite into their whānau network.</p> <ul style="list-style-type: none"> A. Identify existing funding available to support current and future whānau networks and review how the funding is used at present. B. Create a plan to access/reallocate/seek funding (or grants) to support whānau networks. C. Work with whānau to determine appropriate funding parameters based on the needs of whānau, address potential barriers to access funding and determine an appropriate allocation/distribution scheme. D. Establish a whānau-led review process to determine whether the funds meet the needs of whānau, continues to meet all public finance requirements and put in place any key findings as part of the review for the following funding cycle. 	<p>Short-term (0 months – 12 months)</p>

9. Reflecting on personal journeys (continued)

9.4.4. Build and Maintain Cultural and Community Connectedness – Recommendations (continued)

These recommendations seek to build a network of support systems accessible to coroners, so that coroners are well-connected and supported to make decisions collaboratively with whānau in a way that is spiritually and culturally safe for all parties.

Recommendation 16	Key recommended actions	Urgency for action
<p>“Establishment of Pou Tikanga (individual responsible for safe cultural guidance) supported by Kāhui kaumatua (kaumatua governance group that oversees the mauri, culture, tikanga and kawa)”</p> <p>The Chief Coroner is guided by Pou Tikanga and Kāhui Kaumātua to support strategic decisions that uphold Te Tiriti o Waitangi, to ensure the cultural safety of the coronial profession as a whole and to support pathway development to attract Māori coroners into the workforce. Pou Tikanga and Kāhui Kaumātua are available to support all coroners in their everyday work where a regionally based kaumatua (elder) may not be the most appropriate.</p>	<p>Pou Tikanga to support coroners to make culturally appropriate decisions</p> <ul style="list-style-type: none"> A. Identify the scope of Pou Tikanga role against the needs of the coronial system and whānau in discussion with whānau and seek budget available to employ Pou Tikanga on a permanent basis. B. Create a plan to recruit Pou Tikanga and process for whānau inclusion in the recruitment process. C. Execute recruitment and onboard Pou Tikanga. D. Initiate a review process to assess the changes in the coronial system’s approach to applying tikanga and maintaining cultural safety post the recruitment of Pou Tikanga. 	<p>Short-term (0 months – 12 months)</p>

9. Reflecting on personal journeys (continued)

9.4.4. Build and Maintain Cultural and Community Connectedness – Recommendations (continued)

These recommendations seek to build a network of support systems accessible to coroners, so that coroners are well-connected and supported to make decisions collaboratively with whānau in a way that is spiritually and culturally safe for all parties.

Recommendation 17	Key recommended actions	Urgency for action
<p>“Creation and maintenance of a Kāhui Kaumātua & ensuring the respect of kaumātuatanga (ways of doing as kaumatua)”</p> <p>Coroners are connected to kaumātua regionally and nationally to provide local support to ensure they are able to make informed and appropriate decisions. These relationships also support the cultural safety of coroners and whānau.</p>	<p>Kāhui Kaumātua</p> <ul style="list-style-type: none"> A. Identify existing kaumātua networks available to enable coroners and coronial staff (across the justice sector, health and partnership boards) to make culturally safe decisions at a national and regional level. B. Create a plan to strengthen and establish (where necessary) Kāhui kaumātua to meet the cultural needs of coroners to navigate the space between whānau, their kaumātua and the coronial system. C. Execute the stand-up of Kāhui kaumātua and the active use of Kāhui kaumātua for decision-making processes in the coronial system and community facing engagement. D. Initiate a review process to assess the changes in the coronial system’s approach to decision making through the active consideration and adoption of kaumātua advice. <p>Respecting kaumātuatanga</p> <ul style="list-style-type: none"> E. Identify barriers preventing kaumātua, as identified by whānau, from engaging in the coronial process, particularly in relation to safety of whānau members and their loved one from notification of death. F. Create a plan to mitigate, and where possible, remove barriers preventing kaumātua from engaging in the coronial process, particularly in relation to safety of whānau members and their loved one from notification of death. G. Execute mitigation strategies and removal of barriers to kaumātua engaging in the coronial process. H. Establish a whānau-led review process, including examples of good and poor practice, key learnings and further process improvements. 	<p>Short-term (<i>0 months – 12 months</i>)</p>

9. Reflecting on personal journeys (continued)

9.4.4. Build and Maintain Cultural and Community Connectedness – Recommendations (continued)

These recommendations seek to build a network of support systems accessible to coroners, so that coroners are well-connected and supported to make decisions collaboratively with whānau in a way that is spiritually and culturally safe for all parties.

