Māori suicide rates remain too high. Involving whānau more in coronial inquiries should be a priority

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Rates of suicide in Aotearoa have remained stubbornly high, despite government efforts to address the issue through the suicide prevention

strategy and action plan and other measures.

Aotearoa has one of the highest youth suicide rates in the OECD, and suicide rates are particularly high for young Māori. So the latest report from the Office of the Chief Coroner on the annual rates of suicide makes for sobering reading.

While the report shows there has been a slight decrease in the overall number of suspected suicides, the difference in rates between Māori and non-Māori remains a significant concern.

Overall, the suicide rates for Māori are almost twice as high as for non-Māori. For rangatahi Māori (young Māori aged 15 to 24) the suicide rates are almost three times the rates of non-Māori.

These stark differences are an indication of the serious health and social disparities that continue to exist for Māori.

Our new research looks at the extent to which coronial investigations met the needs of Māori bereaved by suicide. Through interviews with coroners and an examination of more than 100 full coronial files, we identified gaps in the processes as well as areas where vital improvements can and should be made.

Investigating a person's life and death

Under the Coroners Act, coroners are charged with determining the causes and contributing factors in sudden unexpected deaths.

In the case of a suspected suicide, a coroner needs to determine, beyond all reasonable doubt, that a person deliberately intended to end their life.

Invariably, coroners rely heavily on documents provided by third parties

such as police officers, mental health professionals and witnesses.

In about 10% of suicide cases, coroners conduct full courtroom inquests. These provide opportunities for people who knew the deceased to provide evidence about the person who died and their living, work and social circumstances.

Importantly, inquests can generate a form of closure by providing answers to whānau after someone dies suddenly. This process is helped by questioning witnesses and others involved.

Disconnect between whānau and coroner

Our research found most whānau who have lost someone by suicide are eager to engage with coronial services—but they don't always get this opportunity.

Rather, most suspected suicides are determined by an investigation that is referred to as "on papers" or "in chambers". This streamlined process means coroners usually never meet bereaved whānau and, as a consequence, depend entirely on documentation from third parties when making their determinations.

When coroners communicate with bereaved whānau, it is usually through a coronial case manager who acts as a conduit between the two parties. Since coroners hardly ever meet with whānau in person, they rely heavily on case managers collecting the information needed to make a decision.

On occasion, a coroner will ask a police officer to meet with the bereaved whānau to obtain relevant information. But for some whānau, this can be traumatizing, especially for those who have had negative interactions with police in the past.

There is also a great deal of variation in how much information is gathered by coroners to make their determination.

Some of the files we examined were large and contained copious amounts of information about the person who had died. Others were very slim and contained only minimal information about the deceased person.

Regardless of size, all files contained letters addressed to whānau which notified whānau that an inquiry had begun. These letters outlined their rights as bereaved next of kin. Whānau could, for example, request that a courtroom inquest be held. But this request needed to be made quickly.

Bereaved whānau were often presented with this information at times of high stress and trauma. And much of the information was couched in formal legal terms, compounding the challenges of dealing with the sudden death of their loved one.

Whānau need wraparound support

Our research made it clear there is an opportunity to provide better wraparound support for families going through the coronial process. This includes informing whānau of their rights in lay terms so they are able to understand what is happening.

Whānau should also be given the chance to add to the data collected by the coronial process, be able to describe the situation of the deceased at the time, and question those who had provided services to their whānau member, especially in the time leading up to the death.

For whānau, being listened to and participating in the inquiry is a critical aspect of therapeutic jurisprudence which in turn will provide better data.

And for government agencies and the wider community, a deeper understanding of the circumstances surrounding suicides would be valuable in developing effective suicide prevention policies.

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