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RESEARCH ARTICLE

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Engaging with whānau to improve coronial investigations into rangatahi suicide

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ABSTRACT

This article reports the findings of two studies of the Aotearoa coronial service that sought to understand how coronial processes engage with whānau who have lost a rangatahi to suicide. The aim of the combined study was to understand the extent to which coronial investigations met the needs of Māori bereaved by suicide. We conducted interviews with coroners to understand how they investigate suicide (Study One) and examined coronial files of rangatahi who had died by suicide, including communications between the coroner's office and the bereaved whānau (Study Two). We found that coroners relied heavily on documentation and only rarely engaged with whānau to gather evidence from those who knew the person who died by suspected suicide. Moreover, forms of communication between the coronial service and whānau were couched in legalese and did not engage with whānau in ways that would add value to the coronial investigation and lead to closure for bereaved whānau. Current efforts to embed Te Tiriti o Waitangi in government policy provide an ideal opportunity to adopt a Tiriti-based approach to coronial investigations so that they align with the needs of whānau in ways that contribute to culturally appropriate suicide investigation, suicide prevention and postvention initiatives.

Glossary: rangatahi (young person), whānau (family), Te Tiriti o Waitangi (Treaty of Waitangi), hapū (sub-tribe), iwi (tribe), tangata whenua (people of the land), tikanga (philosophy), te reo Māori (Māori language), kawanatanga (governance), tino rangatiratanga (sovereignty), oritetanga (equity), tūpāpaku (body), whakamomori (suicide), whakamā (shame), wairua (spirit), tangihanga (funeral), kaumatua (elder), kuia (elder female)

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Introduction

Almost two hundred years after the onset of colonisation, Aotearoa stands out among resource-rich countries as having some of the highest rates of youth suicide in the

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world. These rates are especially high among Māori (OECD Family Database 2023) and constitute one of the most significant contributors to the health and social disparities experienced by Māori in Aotearoa (Beautrais 2018; WHO 2018).

The recent report into rangatahi suicide in Aotearoa has identified colonisation and intergenerational trauma as major contributing factors to the inordinately high rates of suicide among Māori (HQ&SC 2020). In the face of persistently high youth suicide rates, government efforts to address these major challenges have focussed on the multiple roles of key players in suicide prevention, including coroners. The Government's recent inquiry into mental health and addiction, *He Ara Oranga*, has recognised the crucial role that coroners play in investigating suspected suicides and has recommended that the process of investigation be improved to better meet the needs of whānau bereaved by suicide (Government Inquiry into Mental Health and Addiction 2018). *He Ara Oranga* recommends that coroners work closely with other people and agencies with intimate knowledge of suicides in order to improve investigations into suspected suicides. Similarly, a report from the Office of the Auditor General (2016) emphasised the importance of coroners working closely with other agencies to ensure that their findings generate timely and effective recommendations. Currently, only a small number of recommendations are generated from investigations into suspected suicide compared to investigations into other deaths. The Auditor General's report recommends that coroners broaden their investigations into suspected suicide by gathering evidence from multiple parties with knowledge of the person who has died to generate a larger number of suicide prevention recommendations for implementation, and ultimately, contribute to suicide prevention initiatives.

This paper responds to this imperative by examining the role that coroners play in investigating suspected suicides, the role or whānau in this process and how the coronial process might be enhanced over time and contribute to a reduction in Māori suicide rates.

Strategic approaches to engaging with whānau at times of bereavement and involving them in coronial investigations could go some way towards enhancing investigations into suspected suicide and produce long-term benefits for whānau wellbeing and a reduction in the numbers of Māori who die by suicide. To this end we critically examined the intersection between coronial investigations and whānau expectations in relation to the suspected suicides of rangatahi Māori.

The findings we report in this article drew on insights from coroners working in the coronial system (Study One) and the documentation and evidence on which they base their determinations of suicide (Study Two). By drawing on the combination of these two forms of qualitative data we were able to gather crucial insights into how coronial investigations into suspected suicides are conducted and the extent to which whānau who have been bereaved by the death of a rangatahi were involved in these investigations.

Coronial investigations

Coronial investigations into suspected suicide are a crucial element of efforts to understand why a person decided to end their life, and therefore, these investigations are a key foundation of information for the design and implementation of suicide prevention initiatives (Jenkin et al. 2022). The work of coroners in Aotearoa is underpinned by the Coroners Act 2006 which outlines the legislative requirement imposed on coroners to

determine the cause of sudden unexpected deaths (Ministry of Justice 2006). This legal imperative, while important, can mean that the needs and wishes of whānau bereaved by suicide are not prioritised with their voices being minimised during investigations into the suspected suicide of their loved one. This is particularly relevant in the case of post-mortems which are often a key component of the investigation and may contribute to perceptions that the coronial services fail to respond effectively to the needs of whānau bereaved by suicide (Selket et al. 2015).