Recommendation 18	Key recommended actions	Urgency for action
<p>“Creation and maintenance of a network of spiritual and community leaders”</p> <p>Coroners form deep and meaningful relationships with spiritual and community leaders to ensure they are able to make informed and appropriate decisions based on sound and relevant advice to meet the diverse needs of whānau. Coroners actively maintain these relationships.</p>	<p>Spiritual and cultural networks</p> <ul style="list-style-type: none"> A. Identify existing spiritual and cultural networks available to enable coroners and coronial staff (across the justice sector, health and partnership boards) to make culturally safe decisions at a national and regional level. B. Create a plan to strengthen and establish (where necessary) spiritual and cultural networks to meet the cultural needs of coroners to navigate the space between whānau, their spiritual and cultural support and the coronial system. C. Execute the stand-up of spiritual and cultural networks and the active use of spiritual and cultural networks for decision-making processes in the coronial system and community facing engagement. D. Initiate a review process to assess the changes in the coronial system’s approach to decision making through the active consideration and adoption of spiritual and cultural advice. <p>Respecting cultural and community leadership</p> <ul style="list-style-type: none"> E. Identify barriers, as identified by whānau, preventing spiritual and cultural support from engaging in the coronial process, particularly in relation to safety of whānau members and their loved one from notification of death. F. Create a plan to mitigate, and where possible, remove barriers preventing spiritual and cultural support as identified by whānau from engaging in the coronial process, particularly in relation to safety of whānau members and their loved one from notification of death. G. Execute mitigation strategies and removal of barriers to ensure spiritual and cultural support as identified by whānau from engaging in the coronial process, particularly in relation to safety of whānau members and their loved one from notification of death. H. Establish a whānau-led review process, including examples of good and poor practice, key learnings and further process improvements. 	<p>Short-term (0 months – 12 months)</p>

10. We can't catch every raindrop, but there are things we shouldn't leave behind

Outlined below are additional actionable changes across key processes and systems in the whānau experience following suspected self-inflicted deaths. These recommendations were not included as part of the priority recommendations. However, they serve as valuable key action points for further consideration in the short-term to provide immediate improvement toward process that represents the voices and needs of whānau.

Discovery	Short-term Processes	Coronial Processes	Inquest	Findings	Recommendations of the investigation
<ul style="list-style-type: none"> Engage whānau in understanding who else in the family circles may be at risk. Provide free cleaning of the scene of death for all cases across New Zealand. Assure whānau that Police involvement is normal for suspected self-inflicted deaths. Use non-uniformed (or alternatively, Coronial services uniformed) Police officers for attending suspected self-inflicted deaths. Leave the original suicide note with whānau. Allow whānau time to record important information from personal items (e.g., contact numbers etc.). 	<ul style="list-style-type: none"> Clarify with whānau who and what they may need to be able to provide Police statements safely, including requests for follow-up information. Minimise the amount of time taken to return loved ones' personal belongings (e.g., cell phones). Engage with and get approval from whānau on who will be interacting with their loved one. Work with whānau to dress bodies in clothing of their choosing at all stages, where possible, throughout the process. Seek approval from whānau to take loved ones' body parts. 	<ul style="list-style-type: none"> Engage with immediate and extended whānau in-person to understand the context and backgrounds. Engage with whānau to discuss and agree the need for a change of coroner where possible, or explain the reasoning for any changes in the coroner of the case. Agree and follow a frequency for providing updates to whānau. Collaborate with the community and wider whānau to seek to understand how their loved one identified (gender, religion and other). 	<ul style="list-style-type: none"> Decrease the amount of time taken for inquests to be held. Allow all cases to proceed to inquest at request of whānau. Engage whānau in determining the scope of inquests. 	<ul style="list-style-type: none"> Review and cross-check all reports against supporting documentation to ensure accuracy of all personal and identifiable information (e.g., names, spelling, D.O.B, D.O.D etc.). Provide whānau the opportunity to review the documents before they are 'final' to ensure the personal and identifiable information is correct or provide whānau the 'right' to correct the factual information of final reports. Release early, interim, findings ahead of the inquest that determine whether the death was self-inflicted to allow restorative processes to begin. 	<ul style="list-style-type: none"> Mandate all findings to include recommendations or require coroners to provide reason as to why recommendations weren't made. Collaborate with whānau, stakeholders and the organisations responsible for implementing the recommendations in developing them to ensure they are actionable. Include whānau in how recommendations are actioned and inform whānau of the progress being made in implementing them. Maintain an up to date public record of recommendations and consider mechanisms to hold organisations to account for implementing them, such as: <ul style="list-style-type: none"> conducting recommendations audits to ensure they are actioned empowering the Chief Ombudsman or create another role with the role of monitoring the implementation of recommendations.

