You Can’t Print *That*! Suicide Reporting and the Law

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Abstract

Since the publication of the Sorrows of Young Werther in 1774, concerns have existed about the potential for media to cause further suicides. In response to those concerns, New Zealand's Coroners Acts have prohibited the publication of details surrounding individual suicides since 1951. However, those restrictions were narrowed by the Coroners Amendment Act 2016. Now, only publication of information on the method of death and a premature description of a death as a suicide are prohibited, although it is possible to obtain an exemption. This thesis examines whether research into suicide contagion justifies the restrictions in s 71 of the Coroners Act 2006 are justified, and whether the exemption regime in s 71A of the Coroners Act strikes a balance between competing freedom of expression, prevention of harm, and the interests of the whānau of the deceased. Ultimately, I conclude that while the restrictions in s 71 of the Coroners Act are justified, they restrict freedom of expression more than is necessary, and their scope is unclear, which results in unnecessary criminalisation.

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Attestation

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Introduction

New Zealand has compulsorily restricted media reporting of self-inflicted deaths, including suicides, since 1951.[1] Until 2016, the restrictions were extensive and effectively forbade the reporting of any details about self-inflicted deaths, with breaches of those restrictions a criminal offence. This position is unique amongst the common law jurisdictions, although New South Wales Coroners have discretionary non-publication powers concerning self-inflicted deaths.[2]

In 2016, the Coroners Act 2006 was amended to allow more details of suicides to be reported.[3] While reporting the method of suicide remains prohibited and a criminal offence, it is now possible to seek an exemption from the Chief Coroner.

Despite the changes to the Coroners Act, suicide reporting in New Zealand media remains an issue. A recent opinion piece in *Stuff* discusses both the benefits and harms of suicide reporting.[4] Concerns have also been raised over the coverage of a murder trial, where it was alleged that a suicide was staged, which featured graphic descriptions and imagery of the method of death.[5]

I Thesis question and structure

This thesis asks:

a) whether the current publication restrictions in s 71 of the Coroners Act 2006 are justified; and
b) if granting an exemption under s 71A of that Act strikes the appropriate balance between competing public and private interests.

Chapter One of the thesis is a socio-legal history of how the law has attempted, and continues, to regulate suicide in New Zealand's history, including the treatment of suicide as a crime and some of the concerns about how suicide was reported. In this chapter, I will also set out the legal elements of suicide, including the difference between a self-inflicted death and suicide. Finally, I will examine the legislative history of the prohibitions on suicide reporting, which led up to the Coroners Amendment Act 2016.

Chapter Two will discuss the Law Commission's review of s 71 of the Coroners Act 2006, the Coroners Amendment Act 2016, and the issues raised by submissions to the Justice and Electoral Committee. It will include an examination of media codes of practice around the reporting of suicide and the current evidence for both the benefits and risks of suicide reporting.

In broad terms, Chapters One and Two set out the necessary background information to the prohibitions on suicide reporting and the reasons for the Coroners Amendment Act 2016. These chapters provide answers to the following questions:

1. What is the rationale for the suicide reporting restrictions?
2. What are the risks in publication, if any?

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[1] Coroners Act 1951, s 21; Coroners Act 1988, s 29; Coroners Act 2006, s 71.
[2] Coroners Act 2009 (NSW), s 75.
[3] Coroners Amendment Act 2016. This Act amended s 71 of the Coroners Act 2006 and inserted a new section, s 71A.
[4] Jehan Casinader "Is our suicide conversation helping or harming?" *Stuff* (online ed, 17 September 2023).
[5] "Mental health experts issue warning over reporting of Polkinghorne trial" *Radio New Zealand* (online ed, 19 August 2024).

Chapter Three sets out how the exemption regime has operated by examining the exemptions made, their reasoning, and the resulting reporting and impact. It will attempt to identify themes behind the exemptions and analyse whether the balance between public and private interests is met. This section will also examine whether there have been any convictions for the publication of suicide information since the 2016 amendment. Ultimately, the purpose of Chapter Three is to answer the following questions:

1. What is the public benefit of allowing the publication of the method of suicide?
2. How are the interests of the family of the deceased affected?

Chapter Four draws up the previous chapters to consider whether the current restrictions and the exemption regime are a justified limitation on freedom of expression. In that context, I examine to what extent s 71 the law prohibits coroner's findings from being publicised and, as such, reduces the protective element of a coroner's role. Finally, I consider whether changes to the Coroners Act would be necessary to make the exemption process and criminal sanctions less restrictive on freedom of expression.

II Existing literature and research

This thesis fills a gap in the existing legal commentary. Since the passage of the Coroners Act 2006, there has been limited discussion on the legal aspect of the suicide reporting provisions. An article by Sam Blackman was critical of the media's position. He was of the view that the media overstated the benefits of unfettered suicide reporting.[6] A later article by Michael Finucane broadly supported the Law Commission's position. However, he expressed some concerns about the proposed exemption regime.[7] In a Harkness Henry Lecture, Judge Maclean, the then-Chief Coroner, commented that the Law Commission's report and proposed changes to the Coroners Act reflected the broad spectrum of opinion on this topic.[8]

Although relevant legal texts state ss 71 and 71A of the Coroners Act, they do not discuss them in depth. The authors of *Media Law in New Zealand* briefly mention the prohibition on publication but primarily discuss suicide reporting in the media as part of journalistic ethics.[9] The chapters on the coronial jurisdiction in *Health Law in New Zealand* and *Therapeutic Jurisprudence: New Zealand Perspectives* were published while reforms to suicide reporting were still before parliament.[10]

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[6] Sam Blackman "Suicide and the media: whether New Zealand's statutory restrictions on the reporting of suicide are justified" (2012) 2 NZLSJ 746. For an alternative view, see James Hollings "Reporting suicide in New Zealand: Time to end censorship" (2013) 19 Pacific Journalism Review 136.

[7] Michael Finucane "Media reporting of suicide: the risks of suicide news stories and how responsible reporting can be achieved" (2015) 3 NZLSJ 488. See also Linda McIver and Paul Comrie-Thomson "Suicide reporting" [2014] NZLJ 145.

[8] Neil MacLean "The Vision and the Reality: Reflections on the Evolving Role of the New Zealand Coroner in 2015" (2015) 23 Wai L Rev 1 at 20. See Gabrielle LS Jenkin, Ben E Slim, and Sunny Collings "News Media Coverage of Stakeholder Views on Suicide and Its Reporting in New Zealand" (2020) 41 Crisis 248.

[9] Ursula Cheer *Burrows and Cheer Media Law in New Zealand* (8th ed, LexisNexis, Wellington, 2021) at 542–545 and 885–888.