The efficacy of coronial investigations as a means of suicide prevention through the making of recommendations can often be enhanced by facilitating engagement with bereaved whānau (Selket et al. 2015). The extent to which the coroner and case manager engage with whānau can be an indicator of the thoroughness of an investigation into suspected suicide. Even though whānau have critical information about the life of a person who has died by suicide, for a number of reasons, they are often only minimally involved in the investigation into the suspected suicide of the whānau member who has died (Jenkin et al. 2022). The lack of whānau involvement in the coronial investigation ignores the rights and roles of whānau who have been bereaved by suicide and constitutes a missed opportunity to gain a more comprehensive and thorough picture of the life of the person who has died (Carpenter and Tait 2009). Failure to engage appropriately with the bereaved whānau in a timely and respectful manner can also have a significant negative impact on the quality of recommendations that emerge from coronial investigations (Moore 2016). Moreover, when whānau are not involved in the coronial process, they are denied the opportunity to experience the therapeutic benefits that inquests could provide (Spillane et al. 2019). The ability of the judicial system to deliver therapeutic jurisprudence is seriously undermined when the system fails to engage in a culturally appropriate manner with whānau throughout the coronial investigation (Spencer 2014). Rather, in some cases, the judicial system can serve to retraumatise whānau, especially those who have had previous negative encounters with the judicial system (McCabe and George 2021), and more so for Māori who are more likely than non-Māori to experience the negative effects of differential treatment in these spaces (Brittain and Tuffin 2017). For therapeutic jurisprudence to have the desired outcome, it is vital that there be clear and effective communication between court officials and participants in court processes (King 2003).

Suicide and Māori

In traditional Māori society, whakamomori (suicide) was rare, being largely associated with circumstances of significant shame or extreme grief, such as at the loss of a spouse (Skegg et al. 1995), and occurring among adults rather than young people (Lawson-Te Aho and Liu 2010).

Currently however, the rates of suicide among Māori are disproportionally high, and almost double the rate for non-Māori. The most recent data from the Office of the Chief Coroner showed that the rate of confirmed suicide for Māori was 18.2/100,000 compared to 10.6/100,000 for non-Māori (Ministry of Health 2022). Suicide is a serious public health concern that has a major impact on the health and well-being of whānau, hapū and iwi and the wider Māori community. The unacceptably high rates of suicide among Māori have a major negative impact on the health and well-being of Māori

and are a significant contributor to the current disparities experienced by Māori (Health Quality & Safety Commission 2020) with these disparities reflected among indigenous peoples in other countries such as Canada (Kumar and Tjepkema 2019), Australia and the US (Hunter and Harvey 2002; Durie et al. 2009; Clifford et al. 2013). Concentrated and coordinated efforts to drive down these inordinately high rates will be a lynchpin to achieving equity and ensuring the health of communities and that of generations into the future.

The ethnic suicide disparity is particularly stark for rangatahi Māori compared with non-Māori youth (Ministry of Social Development 2016) and is noted as one of the most pressing health and social issues confronting Aotearoa and Māori in particular (Gluckman 2017). It has been argued that the root causes behind this shameful reality are to be found in the broader social, political, legal, and economic systems that originate from the ongoing process of colonisation in Aotearoa (Lawson-Te Aho and Liu 2010). Colonisation has fragmented Māori social structures (whānau, hapū, iwi), dispossessed tangata whenua and disconnected them from their ancestral lands and imposed a decline in knowledge and use of their language (te reo Māori) and cultural practices (tikanga). Inequities in the social determinants of health have been exacerbated and entrenched through colonisation and inter-generational trauma (Lawson-Te Aho 1998; Health Quality & Safety Commission 2020).

Frameworks to address inequities

Te Tiriti o Waitangi provides a means of addressing the systemic disadvantages and marginalisation experienced by Māori, the tangata whenua of Aotearoa (Came-Friar et al. 2019). By acknowledging the central and pivotal role of the articles of Te Tiriti in the provision of health and social services in Aotearoa, we provide a way of enhancing equity for all people in Aotearoa, especially Māori, a position that is clearly outlined in the current health reforms (Department of the Prime Minister and Cabinet 2022). Health programmes that implement kawanatanga and tino rangatiratanga in the delivery of programmes and ensure effective community engagement are well placed to give effect to Article Three of Te Tiriti (oritetanga), and produce equitable outcomes for all. The involvement of whānau as Tiriti partners in coronial processes is an important way of acknowledging their right to tino rangatiratanga and enacting the intentions of Articles One and Two, with this contributing to enhanced equity for people affected by suicide and attempted suicide.

The role of coroners in suicide prevention

In recent years, the role, profile, and potential contribution of coroners in reducing deaths by suicide in Aotearoa New Zealand has become more prominent in the public sphere (Jenkin et al. 2022). A coroner's primary role is determining the causes and circumstances surrounding sudden unexplained deaths. Determinations of suicide resulting from coronial investigations become our national suicide statistics, and are released each year by the Chief Coroner with much public interest. These national records have a role to play in monitoring suicide and informing prevention strategies and activities. They also highlight some of the striking disparities in suicide by age, gender, ethnicity,

socioeconomic status and sexual orientation, if that information is available. As well, rates of suicide differ according to occupation and across industries, with Māori being disproportionately represented in industries with higher suicide rates, such as farming and the construction industry (Beautrais 2018).

In addition, one of the key functions of the coroner is to draw on evidence, when available, to make recommendations on how similar deaths might be prevented in future (Office of the Chief Coroner, Personal communication, 2023). Section 57A of the Coroners Act 2006 says that coroners **may** make recommendations but they are not *required* in any inquiry regardless of there being an inquest held of a hearing on papers. Despite these provisions, little research has been undertaken on coronial recommendations in Aotearoa generally and, to date, few studies have investigated coronial recommendations for cases of suicide (Moore 2016; Manuel et al. 2018). Furthermore, only a small proportion of suicide cases (5–15%) contain any recommendations at all, a figure that is considerably lower than the proportion of recommendations for other causes of death (Moore 2016). One potential reason for this might be that making suicide prevention recommendations is especially challenging (Walter et al. 2012; Jenkin et al. 2022). Coroners, as lawyers, do not have formal training in suicide prevention, and, unlike their Australian colleagues, New Zealand coroners have no specific training in how to make effective recommendations (Office of the Auditor General 2016; Jenkin et al. 2022).