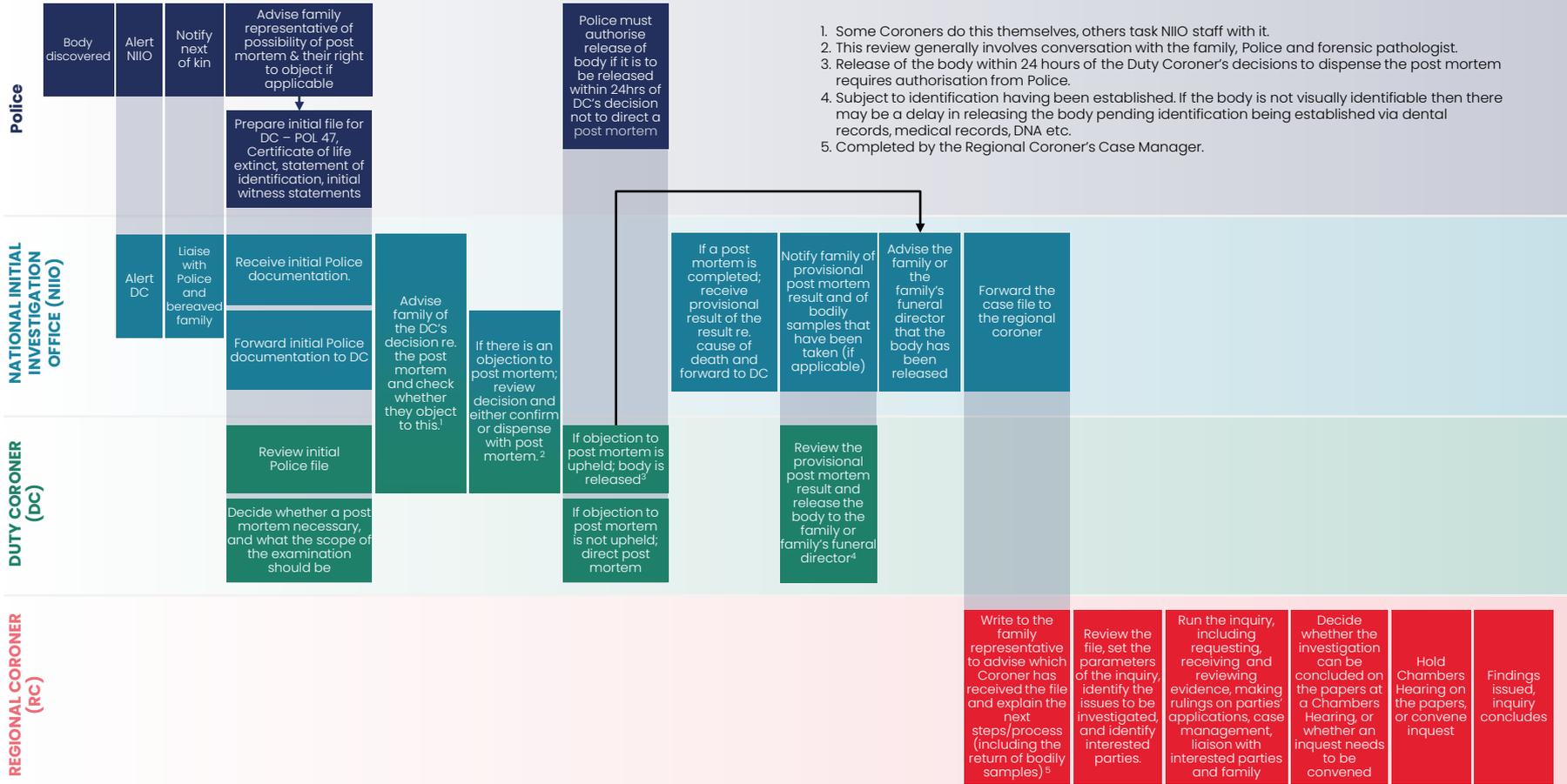
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11. Appendices