[10] Morag McDowell "Coroners" in PDG Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 737 at 766–769. Jennifer Moore "The Impact of Therapeutic Jurisprudence on the New Zealand Coronial Jurisdiction" in Warren Brookbanks (ed) *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters, Wellington, 2015).

There is also a lack of research on how New Zealand media report suicide and adherence to suicide reporting guidelines. While there are a small number of studies, none have covered suicide reporting following the Coroners Amendment Act 2016 or the implementation of the 2021 suicide reporting guidelines.

Chapter One: The regulation of suicide in New Zealand

Suicide has long been the subject of legal regulation, having at one time been a criminal offence. This chapter sets out how suicide has been, and still is, regulated in New Zealand. It will discuss how suicide was once punished and reported, as well as the concerns about that reporting. I will then examine how the concerns about suicide reporting have been reflected in the various Coroners Acts.

I The legal elements of suicide

Suicide is not legislatively defined in New Zealand.[11] The Dictionary of New Zealand Law defines suicide as "self-killing", while *Seales* defined suicide as being "where a man kills himself intentionally".[12] In 2020, the United Kingdom Supreme Court held that the elements of suicide are that the deceased took their own life and that they intended to kill themselves.[13]

However, the Coroners Act refers to self-inflicted deaths, of which suicides are a subset. This is consistent with the Accident Compensation Act 2001, which distinguishes between self-inflicted injuries and suicide. Under s 119(1) of that Act, the Accident Compensation Corporation must not provide any entitlements for self-inflicted injuries, deaths arising from such injuries, and deaths by suicide.[14]

Given the limits of ACC cover for self-inflicted deaths, accident compensation cases provide some guidance on the distinction between a suicide and a self-inflicted death. In *Executor of the Estate of Peter Thomas Goodwin v Accident Rehabilitation and Compensation Insurance Corporation*, Judge Beattie commented that:[15]

> The meaning of suicide is the act or instance of killing oneself intentionally. It is axiomatic that if one's mental state is such that one cannot form that intention, a self-inflicted death cannot be regarded as suicide.

However, given the language of the Coroners Act and Accident Compensation Act, I consider the elements of suicide are where the death is both:

a) self-inflicted; and
b) intentionally inflicted to cause death.

I discuss each of these elements below.

A Self-inflicted

[11] *Seales v Attorney-General* [2015] NZHC 1239, [2015] 3 NZLR 556 at [117].
[12] Dictionary of New Zealand Law (online ed, LexisNexis), and *Seales at* [117].
[13] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2020] UKSC 46, [2021] 3 All ER 1 at [3], per Arden J. See also Paul Matthews and John Jervis *Jervis on the office and duties of coroners* (fourteenth edition ed, Sweet & Maxwell, London : Thomson Reuters, 2020).
[14] However, should a self-inflicted injury or death occur because of a mental injury for which a person has ACC cover, then s 119 does not apply.
[15] *Executor of the Estate of Peter Thomas Goodwin v Accident Rehabilitation and Compensation Insurance Corporation* DC Palmerston North 71/99, 23 March 1999 at 7, cited in *Black v Accident Rehabilitation and Compensation Insurance Corporation* DC Wellington DCA168/99, 7 June 2000 at [36].

As noted above, self-inflicted deaths, rather than deaths by suicide, are a specific class of deaths in the Coroners Act and the Accident Compensation Act. It is self-inflicted deaths into which inquiries must be opened and which are affected by the publication restrictions in s 71.[16]

The Oxford English Dictionary defines self-inflicted as "a wound, suffering, etc.: inflicted or caused by oneself".[17] The Accident Compensation Act defines a self-inflicted injury as a "personal injury" that a person "wilfully inflicts on himself or herself, or, with intent to injure himself or herself, causes to be inflicted upon himself or herself".[18] Section 26 of the Accident Compensation Act sets out the various definitions of personal injury, which includes physical injury.

In *Cohen v Accident Rehabilitation and Compensation Insurance Corporation*, an act can be described as wilful if done deliberately, as opposed to an act that was done "without thought or on the spur of the moment".[19] However, an act may still be deliberate if a person "has not pondered its propriety or reviewed its possible consequences before committing it". As Justice Greig noted in *Accident Compensation Corporation v Stevens*, a deliberately inflicted injury does not require intent to cause injury or harm, rather "the person who deliberately injures or causes an injury such as a pierce or cut on himself must accept the consequences whether he meant to harm himself or whether he meant to pleasure himself".[20]

The other form of self-inflicted injury in s 119(1) of the Accident Compensation Act are injuries that a person "with intent to injure himself or herself, causes to be inflicted upon himself or herself". As noted in *Stevens*, which concerned Mr Stevens's injuries resulting from asking someone to inject him with drugs, this type of injury could include matters such as tattooing or ear piercing, which are physical injuries, but where the intent is bodily modification rather than harm.[21]

In my view, a self-inflicted death means all deaths resulting from either type of self-inflicted injury described above. Such a definition encompasses those deaths that are the result of a deliberate injury, such as cutting or hanging, or indirect, such as where a person has intentionally placed themselves in harm's way or caused themselves harm.

B Intentionally inflicted to cause death

As noted earlier, for a self-inflicted death to be a suicide, the deceased must have intended that their act be fatal and have known the consequences of their action.[22] The evidence must show that at the time of their actions, the deceased understood the nature of their actions. I discuss below the standard of proof for a finding of suicide.

The coronial jurisdiction is distinct from both the civil and criminal jurisdictions. A coroner has no power to find either guilt or liability.[23] A coronial inquiry is an inquisitorial, rather than an adversarial,

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[16] Coroners Act, ss 61, 71, and 71A. See also *Leadbeater v Osborne* HC Auckland M2120/89, 15 May 1991 at 6.
[17] "Self-inflicted" Oxford English Dictionary Online <www.oed.com>.
[18] Accident Compensation Act 2001, s 119(1)(a).
[19] *Cohen v Accident Rehabilitation and Compensation Insurance Corporation* DC Wellington 133/98, 22 June 1998 at 3, citing *Smith v Wemyss Coal Group Ltd* (1927) 21 BWCC.
[20] *Accident Compensation Corporation v Stevens* HC Wellington 194/91, 29 April 1993.
[21] At 5.
[22] At 4.
[23] Coroners Act, ss 4(1)(e) and 57(1).

process.[24] The appropriate standard of proof is the civil standard,[25] rather than the criminal standard.[26] However, until recently, findings of suicide in the United Kingdom were determined based on the criminal standard of proof.[27] In noting that the criminal standard of proof may lead to an under-reporting of suicide statistics and missed opportunities for lessons to be learned, the United Kingdom Supreme Court echoed the concerns of the Wright Committee.[28]

The New Zealand Supreme Court has stated that the civil standard of proof is to be applied flexibly, and that more serious allegations require more serious proof.[29] However, *Re Sutherland (deceased)* notes that suicide must not be presumed "merely because there seems to be no other likely explanation".[30] Similarly, the United Kingdom Supreme Court notes that:[31]

> There is considerable authority for the proposition that suicide is not to be presumed and must be affirmatively proved by some evidence. … It must be proved, and it is not permissible to fill in gaps in the evidence. It is not sufficient to say that, if all other causes of death are ruled out, it must have been a suicide.
>
> (Citations omitted)

Unlike past coronial verdicts of insanity,[32] there are many reasons why intent cannot be formed. A person who is very young, or labouring under a severe mental illness, intellectual disability, or condition such as dementia may not be able to form a suicidal intent. However, the mere presence of such conditions does not automatically mean that a person does not intend to die. The requirement to affirmatively prove intent may be based on the circumstances of the death, such as text messages, comments or suicide notes. It could be inferred from a person's age, history, or experiences.