When recommendations are made for cases of suicide, there is no legal requirement for them to be followed and the extent to which they are implemented remains unclear. Although agencies are not required to respond to or implement the changes suggested by coronial recommendations, they are informed of and consulted on them. While coronial recommendations may on appearance seem to lack teeth, coronial inquests do have considerable power and influence over agency behaviours and practices (Mok 2014).

New Zealand Coroners have the statutory right and obligation to determine the direction and scope of enquiries they open. All conclusions of coronial investigations are determined either through a chambers hearing or in a courtroom inquest open to the public. Around 15% of the coronial case load is concerned with investigating suspected suicides which equates to about 31 cases per coroner annually (Office of the Auditor General 2016). Exactly how coroners go about investigating suicides has been the subject of recent research in which coroners reflected on cultural issues as they related to family concerns in the investigation of suspected suicides (Jenkin et al. 2022). This paper provides further insights into how whānau are engaged in coronial processes related to suspected suicides.

Coronial decision-making processes

It is important to recognise that coroners work collaboratively with a number of other officials with whom they consult when making decisions related to deaths by suicide. While coroners remain the principal decision-maker, they take advice from others and base their decisions on balancing this advice (Walter et al. 2012). It is worth identifying the people with whom they consult in order to understand fully the decision-making processes on which coroners depend (Office of the Auditor General 2016). These include police officers, pathologists, and medical professionals, each of whom may be invited to provide a written statement or report (Clarke and McCreanor 2006). Coroners

work closely with a case manager who liaises with the family and the other providers of data for the inquest. Based on these written documents, a coroner makes a decision about the nature of the proposed coronial investigation. This might be conducted by means of an inquest when people with knowledge of the deceased person are invited to a formal courtroom process during which they provide in-person evidence about the person and their death (Spillane et al. 2019). The second and more common process is conducted by the coroner, who makes a decision about the person's death based on written documents. Since the process is conducted in the office of the coroner, the coroner's decision is referred to as a chamber's hearing or a finding on paper.

The first step in the decision-making process undertaken by the coroner is to determine whether a post-mortem should be conducted. This may be partial or full, depending on the circumstances of the person's death. This decision is made in consultation with the police and the pathologist, with this often contributing to delays in coronial decision-making (Studdert et al. 2016).

Since the police are usually among the first attenders at the site of a suspected suicide they collect the vital information that can be used to help establish the cause of death. This can include police statements from witnesses, photographs of the scene, notes left by the deceased and any objects and paraphernalia that may be connected with the person's death. If the police advise the coroner that there are, in fact, no suspicious circumstances, the coroner is less likely to request that a full post-mortem be conducted.

On occasions, however, the pathologist may recommend that a full post-mortem be conducted, and the coroner must then decide whether one is warranted. Coroners seek approval from whānau to conduct a full post-mortem, and whānau are notified that they can lodge an objection to this process (Selket et al. 2015). However, on most occasions, coroners, with support from a pathologist, will convince whānau of the need to conduct a post-mortem.

Coroners and cultural competency

In Aotearoa, coroners are appointed by the Governor General and candidates must have been qualified to practise as a barrister and solicitor for at least five years (Coroners Act 2006). Currently, there are 18 coroners in Aotearoa, including the Chief Coroner and the Act makes provision to appoint 20 coroners in total to cover the whole country. However, the 2006 Coroners Act does not provide information about any training requirements to fulfil their duties besides their previous legal training and courtroom experience. A review of the coroners' profession in Aotearoa from 1999 explicitly states that coroners are not given any training in relation to the performance of their duties after they are appointed. Coroners are, however, provided with a bench book concerning the exercise of their powers. The Coroners' Report #62 discusses the legislation related to the coroner's office (Law Commission 2000). A review of the available literature did not find, to the present date, confirmation that coroners receive any cultural competency training. Moreover, according to the 2006 Coroners Act, coroners are not legally required to consider tikanga and they can decide (or not) to use culturally appropriate approaches (Coroners Act 2006) despite the fact that some Māori leaders believe that a sound understanding of tikanga should be an integral component of a coroner's professional repertoire (Sharples 2006).

Methods

The current article is based on the findings of two distinct but related studies. The first study was based on in-depth interviews with 13 coroners in 2016, with the aim of understanding how coroners go about investigating suicides and factors that influenced their decision-making. The analysis of this study produced themes using an inductive thematic approach (Clarke et al. 2015) The second study generated findings from a qualitative content analysis (QCA) of a representative sample of 104 full coronial files of rangatahi suicides from 2006 to 2020. We selected every fifth file out of total of 520 cases for the period from 2006 to 2020. Ethical approval for Study One was obtained from the University of Otago Human Ethics Committee (D15/404), and approval for Study Two was obtained from Te Herenga Waka – Victoria University of Wellington Human Ethics Committee (#29140).