11.1 The whānau experience of the coronial process*

This process map was produced during the course of this review in the absence of a formally documented Coronial Investigation Process. The steps below should be considered descriptive, as opposed to prescriptive. The intention is to give a general picture of the process, and broadly speaking it is as described. There are variations on a case-by-case basis, largely due to regional Police practice and individual coroner preference/practice. There is little in the process that is legislatively prescribed, meaning over time differing customs and practices have developed within Police districts and amongst coroners.



11. Appendices (continued)

11.2 Long-listing of ideas

The following long lists of potential opportunities for improvement and recommendations were developed by the Design Group for each 'How Might We' statement during the design workshops. Active discussion, prioritisation and testing tools were used throughout the workshops to iterate, enhance and cross-pollinate ideas from the long list and inform initial recommendations.

A filtering process has been applied to the long lists below to ensure all ideas captured are actionable and represented in standard English, while staying true to the voice of whānau. Where long list ideas overlapped with ideas' canvas, they have been integrated into the relevant canvases.

11.2.1 How might we create a supportive and compassionate coronial system that puts whānau front and centre in a way that is culturally safe and spiritually responsive?

- Involve wider whānau members, friends and communities that are affected by the death in the Coronial process.
- Ask whānau what name they would like to be used when referring to their loved one in reports.
- Ensure that Police attending the scene of the death are aware of all the information required for the preliminary finding.
- Establish a pool of coroners that work specifically with suspected self-inflicted deaths and are trained in the complex drivers of self-inflicted deaths.
- Develop a holistic workforce across all areas of the Coronial services.
- Advise whānau that it is compulsory to provide a statement at the time and day of death.
- Use alternate and culturally appropriate, non-courtroom, environments throughout the process.
- Implement policies and procedures for how and when to engage with whānau.
- Promote a culture that values whānau inclusion.
- Work in partnership with mana whenua.
- Have non-uniformed Police attend the scene of suspected self-inflicted death.
- Train coroners, coronial staff, Police, Victim Support, doctors and mortuary staff on how to engage with whānau in a restorative manner.
- Involve bereaved individuals in developing a whānau-led training for Police and coroners using trauma and bereavement by suicide informed approaches.
- Establish whānau advocacy services and provide support to whānau networks.
- Engage with whānau to understand their religious or cultural practices that must be followed in handling the body.
- Reduce the amount of time take to have an inquest.
- Build and maintain relationships with [local] Iwi Māori [health] providers.
- Develop indigenous models for the coronial process that uphold te Tiriti.
- Develop cultural competency and anti-racism across all workforces involved in the coronial services.
- Provide whānau the time and space they need to deal with the trauma before asking for a statement.
- Create friendly and culturally safe environments for whānau throughout all stages of the process.
- Treat family and whānau with empathy and care throughout all stages of the process.
- Promote a culture of trust and respect among coronial services staff and whānau.
- Involve whānau in conversations in identifying who may be at risk following a suspected self-inflicted death.
- Promote an inquisitorial, not adversarial, coronial and inquest process.
- Proactively check-in on whānau throughout the process to seek out their questions.
- Continuously involve whānau in co-designing an inclusive coronial process.