In my view, the above analysis of the distinction between self-inflicted deaths and suicide is consistent with the way a self-inflicted death is treated in the Coroners Act. I consider that the publication restrictions in s 71 of the Coroners Act apply to all self-inflicted deaths, rather than just deaths due to suicide.

Had Parliament intended s 71 to only apply to suicides, the legislation would have explicitly said so. For example, restrictions on publication could apply to suspected self-inflicted deaths before a finding

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[24] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* [2018] EWHC 1955 (Admin), [2019] 1 All ER 561 at [34]–[40].
[25] The balance of probabilities.
[26] Beyond a reasonable doubt.
[27] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* 3 [2020] UKSC 46, [2021] 3 All ER 1 (UKSC).
[28] At [62].
[29] *Z v Dental Complaints Assessment Committee* [2008] NZSC 55, [2009] 1 NZLR 1 at [102], [105] and [112]. *Z* can be compared with *Braganza v BP Shipping Ltd* [2015] UKSC 17, [2015] 4 All ER 639, which considers the flexible approach in *Z* is incorrect, and that it is the inherent improbability of the claim which affects how much proof is required to meet the threshold of more likely than not. At [33]–[35] it is the improbability of suicide that means it requires stronger evidence to meet the burden of proof.
[30] *Re Sutherland (deceased)* [1994] 2 NZLR 242 (HC) at 250. See also *R (Lagos) v HM Coroner for the City of London* [2013] EWHC 423 (Admin) at [36]– [37].
[31] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire*, 3 [2020] UKSC 46, [2021] 3 All ER 1.
[32] See the discussion in "Suicide and the law" below at pages 7–11.

of suicide, similar to the current distinction between describing a death as "suspected suicide" and suicide.

II Suicide in the law

A Suicide in England and Wales

Historically, suicide was a common law criminal offence. Blackstone's *Commentaries on the Laws of England* describes suicide as a type of "felonious homicide", an unjustified taking of human life,[33] and the "highest crime against the law of nature that man is capable of taking".[34] Suicide, or self-murder, was a felony in two respects. The first was spiritual, as the deceased had invaded the prerogative of God and rushed into "his immediate presence uncalled for".[35] It was also an offence against the crown, as the monarch "hath an interest in the preservation of all his subjects".[36]

Blackstone described suicide as ranking among the "highest of crimes".[37] A person guilty of suicide was a felony upon oneself, or *felo de se*. As with other felonies, attempting suicide was also an offence. Other people could be accessories, meaning that a person who advised a person to take their own life would also be guilty of murder.[38] A *felo de se* was defined as someone who "deliberately puts an end to his own existence".[39] The deceased must also "be of years of discretion, and in his senses, else it is no crime".[40] However, Blackstone cautioned that:[41]

> … this excuse ought not to be strained to that length to which our coroners' juries are apt to carry it, viz: that the very act of suicide is an evidence of insanity; as if every man, who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal non compos, as well as the self-murderer. The law very rationally judges that every melancholy or hypochondriac fit does not deprive a man of the capacity of discerning right from wrong; which is necessary, as was observed in a former chapter, to form a legal excuse.

As Blackstone explained, a *felo de se* could not be punished in the usual sense, such as a fine or imprisonment, as the deceased was out of the reach of human laws. However, their "reputation and fortune" remained.[42] A *felo de se* was punished by being buried on a highway at night with a stake through their body and having their goods and chattels forfeited to the crown.[43] The reasoning behind this was that these punishments would act as a deterrence.

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[33] Thomas M Cooley *Commentaries on the Laws of England* (3rd ed, Callaghan and Co, Chicago, 1884) vol 2 at 187.
[34] At 177.
[35] At 187.
[36] At 187.
[37] At 187.
[38] At 187.
[39] At 187. The text also considers that a person's death that occurs because of any other "unlawful malicious act" was also a *felo de se*.
[40] At 189.
[41] At 189.
[42] At 189.
[43] At 189.

Blackstone noted that the law "borders a little upon severity".[44] Yet "the power of mitigation is left in the breast of the sovereign, who upon this, as on all other occasions, is reminded by the oath of his office to execute judgment in mercy".[45]

In 1823, the laws for the burial of a *felo de se* were changed when parliament forbade coroners from directing that a body should be buried at a crossroads or with a stake through its heart.[46] However, the denunciation of suicide remained, as the law directed that the rites of Christian burials were not to be performed.[47] While a burial could take place in a churchyard, it had to take place within 24 hours of a verdict of suicide and only between the hours of 9 pm and 12 am.[48]

The law was changed again with the enactment of the Interments (Felo De Se) Act 1882, which permitted a suicide to be buried in the same manner as any other person.[49] Suicide ceased to be a crime in England and Wales with the passage of the Suicide Act 1961.[50]

B Suicide as a criminal offence in New Zealand law

Although inquests occurred as early as 1841, the first New Zealand coronial legislation was the Coroners Ordinance 1846.[51] The Ordinance specified that a coroner in New Zealand had "all such powers and privileges and be liable to all such duties and responsibilities as any Coroner by law hath or is liable to in England".[52] Subsequent coronial legislation in 1858 and 1867 maintained the same provision.[53] This provision had the effect of importing not only the common law offence of suicide but also the United Kingdom's burial laws of 1823 and 1882 mentioned above.

a. Felo de se verdicts

In examining verdicts of *felo de* se, I have utilised the National Library's Papers Past database. Papers Past returned a total of 656 newspaper articles containing the term *felo de se* between 1840 and 1893 when suicide ceased being a crime.[54] However, of that number, only 370 were articles covering a New Zealand suicide, although most of those were duplicated across multiple newspapers. The remainder were reports of overseas suicides, poetry or works of fiction, or the use of the term in other contexts, such as political *felo de se*.