Study one

Participants

All 18 coroners practising in Aotearoa in 2016, including the Chief Coroner at that time, were invited to participate in individual semi-structured interviews via a formal letter. Of the 13 coroners who agreed to take part in an interview, the majority were women ($n = 7$, 54%), and were New Zealand European/Pākehā ($n = 10$, 77%). Coroners' experiences on the job ranged from less than a year to more than 20 years, and seven (54%) had five or more years of experience.

Interview schedule

The guiding research questions for Study One were, How do coroners go about investigating suspected suicides; and, What factors influence their decision-making? A semi-structured interview schedule was developed based on the information on the website of the coronial services (see https://coronialservices.justice.govt.nz/coronial-services/), GJ's attendance at two suicide inquests, and feedback from a range of stakeholders in suicide prevention to refine the topics canvassed. The final interview schedule included questions related to the general structure and processes of coronial services, as well as topics specific to suicide investigations. Cultural and family issues faced by coroners were one of a number of subjects canvassed in the interview schedule.

Data collection and analysis

Face-to-face interviews were conducted in all but two cases where interviews were conducted by telephone. Interviews lasted between 60 and 100 min, were audio recorded, and professionally transcribed verbatim.

We followed the six-step protocol for thematic analysis (Braun and Clarke 2006). This involved becoming familiar with the data, generating initial codes, searching and reviewing, defining and naming the themes. We present themes organised around central concepts of *cultural issues* faced by coroners, and *whānau involvement*, during suicide investigations. We note that the study asked about suicide in all groups not specifically rangatahi.

We applied the six-phases outlined by Braun and Clarke (2006) as guides for our analytic framework which entailed familiarisation with data, coding of data, developing initial themes, (re)constructing themes, and refining, defining, and naming themes.

Study two

Research questions

The purpose of Study Two was to examine the full coronial files of rangatahi Māori confirmed to have died by suicide. As an exploratory study, our QCA of coronial files was guided by the following research questions:

- How do coroners arrive at a determination that a rangatahi has died by suicide?
- What is the nature of whānau engagement in coronial investigations?

Data collection

Approval to access and review coronial files was granted by the Ministry of Justice. The selection of coronial files was undertaken by staff at the Ministry of Justice upon our request to examine every fifth file, which was completed on the premises of the Ministry of Justice in Wellington, and on the basis of the files pre-determined numerical order. A total of 104 files (19.85%) were randomly selected out of a possible 524 files on rangatahi Māori (aged 10–24) who died by suicide during the period 2006–2020.

Description of files

The coronial files contained a diverse and eclectic array of material, that included documents such as letters, printed emails, medical records and computer printouts and in some cases, photographs.

Files contained letters to whānau members, usually a parent, health professionals such as pathologists, medical services, and telecommunication providers. The contents of letters included requests for information such as the deceased's mobile phone record or their medical record, notification of the outcome of an inquiry, update on progress of the inquiry, and a request from whānau for the return of property.

Other contents included police reports, witness statements, pathology reports and in some cases, notes written and left by the deceased and photographs of the scene where the person died.

Some files contained only a few of these articles, while others contained multiple and extensive examples of these materials. As a body of material information, however, they demonstrate the rich tapestry of information available to coroners to assist them in arriving at a determination of suicide.

Sample characteristics

Across the 104 coronial files examined, the average age of death for rangatahi Māori was 18.9 years. More than half were male (57%), just over a third were female (38%), and five per cent were identified as non-binary within file reports. Coronial files did not contain information about sexual orientation, and gender was recorded according to sex assigned at birth. Of the total sample, fewer than one in ten of the cases (8%) had full courtroom

inquests conducted, and the majority of decisions were based on a *hearing on the papers* (92%), also known as a 'chambers hearing'.

The average length of the coronial investigation process in the current sample was 1.4 years (66.5 weeks) and ranged in length from six to 216 weeks. From the reports available within each coronial file, we were not able to determine the exact reason for the variations in the length of time to conduct and finalise an investigation. Several reasons, however, may account for the delays, with these including having to wait for reports from relevant agencies, such as district health boards or mental health units.

Data analysis

Textual data from reports within the 104 coronial files were systematically examined using an inductive approach to qualitative content analysis (QCA), a widely employed methodology that offers a systematic way to examine textual data without imposing pre-conceived ideas on the analysis (Hsieh and Shannon 2005; Selvi 2019). In this method, researchers refrain from imposing predefined categories and instead allow themes and patterns to naturally emerge from the data, emphasising a data-driven and exploratory perspective (Elo and Kyngäs 2008).

QCA involves several sequential steps, including becoming familiar with the data, open coding, creating categories, and refining themes through an iterative process (White and Marsh 2006; Vaismoradi et al. 2013). In Study Two, we immerse ourselves in the data, identifying key concepts and patterns within the reports.

We systematically coded the reports for key information regarding (1) the extent to which whānau were involved in coronial investigation processes, (2) what whānau involvement had been, and (3) how the information provided by whānau was used in coronial processes to inform coroners' determinations that a rangatahi Māori had died by suicide. Our QCA was informed by Vaismoradi et al. (2013) and White and Marsh (2006), whereby thematic units (i.e. codes) were organised into key research themes and topics that focused on whānau involvement.

The methodological approach selected for Study Two is particularly advantageous when investigating new or less-explored phenomena, as it permits unexpected insights to emerge and provides a deeper comprehension of the subject matter (Hsieh and Shannon 2005; White and Marsh 2006; Vaismoradi et al. 2013; Selvi 2019). Its adaptability and flexibility make it suitable for accommodating the unique attributes of the data and research context (Selvi 2019).