11. Appendices (continued)

- Adopt a continuous improvement mindset to look for on-going opportunities in making the process supportive of whānau.
- Ensure that Police attending the scene of the death are aware of all the information required for the preliminary finding so they do not need to follow-up with whānau with further questions.

11.2.2 How might we amplify whānau voice and perspectives to create inclusive care and support systems that meet the emotional, financial, and other needs of whānau?

- Ensure whānau have adequate funding throughout the process (e.g., legal support, funeral costs, living costs etc.).
- Provide whānau with free access to expert witnesses and legal support.
- Help whānau to understand the coronial process.
- Provide free and unlimited wrap around counselling for whānau.
- Provide free cleaning of the scene for all cases of suspected self-inflicted death across New Zealand.
- Fund specialty support services where free services are not available for whānau.
- Ensure consistency and clarity of grant/funding criteria and processes.
- Provide whānau free access to emotional support services for as long as they need it, beyond the findings being released.

11.2.3 How might we enable whānau to sit at decision-making tables as equals in environments that are inclusive and power neutral?

- Develop a whānau co-governance model to design, plan and oversee the implementation of recommendations.
- Make recommendations binding and hold organisations to account for implementing them.
- Track inquest findings against their organisation to identify trends emerging at specific facilities/providers.
- Involve whānau in determining the scope of each inquest.
- Ensure coroners have an understanding (through lived or consulting experience) of the DHB processes that whānau go through.
- Ensure there is equal power among all parties involved in the process of each case (e.g., insurance companies, lawyers, whānau DHBs etc.).
- Provide all parties (e.g., insurance companies, lawyers, whānau DHBs etc.) access to the same information at inquests.
- Treat the information received from whānau as equal to the information received from other organisations or individuals.
- Address conflicts of interests in inquests (e.g., peer-reviews).

11.2.4 How might we awahi whānau to navigate the coronial system and its communications to ensure whānau are well-informed and engaged to enable whānau confidence, dignity and trust in it?

- Provide whānau information about each process and event ahead of time (e.g., how long it will take, the role of whānau, the physical settings etc.).
- Produce documents and reports in easily understood (non-legal) language.
- Provide whānau a 'bereavement navigator' to help them understand and navigate the Coronial process.
- Release findings/reports in Te Reo Māori.
- Provide whānau notification in advance that findings/reports are being released.
- Ensure whānau are aware of the role of the coroners counsel.
- Provide translation services.
- Provide access to Te Reo Māori speaking first responders.
- Explain to whānau what an expert witness is and when they should be used.
- Provide regular and proactive updates to whānau on a consistent cadence.
- Explain and reasoning for a change in coroner to whānau.
- Ensure all questions raised by whānau are followed-up and responded to.

11. Appendices (continued)

- Release early, interim, findings ahead of the inquest that determine whether the death was self-inflicted to allow restorative processes to begin.
- Explain why each event, activity or process is happening (e.g., why photos are being taken etc.).
- Establish and implement a consistent Police response process to all suspected self-inflicted deaths across New Zealand.
- Inform Suicide Prevention Coordinators of findings being released to whānau in their locality.
- Develop consistent mortuary processes across New Zealand that support whānau Tikanga.
- Explain the communication pathways to whānau.
- Ensure whānau are aware of the role of coroners in the process.
- Develop a simple to understand 'coronial process guide', available in multiple formats (e.g., video, written etc.).
- Create consistency in the process across New Zealand and all coroners.

11.2.5 How might we ensure the sacredness of our loved ones and their mana, mauri and tapu is upheld, treasured and respected?

- Minimise the amount of time taken to return loved ones' personal belongings (e.g., cell phones).
 - Utilise iwi Māori providers to support whānau following suspected self-inflicted deaths.
 - Engage with and get approval from whānau of who will be interacting with their loved one.
 - Leave the original suicide note with whānau.
 - Tell whānau who will be with their loved one throughout all stages of the process.
 - Explain the purpose of autopsies to whānau.
 - Work with whānau to dress bodies in clothing of their choosing at all stages, where possible, throughout the process.
 - Seek approval from whānau to take loved ones' body parts.
 - Review and cross-check all reports against supporting documentation to ensure all accuracy of all personal and identifiable information (e.g., names, spelling, D.O.B etc.).
 - Explain to whānau why personal belongings are being taken.
- Allow whānau time to record important information from personal items (e.g., contact numbers etc.).
 - Engage with whānau in the investigation for deeper context on the loved ones' circumstances.
 - Allow for iwi affiliations, opposed to ethnic identities only.
 - Allow whānau to keep their loved ones' with them in all cases if they would like to.
 - Gain approval from whānau before completing an autopsy in all cases.