As can be seen from Table 1.1 below, only 51 verdicts of *felo de se* were reported, along with 21 reports where the jury could not reach a verdict or delivered verdicts of temporary insanity. With

[44] At 189.
[45] At 189.
[46] Burial of Suicides Act 1823 (UK) 4 Geo c 4, s 1.
[47] Section 2.
[48] Section 1.
[49] Interments (Felo De Se) Act 1882 (UK) 45 & 46 Vict c 19, s 3.
[50] Suicide Act 1961 (UK), s 1.
[51] One example is the reporting of the inquest into Arthur Turtley in "Domestic Intelligence" *New Zealand Herald and Auckland Gazette* (7 August 1841) at 2. The legal basis for a coronial system before 1846 is unclear. However, the effect of s 1 of the English Laws Act 1858, which retrospectively applied English law from 14 January 1840.
[52] Coroners Ordinance 1846 Vict c 5, cl 4.
[53] The Coroners Act 1908 also contained the same provision. However, this was a consolidated act, created by the Consolidated Statutes Enactment Act 1908. In essence, it was a reprint of, the Coroners Act 1867, containing the changes made in the Coroners Act 1867 Amendment Act 1885 and the Coroners Amendment Act 1888.
[54] See page 12.

respect to the punishment of suicide, only two articles mentioned the forfeiture of property, while 10 articles discussed burial of the deceased.

Table 1.1: Felo de se articles 1840-1893			
Unique guilty verdicts	Insanity verdict/No verdict	Reports of property forfeiture	Reports about burial
51	21	2	10

The above results suggest that verdicts of *felo de se* were rare, consistent with reports of statistics and comments in newspaper articles. In 1885, of the 51 inquests into suicides that were held, verdicts of *felo de se* were returned in only three instances.[55] In an inquiry into the death of Gideon Withers, the Coroner was said to have told the jury that "during his thirty years' experience as Coroner, this was the first verdict of suicide while not of unsound mind that he had received".[56]

b. Reporting of *felo de se* verdicts

While verdicts of *felo de se* were made, and subsequently reported on, the orders for property forfeiture and burial were seldom mentioned. The first reported verdict of *felo de se* was Joseph Zillwood in October 1854.[57] The notice announcing his death and upcoming inquest stated that Mr Zillwood:[58]

> … escaped the vigilance of some persons watching him, and deliberately shot himself, discharging a small pistol, loaded with ball, in his mouth. He lingered in great agony, although sensible, till Thursday last, about 11 o'clock in the morning.

Following the verdict of *felo de se*, Mr Zillwood was "interred at night, without funeral rites".[59]

Negative articles regarding the burial of suicides were prompted by a view that such burials were either unjust or morally wrong. The death of Ann Fooks in March 1873 is one such example.[60] Mrs Fooks was a 73-year-old widow who lived in Howick, Auckland. The circumstances of her death and inquest were set out in several articles,[61] one of which described Mrs Fooks's death as follows:[62]

> We have been greatly shocked here by the miserable case of poor Ann Fooks, an unfortunate imbecile who lately destroyed herself at Howick, a pensioner settlement 13 miles from Auckland city. The poor creature had no friend in life, and, for that matter, seems to have had no friend after death. She hung herself and was left hanging for many hours after she was found suspended. An ignorant jury held the inquest whilst the corpse

[55] "Miscellaneous" *Western Star* (10 November 1886) at 3. In total there were 330 inquests held that year, meaning that suicides accounted for 15.4 per cent of inquests. These statistics were published in a total of 14 newspapers.
[56] "Determined Suicide" *Lyttelton Times* (12 December 1889) at 6.
[57] "Local Intelligence" *Lyttelton Times* (25 October 1854) at 5.
[58] *Lyttelton Times* (21 October 1854) at 5.
[59] "Local Intelligence", above n 16.
[60] As discussed in Peter Luke "Suicide in Auckland 1848-1939" (MA Thesis, University of Auckland, 1982) at 209; Ruth McManus "Freedom and suicide: a genealogy of suicide regulation in New Zealand 1840-1970" (2005) 18 Journal of Historical Sociology 430 at 451. Note that various newspaper articles and reports spell Mrs Fooks's name differently, including as "Folks" or "Fawkes".
[61] Seven articles commented on Mrs Fooks's death, one of which was a duplicate.
[62] "Auckland" *Christchurch Star* (1 April 1873) at 3.

> dangled before their eyes; then a verdict of felo de se was given, and the poor cold remains were hastily thrust into a hole as hastily dug for their reception.

Another article notes that Mrs Fooks's inquest was held 36 hours after her body was discovered.[63] Following the inquest, she was buried "in the corner of the cemetery away from all others". The police buried Mrs Fooks at 4 pm, as the local clergy refused to do so until 7 pm.

While both Luke and McManus noted the circumstances of Mrs Fooks burial,[64] the practice was hardly unique. Of the 51 identified *felo de se* verdicts, newspapers reported on the burials of 10 people, including Mrs Fooks, as being in accordance with the law. In another case, the death of Eugene Cassett, the jury prevented an unusual burial.[65] One of the members of the jury claimed that the coroner had not explained the consequences of their verdict to them and was quoted as saying they had "no idea that the barbarous felo de se law had been extended to New Zealand".[66]

Property forfeiture was reported in only two instances. However, it is unlikely that this represents the true extent of the practice. The articles about the death of Robert William Eves in 1864 did not mention property forfeiture.[67] It was not until an article about theft by the Sheriff of Otago, Robert Forman, that the forfeiture of Mr Eves's property was mentioned.[68] The directions were that the goods found on Mr Eves's body were to be sold by auction and that the proceeds were to be paid into the Treasury.[69]

I also undertook a search of the Archives New Zealand collection for the phrase "felo de se" via their website.[70] The 12 results were broken down as follows:

a) five records of inquest proceedings of *felo de se* verdicts, only one of which had been reported in newspapers; and
b) seven relating to dealing with the property of a suicide, only one of which had not been reported in newspapers.

The seven property records were in respect of local sheriffs who were dealing with the property for the purposes of sale.

The lack of reporting on burial and property forfeiture may simply be due to them not being sufficiently newsworthy to note. This could be similar to, as Luke notes,[71] the press reporting verdicts of insanity as "the usual verdict".