Results

Our analysis of the data from the two studies revealed five key themes related to Māori whānau involvement in coronial investigations into suspected suicides as well as a number of cultural issues.

Study one findings

Several of the coroners we interviewed told us that, in their experience, where whānau raised objections, it was often at the beginning of the coronial investigation. In some cases, this involved whānau expressing their wish for the coroner to make a speedy

determination about how their whānau member died. Some whānau said that they knew how their whānau member died and they found it hard to understand why the coroner had to take so much time in making a determination of suicide. In other cases, coroners told us that whānau objections usually occurred at the beginning of the coronial investigation when decisions were being made about whether to conduct a post-mortem and the type of post-mortem. Coroners cited a range of reasons for these objections and described many of them as 'cultural issues'. Other reasons for objections included feelings of shame, delays in the grieving process, achieving closure, and sanctity of the body.

In total, three themes were developed using an inductive approach to Braun and Clarke's (2006, 2021) RTA. The first theme, *Objection and Decision Making*, refers to coroners' discussions of the reasons whānau object to post-mortems, the tensions between coronial processes and whānau wishes, and the role of coroners as decision makers. The second theme, *Information and Communication*, outlines how coroners understood the knowledge that whānau had about coronial investigations and the fraught ways in which information was communicated to whānau. The sense of whakamā or shame that whānau felt in regard to the loss of a loved one to suicide is presented in the third theme.

Theme one: objection and decision making

The first theme describes coroners' experiences of whānau raising objections at the beginning of the coronial investigation due to post-mortem examinations. Coroners talked about tensions between professionals involved in coronial processes (e.g. pathologist, police) and the whānau of the deceased regarding the necessity and cultural appropriateness of post-mortems. On one hand, coroners explained that pathologists could request a full post-mortem to determine the cause of death and factors that may have contributed. Conversely, whānau reportedly objected to post-mortems on the basis of believing that these (1) were unnecessary when the cause of death was 'obvious', (2) compromised the sanctity of the tūpāpaku (deceased's body), and (3) prevented access to the tūpāpaku and delayed tangihanga (Māori funeral practices):

> Sometimes it's a balancing act though, because sometimes we will have families objecting to our post-mortem on cultural grounds. And they're genuine grounds, and the family has very strong views that culturally it's offensive. But there will be pressure coming from another perspective, there'll be pressing needs for a post-mortem. We may have a pathologist saying we need a post-mortem, and so it's up to [coroners] to make that decision. (Coroner 11)

As highlighted in this extract, Coroner 11 describes the tension between the pathologist and the whānau, with coroners acting as intermediaries between the two parties. Coroners are the decision makers regarding the necessity of post-mortems, and for some coroners, there were only conducted for good reasons and were requested so long as they did not go against the wishes of the whānau. In contrast, responsiveness and compromise to the cultural needs of whānau were seemingly constrained by the 'needs of the system' and information required for the coronial investigation:

> […] particularly if there's a history of violence or something in the home, that would be an indicator that you should more seriously look […] because you want to exclude any third-party involvement in it. […] [whānau] still blatantly object to a post-mortem, but I think for whatever reason that it's necessary in this case, I will still direct it. (Coroner 10)

Here, Coroner 10 talks about family violence as a rationale for inquiring whether another person was involved in the death through post-mortem. Other questions that could be answered through post-mortem examinations included, Were drugs or alcohol involved in the death? and, Was the deceased being treated for mental illness? Several coroners discussed proceeding with post-mortems when faced with an 'impasse situation' (i.e. tensions between the opinions of professionals and objections from whānau), and explained that whānau could escalate their objections to the High Court:

> You can go to the High Court, sure. But it's going to take time, and in the meantime nothing happens. Perhaps we can allow you access under certain circumstances into the mortuary. But inevitably they'll back down and say, 'you go ahead and do whatever you have to do. We don't like it'. And then get on with it. (Coroner 2)

Coroner 2 outlines how whānau yield to the decision of post-mortem examinations on the basis that they will get their loved one back more quickly rather than proceeding with an objection to the High Court. This point was reinforced by other coroners who mentioned that appeals to the High Court were 'rare' or situations that they had not experienced.

Theme two: information and communication

The second theme was constructed from coroners' perspectives of the (lack of) knowledge held by whānau regarding coronial investigations and the ways of communicating information to whānau during these investigations. Coroners believed that whānau had minimal understandings of the factors related to coronial investigations and described the limited ways in which knowledge gaps were addressed. Indeed, none indicated that they were aware of any proactive provisions in place to redress this knowledge gap. While coroners were well informed by legislative requirements, whānau, on the contrary, reportedly knew little about the processes involved in post-mortems, inquests, and the courts:

> You don't know what a post-mortem is, you're already shocked, you might get a variation in the level and nature of explanation of the police provide. Some police officers would be very good and experienced. I mean certainly the nature of your rights, and being aware of those, is an issue that's worth considering. (Coroner 12)

Here, Coroner 12 discusses the variable level of information that could be communicated to whānau regarding the post-mortem and the rights of whānau, noting that this is dependent on the experience of the police officer. Invariably, whānau relied on information from case managers and police officers to understand the coronial obligations and expectations. While talking about pre-inquest conferences, Coroner 12 also indicated that whānau were not automatically assigned a legal advisor during court proceedings:

> So normally if families do have questions, they can be raised [with case managers and police inquest officers]. However, there's no dedicated adviser. So, in the coronial context, there is not necessarily an assigned person. Unless we assign one of the counsel assisting in a specific case, there's not necessarily an assigned person. (Coroner 12)

For some whānau, reliance on the police for information posed significant problems because of a history of distrust and prior relationships with police. As one coroner we interviewed noted:

> [Court is] an intimidating experience for families, partly because of the setting. And some families we deal with have experienced court processes that are not favourable. Some families have criminal experience. And so, I don't know how well they understand our role, given that we're sitting up the front on the Bench, and they may have encountered other people sitting up there doing a different job, but one which they don't necessarily differentiate. (Coroner 11)

Tangihanga

The coroners interviewed for this study indicated that they were intimately aware of the protocols and rituals associated with tangihanga practised by Māori. They understood the need for the tūpāpaku (body) to be returned to the whānau as soon as possible after death so that the grieving rituals could be conducted in a timely manner that preserved the mana of the deceased and of the whānau to which they belonged. Further, they acknowledged the tikanga that required the need for the body to be present with the grieving whānau as soon as possible after the moment of death (Selket et al. 2015). Coroners also acknowledged that the requirement of a post-mortem often posed challenges for whānau. Since a post-mortem invariably led to delays in tangihanga, coroners understood that this was often the reason whānau lodged objections to the conducting of a post-mortem.

Shame – whakamā

The third theme was organised around the idea of the whakamā (shame). Several coroners indicated that they encountered occasions when whānau felt significant shame in relation to the suicide of their whānau member, a sentiment not confined to Māori. One coroner described the act of suicide as 'a real anathema' to bereaved whānau with this often driving the wish of the whānau that the coroner not make a determination of suicide. In cases such as this, it was noted that some whānau found it difficult to be open and transparent about the circumstances surrounding the death of their whānau member.

> During the investigation, some people have just a cultural dislike of having the death identified as suicide, because it's not seen as a good … seen as a shameful thing in their culture. So, you may find that they don't cooperate terribly well with the investigation, because they don't want you to find that it's a suicide. So that can be difficult in some cases. (Coroner 1)

According to our informants, whānau members often expressed their wishes for the coroner to make a finding on papers rather than to conduct an inquest. Whānau expressed their fears that an inquest would bring undue attention to the death of their whānau member. Moreover, they expressed concern that evidence might be presented at the inquest that would increase the shame and anxiety that the whānau already felt.

> […] suicide is quite a shameful thing for some and some just don't want to talk about it compared to other types of death […]. They get over [other forms of death] as quick as they can and move on, but with suicide it had such a lingering impact on families. […] they have

> cultural issues, don't like to talk about it, don't want it public, rather just have a finding data and chambers rather than turn up to court. (Coroner 6)

One coroner acknowledged the importance of understanding the impact of suicide on whānau and the potential for elevated levels of anxiety and shame within the whānau. This respondent indicated that this awareness could influence the decisions taken by coroners and cited cases in which a determination of suicide was not recorded in deference to the wishes of whānau.

Coroners were also aware of the personal nature of the information that would be made public at an inquest and took measures to avoid situations that would compromise the privacy of whānau. As one coroner said,

> Some families don't want everything in public when it comes to suicide. … You know it's just, so there's all this quite personal, and what I would regard as quite private, information. (Coroner 9)

Who informs the coroner?

Coroners described the decision-making process that underpinned coronial investigations as one of the very real tensions involving the various parties. With regard to decisions to hold a post-mortem, serious tensions can often rise between the pathologist and the family with the coroner acting as the intermediary between the two parties. A pathologist approaches the situation with various questions that can only be answered by conducting a post-mortem. Based on data from both our studies, it was clear that the pathologist seeks to conduct a post-mortem to answer questions such as, Was another person involved in the death? Were drugs or alcohol involved? Was the bereaved being treated for mental illness? How did the person die? In contrast, the bereaved whānau saw this line of questioning as unnecessary partly because they believed the answers were clear and obvious. Their intimate knowledge of the person who had died gave them insights that were not available to the pathologist who did not have the same intimate knowledge but who placed confidence in the post-mortem to provide the answers. While coroners say they understand the tensions this causes for whānau, their decision to request a post-mortem is determined by the need to find answers to explain why and how the person has died, and this subsequently overrides the concerns of the whānau.

> And really real tension between coroners on the one hand, pathologists on the other, police on the other, family, is around that area. The family will say, 'For heaven's sake, we saw her. She was in distress; we saw her hanged. Why on earth do you need a post-mortem? (Coroner 2)

The integrity of the coronial process relies heavily on the ability of coroners to listen carefully to all parties before making a decision about how to proceed with the investigation into deaths by suspected suicide. Multiple parties with differing views can exert pressure on coroners who act as arbiters between conflicting issues, a situation that was described by one respondent as an 'impasse situation'.

In situations such as these, it is not surprising that coroners might struggle to accommodate the wishes of whānau and instead override the requests by whānau for a speedy resolution to a distressing situation.

Study two findings

Contents of coronial files

A coronial record is an official document generated by the New Zealand Coroner's Office during the inquiry into a person's death (Coroners Act 2006, Section 27). Coronial records provide a diverse range of information about the person who has died and the circumstances in which they lived. Our examination showed that some files contained very detailed information and recorded numerous examples of ongoing communication between the bereaved whānau and the coronial service.