11. Appendices (continued)

11.3 Stakeholder acknowledgements

11.3.1 Design Group

The 18 individuals with lived experience of bereavement by suicide across New Zealand. The 18 individuals with lived experience of bereavement by suicide across New Zealand:

- Amanda Christian
- Carey Hume
- Caroline Roche
- Corinda Taylor
- Deborah Thomason
- Heeni Morehu
- Ivan Yeo
- Jane Stevens
- Joanne Henare
- Leilani Clarke
- Lynne Russell
- Mark Wilson
- Michael Naera
- Paul Martin
- Suzy Taylor
- Tasi Huirama
- Tricia Hendry
- Virginia Brooks

11.3.2 Additional personal sessions

- 5 individuals with lived experience of bereavement by suicide across New Zealand.

11.3.3 Agencies interviewed

Representative(s) from the following stakeholder or agency groups:

- Coroners
- District Court Judge
- Health Quality & Safety Commission
- Independent researcher and psychologist (in the field of Suicide Prevention and Postvention)

11.3.4 Steering Group

Representative(s) from the following stakeholder or agency groups:

- New Zealand Police
- Health Quality & Safety Commission
- Office of the Chief Coroner
- KPMG
- Asian Family Services
- Suicide Prevention Office, Ministry of Health
- Mental Health and Wellbeing Commission
- Ministry of Justice
- Le Va

- National Suicide Bereaved Advisory Group
- Other subject matter experts in the fields of whānau lived experience advocacy, coronial investigative processes and whānau experiences following suspected self-inflicted deaths.

11.3.4 Advisory group

Representative(s) from the following agencies group:

- Le Va Pasifika
- Asian Family Services
- Te Rau Ora
- Additional contributions Aoake te Rā – Design workshop clinical advisory support.
- Kaumātua – Design workshop cultural safety advisory and support.
- KPMG – project management support; steering group secretariat; personal session facilitation; agency session facilitation; design workshop facilitation and cultural support; documentation of outputs.

11. Appendices (continued)

11.4 Steering Group Terms of Reference

11.4.1 Opening

*Tirohia te pae whānui, tuātu i te pō.
Tūramarama ki te ora, whakamauā kia tīnā!*

*See the broad horizon (beyond the
darkness), hold on to life!*

He mihi ki te kaihanganga Io Matua Kore me ngā
Atua maha o tēnā iwi, o tēnā iwi, o tēnā iwi.

E rere nei ngā tai o te mihi aroha, o te tangi
apakura mo rātau kua wehe ki te pō, ngā
reo whakamomori, ngā reo kua ngaro. Moe
mai, moe mai, moe mai koutou.

Ki a koutou, te hungā ora, ngā kaiarotake,
ngā kaitātaki i te waka o te kaupapa nei, he
mihi mahana tēnei ki a koutou katoa.

Ki ngā tāngata whai ora ana, ki ngā whānau
e noho ana i raro i te kapua pouri, ki ngā
whānau me ngā ratonga hauora e manaaki
nei i ngā whānau, i ngā hapori kei te mihi, kei
te mihi, kei te mihi ki a koutou katoa.

‘Kimihia, rapuhia ngā maunga teitei o te
mōhio kia mārama te katoa’

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

One of the recommendations in He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction, released in November 2018, was that the process by which suspected self-inflicted deaths are investigated by coroners should be reviewed in collaboration with whānau and families who have been bereaved by suicide to ensure the most responsive and supportive system is in place. This recommendation was included in He Tapu te Oranga, the national suicide prevention strategy and action plan, the key outcomes of which are reduced suicide rates and wellbeing for all.