The vast majority of *felo de se* articles reported the method of death, not all of which could be described as sensationalist,[72] However, where there was some newsworthy element to the death, such

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[63] "Some Peculiar People" *Westport Times* (8 April 1873) at 4.
[64] Luke, above n 60, at 209; McManus, above n 60, at 451.
[65] See "The Late Suicide at the Thames" *Daily Southern Cross* (26 September 1870) at 3.
[66] At 3.
[67] For example, "Local Intelligence" *Wellington Independent* (12 March 1864) at 3.
[68] "Resident Magistrates Court: Charge of Robbery by a Bailee" *Otago Witness* (10 February 1866) at 7.
[69] While out of the scope of this thesis's topic, a socio-legal history of the criminalisation and punishment of suicide in New Zealand is an area into which more research is required.
[70] Search undertaken on 1 August 2022 at Archives New Zealand <archives.govt.nz>. However, please note that, save for the records of one inquest, there were no scans of any of the material.
[71] Luke, above n 22 at 77.
[72] Such as simply saying they had died from hanging.

as a murder-suicide, the level of detail increased. For example, the suicide of Mrs Scott described the circumstances of her death as follows:[73]

> Thomas Scott, the husband of the deceased, had for some time past been drinking heavily, and on Sunday, the 5th inst., returned to his home in a state of delirium tremens. On that same day, his wife, a young woman of 29 years of age, gave birth to her seventh child, and the scene of misery that the house presented at that time, the wife in childbed without medical or, so far as we can learn, any other assistance whatever beyond what could be afforded by her children, the eldest of whom was a boy of 14, the husband in a state of temporary madness, and the little ones having to shift for themselves as best they might. This state of things lasted from the Sunday until the following Thursday, when Scott went out to work on his land, and the children left the house to play outside. Before very long one of the children named Ellen heard the report of a gun in the house, went inside to see what was the matter, and there saw a sight which will probably haunt her to her dying day. The room, as may be imagined after what we have related, was in a horrible state of filth and confusion, and on the floor lay her mother perfectly dead, the upper part of her head having been blown off by the gun, which was lying on her body. The poor little thing ran out and gave the alarm, and a man named Webley, who was passing at the time, went into the house with her and saw the sickening sight as she had described it.

The practice of *felo de* se verdicts was also the subject of 22 newspaper articles. One article described an "epidemic" of suicides from taking a poison sold as "rough on rats".[74] The article called for restrictions on the sale of the poison and commented that a coroner's jury would have to "cease regarding taking "Rough on Rats" as an evidence of temporary insanity". This was considered to be beneficial as:[75]

> Persons who are inclined to indulge in this luxury are not to be regarded as ordinary individuals. They are almost certainly of a morbidly sensitive disposition, and on such temperaments the knowledge that a verdict of felo de se is pretty sure to be returned, and that their bodies will be consigned with marks of ignominy to an unknown grave, might not improbably exercise a deterrent effect. Suicidal epidemics of a kindred character have been checked in this way before now.

A second article commented on how newspapers reported suicide.[76] The article noted that "medical men were quick to observe how any peculiar mode of self destruction selected by a suicide was, within a very limited period, adopted by a host of imitators". While describing suicide as a "disease of the mind", the article pointed out that the media had a role to play, stating:[77]

> The newspaper press can do much, not actively, but passively. Instead of publishing with all their ghastly details, narratives of murders, and deaths from violence or other unnatural causes; let the facts be chronicled and no more. The practice which now obtains of giving

[73] Reports of this death did not give the deceased's name. "Painful Tragedy at Takaka" *Nelson Evening Mail* (17 March 1876) at 2. Luke, above n 23, at 205–206, makes similar observations regarding sensationalist reporting.
[74] "Rough On Rats" *Evening Post* (14 July 1885) at 2.
[75] At 2.
[76] "Murder and Suicide" *The Feilding Star* (9 October 1886) at 2.
[77] At 2.

> exaggerated prominence to every horror, must have a baneful effect on hysterical or other weakly persons. That a morbid craving for this kind of literature exists already in too many minds, is evidenced by the craving evinced day after day for the most filthy and minute details of evidence given at certain trials in the Supreme Court at Home, which have recently blotted and smirched the good names of many leading persons in England. That is a mania which grows with the food it feeds on; let the supply be cut off and the desire will vanish. With a person predisposed to suicide, the continued iteration of self murder by individuals in other parts of the world, is an exciting cause for him to follow their example.

C Decriminalisation of suicide

Forfeiture of property as a punishment for *felo de se*, along with other felonies, was abolished in New Zealand in 1871.[78] As noted above, the enactment of the Interments (Felo De Se) Act 1882 in the United Kingdom permitted a suicide to be buried in the same manner as any other person.[79] While suicide remained a common law offence, and New Zealand coroners continued to have the powers of coroners of England and Wales, suicide effectively became a crime without punishment.

Suicide ceased being a crime in New Zealand with the enactment of the Criminal Code Act 1893, which specified that a person could not be tried for a common law offence.[80] However, attempted suicide remained an offence, with a maximum sentence of two years of imprisonment with hard labour.[81] Aiding, abetting, counselling or procuring another person's suicide was also severely punished, with a sentence of life imprisonment with hard labour.[82]

Attempted suicide ceased being a crime with the passage of the Crimes Act 1961. However, aiding and abetting suicide remains an offence, under s 179 of the Crimes Act. To be liable for a conviction under s 179(1) of the Crimes Act, punishable by up to 14 years imprisonment, the person must attempt suicide. However, the outcome of that attempt is immaterial to the offence. Even if a person does not attempt suicide, it is an offence to incite, counsel, or procure a person to commit suicide, punishable by up to three years imprisonment.[83]

The Crimes Act also created a new section relating to suicide pacts.[84] A suicide pact is defined as an agreement, where the object of that agreement is the death of all parties.[85] If a person kills another person as part of a suicide pact, they are guilty of manslaughter rather than murder and are liable for

[78] Convicts Forfeitures Act 1871, s 2.
[79] Interments (Felo De Se) Act 1882 (UK) 45 & 46 Vict c 19, s 3.
[80] Criminal Code Act 1893, s 6.
[81] Section 173. Section 345 (4) specified that a person accused of attempted suicide was also not bailable as of right.
[82] Section 172.
[83] Sections 179(2) and (3).
[84] Section 180.
[85] Section 180(3).

up to life imprisonment.[86] However, if the other person kills themselves, then the remaining person is liable for up to five years imprisonment.[87]

A search of Westlaw and LexisNexis for cases referencing s 180 of the Crimes Act shows that there have been very few convictions under s 180, and no sentences of imprisonment have been imposed.[88] Sentences of intensive supervision were imposed in *R v Robson*, *R v Karnon*, and *R v W*. while in *R v CE*, CE was discharged without conviction. As Asher J noted in *Robson*, the reason for such a lack of charges under s 180 is that it is likely that when suicide pacts occur, all parties to that pact die.[89]

D End of Life Choice Act 2019

The most recent legislation regulating suicide is the End of Life Choice Act 2019, originally a member's bill put forward by David Seymour MP. An assisted death under this legislation is a type of self-inflicted death that is explicitly carved out from both the Crimes Act and the Coroners Act.

Under s 37 of the End of Life Choice Act, a health practitioner is immune from criminal liability under s 179 of the Crimes Act.[90] A person is no longer justified in using force to prevent suicide or in the defence of another person.[91] A death that occurs as the result of the End of Life Choice Act is not required to be reported to the coroner.[92] Section 37 also provides an exemption to s 63 of the Crimes Act, meaning that a person, for the purposes of the End of Life Choice Act, can consent to their own death.