Our examination showed that coroners' records demonstrate diversity in the nature and quantity of information they encompass. This finding is aligned with published research in New Zealand that also analysed the content of coronial records (Beautrais 2018). Some files contain detailed information and record numerous examples of ongoing communication between the bereaved whānau and the coronial service. In contrast, other files were very small and contained only minimal information about the person who had died.

All files contained details about the deceased, such as their name, age, date of birth, gender, and other identifying particulars. They also contain information about the date and location of the death. Additionally, all files included information pertaining to the circumstances surrounding the suicide. This typically included the location of the incident, the time of discovery, and any individuals or witnesses involved. Coronial records files also encompass medical records, a post-mortem report, an autopsy report (when conducted), toxicology reports, a copy of the official letters from the coroner's office to whānau, and transcripts (in the case of any pre-hearing meetings and/or inquests being conducted).

In contrast, other files were very small and contained only minimal information about the person who had died. In general, all files contained medical records, a post-mortem report, an autopsy report (when conducted), toxicology reports, police and witness statements, a copy of the official letters from the coroner's office to whānau, and transcripts (in the case of any pre-hearing meetings and/or inquests being conducted).

Some files also contained notes left by the person who died, photographs, mobile phone records requested by the coroner, social media records (e.g. Facebook, Instagram), notes of telephone conversations, emails exchanged between police and coroner, between whānau and case manager, and between coroner and case managers.

Our analysis of the coronial records indicated that there was almost no evidence of direct communication between a coroner and the whānau. Rather, communication with the whānau took place via a third party such as the case manager (each coroner has a case manager for this purpose), or a police officer. One coroner we spoke to in Study One explained that, in efforts to remain objective, coroners deliberately avoid engaging in one-on-one discussions with whānau.

> So, one of the issues that you've got to be quite careful of is not to overly engage in one-on-one discussions with families, because you need to maintain your objectivity and independence as an impartial party, or an impartial finder of fact. (Coroner 10)

A quarter of our sample contained extended communication between the coroner's office and whānau, with this including telephone calls and emails.

Evidence extracted from communications between whānau and the coroner's office showed that most of the communications between whānau and coroner office were related to

- Information about the process, why it was taking so long, and complaints about the lack of information;
- Whānau saying that they did not want to talk to the police, that they did not want to give further evidence and that they did not want a full post-mortem to be done;
- Requesting the return of personal items or body samples; and
- A need for closure.

The few insights from this project about the need to improve the communication processes indicate that whānau would benefit from being involved as it gives them closure. As one record stated, 'I would really appreciate your help with this, as a family we all want some kind of closure.'

Given the diverse range of information available to them, coroners face significant challenges in arriving at a determination of suicide. Our analysis showed that in almost all cases (92%), the coroner's conclusion that a rangatahi had died by suicide was based entirely on reports from police and medical experts and that there was no apparent evidence from the bereaved whānau in the coroner's findings.

There was evidence of heavy reliance on police information, with numerous comments such as, 'Thanks to the police for their assistance so I could make my conclusion' and 'My findings were based on the police investigation and the pathologist's report.' For many Māori bereaved by suicide, comments such as these provide sobering evidence of the ongoing imposition of colonising influences at times of deep sadness and sorrow.

Communication

Findings from Study Two demonstrated that there is no standard form of communication between coroners and whānau. Additionally, most communication, such as official letters, used legal terminology and a language that does not facilitate the understanding of the process. Such practices can be viewed as a means of sustaining colonising behaviours that contribute to the power inequalities faced by Māori.

This finding must be balanced with the fact that investigations into suspected suicides bring an element of complexity because of the imperative to determine intent. The diverse and multiple circumstances surrounding a death by suicide make arriving at a definitive decision complex and raises questions about how coroners from diverse social backgrounds actually determine a person's intent to end their life.

The complex challenges associated with arriving at a determination may account for the fact that some coroners prefer to avoid direct communication with whānau. As one coroner we spoke to in Study One explained, deliberately avoiding one on one discussions with whānau is a key to maintaining a professional distance and remaining objective.

This finding is confirmed by those of a qualitative study in Australia which found a high level of inconsistency among coroners' communications. Their findings attributed this variability in communication to different levels of professional experience and the lack of training. Moreover, their interviews demonstrated that coroners with different

worldviews directly impacted how they communicated with families and whether they would involve families or not during the coronial process (Tait and Carpenter 2013).

Discussion

The heavy reliance on pathology reports and forensic information such as post-mortem affects Māori and demonstrates the dominance of Western, scientific, legal and colonial worldviews in the coronial processes. Australian action research conducted in 2014 for three years interviewed coroners. Their findings demonstrated that coroners have different perspectives when dealing with death and families through the coronial process. They concluded that it is usual for coroners to be very objective and focusing only on the facts about one's death by suicide (Carpenter et al. 2014). While western approach to death usually reduces the body to an object, this is not true for Māori. Some practices, such as post-mortem, represent cultural violence as they can be interpreted as a disruption of the wairua of the diseased (Selket et al. 2015). According to Sharples (2006), although the Coroners Act from 2006 is an improvement compared to previous legislation, it still does not improve coroners' knowledge about Māori worldviews. Moreover, Sharples (2006) strongly advises that coroners should receive tikanga training and that more Māori coroners are appointed. Failure to appoint a full and ethnically representative complement of coroners to the coronial services means that the service becomes under-resourced with this accounting for the delays in conducting investigations.