It is also acknowledged in He Tapu te Oranga that the review would provide opportunities for the voices of whānau, families and communities to have their say on what a system that validates the impact of self-inflicted deaths and supports healing looks like.

Importantly, He Tapu te Oranga is based on equity. This review of systems and processes that are triggered by a suspected self-inflicted death, focussing on but not limited to the coronial processes, recognises the standing of Māori as the tangata whenua of Aotearoa and as Te Tiriti o Waitangi partners of the Crown.

The review will focus on developing a genuine understanding of the experiences of whānau and families who have been bereaved by suspected self-inflicted deaths. While it is acknowledged that every unexpected death has an impact on whānau, the impact of loss by self-inflicted death is intensified by unique issues such as stigma, shame, and isolation, which often complicate the grieving and healing process.

Various legal procedures and processes, including coroners' investigations, are immediately triggered by a suspected self-inflicted death. However, whānau and families are often left unsupported, and without the adequate cultural/pastoral support or the resources required to fully engage with the processes and voice their needs.

Whānau and families are hugely impacted by the loss of whakapapa and the shattering of their known world following a suspected self-inflicted death. The stigma, isolation, mental distress and barriers to support leave them vulnerable to long-term health problems; whānau disruption; breakdown of relationships; financial difficulty; shame; self-blame; and a heightened risk of self-inflicted death.

11. Appendices (continued)

11.4.2 The legal context

The Coroners Act 2006 requires coroners to investigate suspected self-inflicted deaths, and it is coroners who determine whether a suspected self-inflicted death was, in fact, intentionally self-inflicted/a suicide.

Coroners may also make recommendations for the purpose of reducing the chances of future deaths in similar circumstances. Recommendations coroners make must be clearly linked to the factors that contributed to the death being investigated, and be based on evidence considered during the investigation. However, coroners do not have any power to enforce their recommendations.

The Ministry of Justice has a statutory obligation, pursuant to s116 of the Coroners Act 2006, to provide the administrative support necessary to enable coroners to perform their role efficiently and effectively.

All Crown Agencies have a unique role in the stewardship of Te Tiriti o Waitangi (the Treaty of Waitangi) and in recognising their obligations to upholding Te Tiriti as the founding document of Aotearoa New Zealand. This review will ensure principles consistent with Te Tiriti o Waitangi are integral to all stages of its work.

11.4.3 Approach

The experiences and perspectives of individuals with lived experience of bereavement by suicide are fundamental to the review process. The review will focus on developing a genuine understanding of the experiences of people who have lost loved ones to self-inflicted death, and designing a solution to serve them. The review will embrace a human-centred approach, meaning that individuals and whānau with lived experience will be fully engaged at all stages of the review, and their voices will:

- Define problems and pain points within processes and systems triggered upon a suspected self-inflicted death, including current investigative processes.
- Prioritise issues to address.
- Develop a long-list of potential solutions to address the identified issues.
- Develop and refine solutions to ensure they will deliver meaningful change for whānau, families and communities bereaved by suicide.
- Inform recommendations for implementation of identified solutions.

The review will also engage with the agencies and organisations involved in the processes triggered by suspected self-inflicted deaths including, but not limited to, New Zealand Police, the National Initial Investigation Office, Coronial Services of New Zealand and Coroners, the Ministry of Justice, the Health Quality and Safety Commission, the Office of the Health and Disability Commissioner, the Independent Police Conduct Authority, the Department of Corrections, the Ministry of Health and Health New Zealand for on-going input and feedback throughout the design process.

11. Appendices (continued)

11.4.4 Purpose

The purpose of this review is to develop recommendations for the establishment of new systems and processes for investigating suspected self-inflicted deaths that embrace human vulnerability, are compassionate and respectful, and that effectively support the emotional, cultural, and practical needs of bereaved whānau and family.

The review will take a multi-cultural, human-centric approach and focus on how to best support the needs of bereaved whānau. The scope of the review will include, but is not limited to:

- Response to a suspected self-inflicted death by Police and the coronial service.
- Immediate support offered to whānau.
- Investigative processes following a suspected self-inflicted death.
- The way recommendations to reduce risks of future self-inflicted deaths are released.