III History of the suicide reporting restrictions: Coroners Act 1951 – Coroners Act 2006 and the End of Life Choice Act 2016

A Wright Committee report (United Kingdom)

In setting out the history of New Zealand's prohibition on suicide reporting, it is necessary to discuss the *Report of the Departmental Committee on Coroners*, more commonly referred to as the Wright Committee report.[93] The report's conclusions on suicide reporting influenced coronial reform in New Zealand and are reflected in our legislation.

[86] Section 180(1) and (2). Claims of the existence of a suicide pact have been rejected as an explanation for homicide, see *R v Law* (2002) 19 CRNZ 500 (HC). See also *R v Morton* [2021] NZHC 1096 as an example of a conviction for attempted murder as the deceased would not have had the capacity to enter into a suicide pact.
[87] Section 180(2)
[88] *R v Karnan* HC Auckland 814/99, 29 April 1999; *R v CE* HC Palmerston North CRI-2011-054-776, 26 October 2011; *R v Robson* [2012] NZHC 2157; and *R v W* [2023] NZDC 11662. Note, *R v W* was provided by the District Court on 16 January 2024.
[89] At [12].
[90] End of Life Choice Act, s 37(1), referring to the offence of aiding and abetting suicide.
[91] Section 37(4) referring to the Crimes Act, ss 41 and 48 respectively.
[92] Coroners Act, s 13(2A).
[93] Home Office *Report of the Departmental Committee on coroners* (Cmd 5070, 1936).

In discussing the "proper procedure to be adopted at inquests on suicide",[94] the committee noted that cases of suicide accounted for a "considerable portion" of coronial inquests,[95] and identified three areas of concern:

a) the publication of letters or other intimate details;
b) imitative suicides; and
c) the state of mind of the deceased.

I discuss the Wright Committee's views below.

a. Publication of letters or other intimate details

As part of coronial practice at the time, coroners would read letters, or other writings, out in open court.[96] The reason for doing so was to assist in determining whether the deceased had taken their own life and their state of mind at the time.[97]

Publicity of the contents of the deceased's writings was described as widespread, particularly if "the deceased is a person of any position, or if the circumstances of the death are of a sensational character".[98] Many of the witnesses took:[99]

> … strong exception to the publication of letters and other matter, often written by a person whose mind was unbalanced, which dealt with intimate domestic details or made personal reflections, as to the truth of which no one could judge, on other people. Several cases were brought to our notice in which the publication of evidence of this kind in suicide cases caused much mental anguish, and indeed actual injury, to persons connected with the deceased.

b. Imitative suicide

Relatedly, the Wright Committee considered that there was a "danger of imitative suicides resulting from the publicity given to inquest proceedings at which methods of suicide are described.[100] It was considered undisputed "common knowledge … that a suicide in which some particular means is adopted is frequently followed by a chain of similar suicides".[101] The Wright Committee also heard arguments that publicity "did no more than suggest a particular means of suicide to a person who intended to commit suicide and who was only influenced as to the means to adopt".[102]

Submissions from the newspapers argued that newspapers were reporting information publicly revealed at an inquest.[103] However, the Newspaper Proprietors' Association also reported that they had

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[94] "Coroners' Law and Practice: The Departmental Committee's Report" 4 at 16.
[95] Home Office, above n 93, at 16. Out of 30,000 inquests, a verdict of suicide was returned in 5,500 cases or 18.33 per cent.
[96] At 17. However, the report notes that the extent of the material read out would vary between coroners.
[97] A verdict of suicide would include whether the deceased was of sound or unsound mind at the time.
[98] At 17.
[99] At 17.
[100] At 18.
[101] At 18.
[102] At 18.
[103] At 18.

received a letter from the National Council for Mental Hygiene requesting that "newspapers should refrain from treating the subject of suicides in a detailed or dramatic way".[104]

In the Wright Committee's view:[105]

> there are at one time a number of people contemplating suicide to whom the knowledge of what may appear to be an attractive and painless method of ending life is an important factor in making up their minds to destroy themselves.
>
> …
>
> the present publicity of inquests on suicides often causes very great hardship and does a great deal of social harm.

The Wright Committee described themselves as being reluctant "to propose anything which would restrict the freedom of the Press" as it "is a matter of the highest public importance and it should be jealously guarded".[106] However, due to the harm of publishing details of the method of death, they recommended that when reporting on suicide inquests, the publication should be limited to "a statement of the name and address of the deceased and of the verdict that the deceased died by his own hand". This restriction should be mandatory, so that responsibility for making such orders would not rest on individual coroners and so that all newspapers were "on the same footing".[107]

The Wright Committee also considered there would be practical difficulties in giving effect to this restriction, particularly when a coroner was not able to indicate whether a death was a suicide.[108] The preferred solution was to grant a coroner the power to state that the circumstances of the deceased's death suggested that their death was a suicide.[109] This statement would effectively prohibit the publication of any detail of a proceeding until a verdict was returned.

c. The state of mind of the deceased

The Wright Committee also considered whether a coroner should inquire into the deceased's state of mind. As noted earlier, the property of a *felo de se* was forfeited to the Crown, and until 1882, their burial would reflect the religious condemnation of suicide. However, if a coroner had found that a person had taken their own life while of "unsound mind", then that person was not a *felo de se*. Consequently, from this distinction:[110]

> … arose the practice of finding that suicides died while of unsound mind; and the practice has continued long after any material considerations were at issue. Relatives and friends naturally prefer a verdict of suicide while of unsound mind to a verdict of felo de se, if it must be one or the other.

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[104] At 18.
[105] At 18.
[106] At 18.
[107] At 19.
[108] At 19.
[109] As opposed to a blanket restriction on reporting the proceedings of any inquest until a determination on whether the death was a suicide was made.
[110] Home Office, above n 93, at 19.

The Wright Committee noted that out of 5543 coronial verdicts of suicide in 1933,[111] verdicts of *felo de se* were returned in only 71 cases.[112] In the remaining verdicts, the deceased was found to be of unsound mind, at the time they took their own life (Unsound Mind verdict). Consistent with Blackstone,[113] the view that the act of suicide itself was evidence of an unsound mind was emphatically rejected as it could not be "reconciled with any accepted view, either legal or medical, of what constitutes unsoundness of mind".[114]

The Wright Committee considered that if the tests of insanity in the criminal jurisdiction and the "scientific tests now preferred by medical authorities" were used, only a small number of Unsound Mind verdicts could be returned.[115] Based on the evidence from medical of "eminent medical authorities",[116] their view was that the large number of Unsound Mind verdicts was not justified and that the procedure at an inquest was inadequate for determining whether someone was of unsound mind.[117] The Wright Committee described the Unsound Mind verdict as being "almost in the nature of a dishonest verdict".[118]

The overuse of the Unsound Mind verdict had other consequences.[119] When the findings were not in accordance with the facts, the statistical value of coronial findings was reduced. Furthermore, such verdicts served no "useful purpose" and could not be relied upon for the purposes of an insurance policy. The Wright Committee also observed that:[120]

> … a finding of insanity may do harm to relatives by placing the stigma of insanity on the family. One witness referred to the position of the marriageable daughters of a man who had committed suicide and had been found to have been of unsound mind.