The first study, based on a thematic analysis of interviews with coroners found that coroners reported that family factors were an important consideration on whether to take a case to inquest. Coroners stated that families play a major role in a decision to conduct an inquest as opposed to a chamber's hearing and that they have a right to request an inquest. Coroners also described an inquest as a potential therapeutic process of benefit to families and that an inquest provided an opportunity for families to question witnesses and raise criticisms of involved agencies. Adverse emotional impact, social stigma around suicide, and a possible desire on behalf of a family to seek blame were cited as reasons for coroners not to proceed with an inquest.

The second study focused on documented interactions between coroners and whānau bereaved by suspected suicide through a direct examination of coronial files. The conclusions from this study paint a somewhat different picture from those drawn from the first study. Study Two revealed that whānau are not usually engaged in coronial investigations into the suspected suicide of their rangatahi. Letters to whānau from coroners and other legal or administrative staff were found to be formulaic and full of legalese. Such formal and technical communications may be complex for whānau to deal with and understand, especially during grief and anxiety.

While whānau have the right to request an inquest, they may not be aware that this is the case, especially in times of trauma and grief caused by the death of a whānau member. Even though formal letters explain that whānau have the right to request an inquest, and further, that they have the right to question witnesses if the inquest goes ahead, the whānau may not be fully aware that they have such rights. Conversely, communications from whānau members to coroners were very scarce. This suggests that whānau do not

feel engaged in the coronial process or feel unable to engage in ways that are comfortable for them.

These contrasting results highlight a significant discrepancy between the perceptions and experiences of coroners and those of bereaved whānau regarding coronial inquests into suspected suicide.

Limitations and further research

It is important to acknowledge that this study is based on two limited, albeit significant, sources of data: the perceptions and insights of coroners, and the evidence contained in the documents on which coroners based their investigation and determination that a person has died by suicide. The findings of this study would be strengthened by engaging with and hearing directly from whānau who have been bereaved by suicide, as well as case managers, police officers and others with intimate knowledge of coronial processes. Further research that focused on insights from whānau would respond directly to the imperatives of Aotearoa's suicide prevention strategy *Every Life Matters. He Tapu te Oranga o ia Tangata*, which stresses that whānau must be at the front and centre of efforts to drive down the unacceptably high rates of rangatahi suicide (Ministry of Health 2019). Building and strengthening whānau networks in the face of ongoing challenges related to the high rates of suicide in Māori and indigenous communities is fundamental to building resilience and taking action to drive down the rates of suicide among Māori, a key concept of the Māori-led Turamarama Declaration (2017).

Close and respectful engagement with whānau affected by suicide would go some way towards determining the extent to which whānau and the coronial service can contribute to rangatahi suicide prevention. Conversations with whānau will help to provide clarity on this issue. Crucially, whānau who are empowered by knowledge and insights related to rangatahi suicide are well placed to become agents of change and of suicide prevention and postvention. We note that other work has also pointed to the need and benefits of involving family in death investigations, especially in terms of tapping into further evidence around sudden unexpected deaths (Spillane et al. 2019).

A number of factors may account for the variation in communication between the coronial service and whānau. The independent nature of judicial officers such as coroners means that they can determine their own parameters and make decisions without having to resort to the use of a standardised template or a list of questions to ask. Given that the key objective of the coronial investigation is to determine intent rather than risk, the coroner's determination is usually based on the former at the expense of the latter. The heavy workload of coroners places further pressure on them to find expedient answers to generally complex investigations.

Finally, this research project has highlighted a number of areas where a Tiriti-based approach could enhance the responsiveness of the coronial service to the needs of whānau bereaved by suicide. The application of the articles and principles of Te Tiriti o Waitangi to coronial investigations into suspected suicides has the potential to allow the voices of whānau to be heard so that whānau become part of the solution to this complex and entrenched social problem. The articles of tino rangatiratanga and kawanatanga provide a firm foundation on which to base investigations that are more likely to lead to equitable outcomes than investigations that have minimal or no engagement with

whānau. A genuine commitment to applying Tiriti-based articles to coronial investigations could include active engagement with whānau, hapū and iwi, the application of tikanga Māori to all aspects of the coronial investigations, engagement with kaumatua and kuia, and processes that facilitate Māori leadership and decision-making. Furthermore, a commitment by the coronial service to the use and application of te reo Māori in documentation and processes would signal to Māori in general and those bereaved by suicide in particular that the service is well equipped to improve its processes so that they align more closely with the needs of Māori than is currently the case. Current government policy calls for strategic Tiriti-based approaches to achieving equity and a framework that demonstrated this commitment to partnership and protection based on the articles of Te Tiriti would be a powerful mechanism for bringing about beneficial change for Māori.

Conclusion

This paper addresses one of the most pressing health and social issues confronting Aotearoa – the high rates of suicide among Māori, and especially among rangatahi. The combined evidence from two distinct but related data sources provides clear evidence of some of the shortfalls in coronial investigations into suspected deaths by suicide of Māori. The article makes a strong case for enhanced engagement with whānau at all stages of the coronial investigation in the belief that this will provide insights and information about the suspected suicide that will provide a sense of closure while empowering whānau to become crucial agents of change that over time, will lead to a reduction in the numbers of rangatahi lost to suicide.

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