The output of the review will be a set of recommended changes to current systems and investigative processes, and may include both short- and long-term recommendations, including for legislative change, or an identified need for more specific legislative review.

The aim of all recommendations will be to improve current systems and investigative processes extending across the entire network following suspected self-inflicted deaths to:

- Support and resource healing for bereaved whānau and communities following the loss of a loved one to a suspected self-inflicted death.
- Support and resource equitable and safe whānau engagement in all investigations subsequent to the loss of a loved one to a suspected self-inflicted death.
- Provide opportunities for bereaved whānau, families and communities to understand the causes and drivers of their loved one's death.
- Contribute to the timely release of information and rate of implementation of recommendations which aim to reduce the risk of future deaths in similar circumstances.
- Embrace a human-centric, non-transactional, approach to legal processes.

Recommendations will be directed at the various Government and non-Government agencies involved in the processes and systems at issue. It is acknowledged that the decision on whether to implement any recommendation will sit with the relevant agency including, but not limited to the Ministry of Justice, New Zealand Police, the Health Quality and Safety Commission and Health New Zealand, as well as non-government organisations.

Recommendations may also be directed to Coroners. Notwithstanding that they are independent judicial officers, it is open to them as individuals or a collective to decide to implement in their practice any recommendations made.

11.4.5 Role of the Steering Group

The role of the Steering Group is to provide subject matter expertise and oversight to the project, including endorsing the direction of travel and interim outputs; and assisting in the mitigation and resolution of risks and issues should they arise.

Where Steering Group members attend on behalf of an organisation they will also be asked to communicate key information to, and consolidate feedback from, the organisations they work for to provide a broader perspective for review and consideration by the wider Steering Group.

11. Appendices (continued)

Attendance on behalf of an organisation and/or providing specific expertise including subject matter expertise, will not prohibit some organisations who may hold a mandate to monitor, review and report on the Health and Disability system and services, the right to independently comment on all formal and/or public reports, findings and recommendations made by the Steering Group.

Steering Group members who do not formally represent an organisation will be asked to communicate key information to, and consolidate feedback from, any relevant networks they are part of.

Steering Group members will also be requested to nominate individuals from their networks, in particular individuals with lived experience of bereavement by suicide, to contribute to the design process and development of recommendations.

The Steering Group will be supported by a Cultural Advisory Group made-up of representatives from Te Rau Ora, Asian Family Services and Le Va. It is envisaged that this group will provide cultural advice and support to the project and Steering Group, via the Chair.

11.4.6 Term

This Terms of Reference is effective from 1 April 2022 and continues until 30 June 2022, on completion of the first phase of the review. An extension to the timeframes may be required to enable appropriate engagement and deliver meaningful recommendations, and the term of the Steering Group will be adjusted in agreement with the SRO.

11.4.7 Membership

The CIR Steering Group is comprised of the following members. All Steering group members hold an equal role, responsibility, and authority within the group, and all voices and opinions will be considered equally.

- Carla na Nagara, Chair
- Sarah Hetrick / Jackie Andrews (shared role), Suicide Prevention Office, Ministry of Health
- Virginia Brooks, National Suicide Bereaved Advisory Group
- Jane Stevens, Whānau lived experience advocate
- Ivan Yeo, Asian Family Services
- Tiana Watkins, LifeKeepers, Le Va
- Jamie-Lee Tuuta, Independent Barrister
- Anna Tutton / Katharine Grieg (shared role), Office of the Chief Coroner/Coroner

- Matthew Mitchell, Ministry of Justice
- Amelia Steel, Coronial Services, New Zealand Police
- Clive Bensemam, Health Quality & Safety Commission
- Deidre Maxwell, Health Quality & Safety Commission
- Rachel Scott / Geneveine Wilson / Sarah La Haye / Jack Partridge (shared role), Secretariat, KPMG
- Guest attendees, as relevant
- Māori cultural expertise: Maraea Johns, Chief Advisor Māori, Mental Health and Wellbeing Commission (providing te ao Māori cultural expertise to the Steering Group).

**“Whānau should be the
first and last voice”**