The Wright Committee recommended that the verdict of *felo de se* be abolished.[121] In this, they were repeating the recommendation of a 1910 report,[122] as they did not consider the verdict of *felo de se* a deterrent to those wishing to take their own life and induced juries to make findings of "temporary insanity".[123] However, this recommendation would not imply that suicide was not "self-murder" in law.[124] Rather, it was not the coroner's duty to attribute criminal responsibility. The Wright Committee also recommended a coroner should not inquire into the state of mind of the deceased unless it was

[111] Suicide rates in England and Wales peaked during the Great Depression. See Kyla Thomas and David Gunnell "Suicide in England and Wales 1861–2007: a time-trends analysis" (2010) 39 International Journal of Epidemiology 1464.
[112] Home Office, above n 93, at 20.
[113] Cooley, above n 33, at 189.
[114] Home Office, above n 93, at 20.
[115] At 20.
[116] At 20.
[117] At 20.
[118] At 20.
[119] At 20.
[120] At 20.
[121] At 21.
[122] Committee on Coroners *Second report of the Departmental Committee appointed to inquire into the law relating to coroners and coroners' inquests, and into the practice in coroners' courts* (Cd 5004, 1910).
[123] Home Office, above n 93, at 20.
[124] At 21.

relevant to whether the deceased had taken their own life and that the verdict should not reference the deceased's state of mind.[125]

B Coroners Act 1951 (New Zealand)

The Coroners Act 1951 (the 1951 Act) was a significant piece of legislation in that it codified the powers and duties of a coroner into a single statute, abolishing both the coronial jurisdiction into the investigation of fires and the coronial jury. Coroners were given powers to restrict the publication of evidence given at inquests, on grounds of interests of justice, decency, or order,[126] as well as restricting the reporting of self-inflicted deaths.[127]

During the second reading of the Coroners Bill, it was noted that the Newspaper Proprietors' Association objected to these provisions.[128] The Attorney-General cited the Wright Committee report as justification for the restrictions on suicide reporting.[129]

Debate on the suicide reporting restrictions centred around whether such restrictions were in the public interest when there could be doubt over whether the death was suicide.[130] It was also questioned whether such restrictions were necessary given that newspapers in New Zealand were "not like some newspapers in the United States of America and elsewhere where lurid reports of such cases are published". However, the MP for Brooklyn commented that

> … there may be circumstances in which it is undesirable that the full facts concerning a suicide should be made public. It may be undesirable because the method of the suicide may suggest to one who has suicidal tendencies a method of ending his or her life. Cases have occurred where a run of suicides has taken place which can, I think, fairly be attributed to the publicity given in an earlier case. I believe that because of that the Government has included this desirable provision in the Bill.

While the bill was referred to the Statutes Revision Committee, the suicide reporting provisions were unchanged in the 1951 Act. Unlike later statutes, the coroner had the discretion to prohibit the reporting of self-inflicted deaths before the completion of the inquest into the death. However, once a coroner had found that a death was self-inflicted, the restrictions were mandatory. The 1951 Act made the publication of prohibited details, such as self-inflicted deaths, an offence punishable by up to one month's imprisonment and a fine of up to 100 pounds.

C Coroners Act 1988

Like the 1951 Act, the Coroners Act 1988 (the 1988 Act) continued to restrict the reporting of suicides. As originally drafted,[131] prior to a coroner completing their findings, publication of any information relating to the "manner" of death was prohibited if there was "reasonable cause" to

[125] At 21.
[126] Coroners Act 1951, s 16(1).
[127] Section 29.
[128] (29 November 1951) 296 NZPD 1185.
[129] At 1185 and 1888.
[130] At 1186 per the MP for Petone.
[131] Coroners Bill 1987 (170-1).

believe that a death was a suicide.[132] The reason for this restriction was to prevent "copy cat" suicides.[133] Should a coroner find that a death was suicide, then:[134]

> … no details of a death, or of an inquest into a death, that a coroner has found to be suicide other than the name, address, and occupation of the person concerned and the fact that the coroner has found the death to be suicide shall be published in any newspaper or by means of any broadcasting station.

The Justice and Law Reform Committee changed the wording of cl 29, from "suicide" to "self-inflicted". In Parliament, Bill Dalton commented:[135]

> There was general debate in the committee on the use of the term "suicide". In the Bill as reported back the word "suicide" has been deleted and replaced with the term "self-inflicted". However, as those two terms are not exactly the same, the term "suicide" has been retained whenever appropriate. Grieving relatives will experience less trauma and drama, because appropriate language is used in the Bill.

The 1988 Act was otherwise unchanged and read:

> 29. Publication of details of self-inflicted deaths-
>
> (1) If there is reasonable cause to believe that a death that occurred in New Zealand after the commencement of this Act was self-inflicted, without the authority of a Coroner no person shall publish any information relating to the manner in which the death occurred.
>
> (2) Without the authority of a coroner no person shall publish any details of a death that a coroner has found to be self-inflicted, of the circumstances of the death, or of an inquest into the death, other than the name, address, and occupation of the person concerned, and the fact that the coroner has found the death to be self-inflicted.
>
> (3) In this section, "publish" does not include publication by means other than a book, magazine, journal, newsletter, or other similar document, a sound or visual recording, or a newspaper or broadcasting station within the meaning of the Defamation Act 1954.

Like the 1951 Act, it remained an offence to publish prohibited information, which was punishable by a fine of up to $5000 for a body corporate and $1000 for an individual.

Unlike the 1951 Act, where coroners investigated deaths that were violent or unnatural, the 1988 Act specifically recognised suicide as a distinct "class" of death. If a death was suspected to be a suicide, an inquest was required to be held.[136] As the focus of the 1988 Act was the timely release of bodies, the reason behind this change is unclear from either Hansard or the Select Committee's report.[137]

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[132] Clause 29(1).
[133] (Explanatory note) at 4.
[134] Clause 29(2).
[135] (19 April 1988) 488 NZPD 3412.
[136] Coroners Act 1988, s 17(a)(i).
[137] These changes came about following a report on this issue, see A G Protheroe *Final report of the Working Party on Delays in the Release of Bodies for Burial* (Department of Justice, Wellington, 1984).

However, at the first reading, the Minister of Justice commented that the bill would clarify the "categories of death for which inquests must be held".[138]

D Coroners Act 2006

In 1998, the Law Commission reviewed the coronial system, with a view to legislative reform. The report was published in August 2000, [139] and made several recommendations, including creating the position of Chief Coroner who, amongst other functions, would issue practice notes. The purpose of practice notes was to ensure consistency of coronial decision-making, a point I will return to in Chapter Four.

The Government adopted the Law Commission's report and, in response, proposed a new Coroners Act. The Coroners Act 2006 created a full-time coronial bench, with the Chief Coroner fulfilling the role of head of bench.[140]

Under s 14(2)(a) of the Coroners Act, self-inflicted deaths must be reported to the coroner. While this does not explicitly describe suicides, self-inflicted deaths include deaths by suicide.[141] Like the 1988 Act, an inquiry must be opened into a self-inflicted death.[142]

Unlike the 1988 Act, where deaths were reported to whichever coroner was nearest to the place of death,[143] the Coroners Act created the role of "designated coroner" who "received reports of, and perform every other part of the coroner's role in relation to, all deaths in the area in which the death occurred".[144] The Coroners Amendment Act 2016 changed the term to "responsible coroner",[145] who "must perform every part of the coroner's role in relation to a death". Throughout this thesis, I will refer to the responsible coroner to distinguish a coroner's role relating to a specific death, as opposed to a coroner's role generally.

As drafted, and ultimately enacted, the suicide reporting restrictions were similar to the 1988 Act and set out essentially a two-tier regime.[146] In essence, the regime prohibited:[147]

a) publication of any "particular relating to the manner of death" before a coroner completed their findings if there was "reasonable cause" to believe that a death was self-inflicted; and
b) if a coroner has determined a death to be self-inflicted, publication of any "particular" of the death, except the identity of the deceased and the fact the death was self-inflicted.

Like the 1988 Act, a person could get permission from the coroner to publish the prohibited details. However, a coroner could only permit publication if the particulars were "unlikely to be detrimental to public safety" and taking into consideration factors such as the "characteristics" of the deceased.[148]

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[138] (14 July 1987) 482 NZPD 10430.
[139] Law Commission *Coroners* (NZLC R62, 2000).
[140] Coroners Act 2006 (as enacted), s 7(J).
[141] See "The legal elements of suicide" above.
[142] Coroners Act, s 60(1)(a).
[143] Coroners Act 1988, s 5(4).
[144] Coroners Act 2006 (as enacted), s 9.
[145] Coroners Act 2006, s 16.
[146] Section 71.
[147] Section 71(1) and (2).
[148] Section 71(3) and (4).

Regarding self-inflicted deaths, the Law Commission considered that the Chief Coroner could develop practice notes which could govern "when a coroner can or should give authority for the publication of details relating to a potentially self-inflicted death".[149] Particulars were defined in s 73 of the Coroners Act as "a detail relating to the manner in which the death occurred, to the circumstances of the death, or to an inquiry into the death".[150]

The Justice and Electoral Committee justified the suicide reporting restrictions, stating that:[151]

> We considered amending the bill to permit more detail about self-inflicted deaths to be made public, as some submitters had suggested that greater transparency might lead to better understanding of the issues relating to self-inflicted death. However, we remained concerned about the implications for public safety and the possible consequences of such a change and support some restriction continuing in the interest of public safety.
>
> We note that family members of the deceased would be covered by the provisions restricting making public details of a self-inflicted death. People who wanted to make public the details of the self-inflicted death of a family member would have to apply to the coroner for authorisation. We expect that, when considering whether or not to authorise the making public of details of a self-inflicted death, coroners would weigh carefully the interests of family members of the deceased and the potential risk to public safety if particular details were made public.

The concerns raised by both media organisations and members of the public who had lost whānau to suicide were discussed in Parliament.[152] The media organisations did not consider that the proposed restrictions were necessary, describing them as "even more controlled than they are currently". The submission of Paul Thompson, the editor of the Christchurch Press also noted that:[153]

> … statutory restrictions of this kind are unusual in the Western World, if not unique, and saw no reason why New Zealanders should be any different in relation to this matter than Australians, Canadians, or Americans.
>
> …
>
> the restrictions suggested a paternalistic, patronising attitude towards New Zealanders that was outdated and unnecessary. He said that suicide cases may be many and complex, and that although they may be difficult to deal with, they are no longer a matter that is too shameful to mention. Discussing the issues, he said, in a sober and sensible way would hardly be consistent with glamorising suicide.

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[149] At 133.
[150] This definition also applied to s 74 of the Coroners Act.
[151] Coroners Bill 2006 (228-2) (Select Committee report) at 3–4. Following the first reading in Parliament, all bills (except those passed under urgency) are referred to select committees for public submissions. The Justice and Electoral Committee (now the Justice Committee) considered bills related to "crown legal and drafting services, electoral matters, human rights and justice", see Standing Orders of the House of Representatives 2005, SO 189. Generally, see Phillip A Joseph *Joseph on Constitutional and Administrative Law* (5th ed, Thomson Reuters, Wellington, 2021) at [12.7.5].
[152] (2 August 2006) 633 NZPD 4666–4667.
[153] At 4666.

The Commonwealth Press Union suggested that "there should be a cooperative approach to the whole issue of suicide".[154] The alternative to restrictions was a media code of conduct for the reporting of suicides. In contrast, although families of those who had died by suicide supported the media organisations' views, there was "a real fear of tabloid journalism".[155] Given the submissions made, it was noted in Parliament that it was the Law Commission could review the law in the future.[156]

Under s 139 of the Coroners Act, publication of information in breach of s 71 is an offence. As enacted, the penalty for the offence was identical to the 1988 Act, a fine of up to $1000, although this was later increased by the Coroners Amendment Act 2016. The definition of "make public" was modernised to include publication on an "internet site generally accessible to the public".[157]

E End of Life Choice Act 2019

In addition to being the most recent legislation to regulate suicide, the End of Life Choice Act is also notable because it creates its own suicide reporting restrictions. Section 36 of the End of Life Choice Act states that no person may "make public" the method of death, the place of death, or the identity of the person who assisted the death. The definition of "make public" is identical to s 73 of the Coroners Act.[158] Under s 36(3) of the End of Life Choice Act, making public the prohibited information is an offence, and the penalties are identical to those in the Coroners Act. However, unlike the Coroners Act, the prohibitions do not apply to "court or tribunal proceedings or to reports or publications of those proceedings".[159]

The End of Life Choice Act's suicide reporting restrictions were added following the bill's second reading as part of a Supplementary Order Paper.[160] As such, there were no submissions to the Justice Committee about whether such restrictions were appropriate. In Parliament, David Seymour MP commented that those restrictions enforced "the rules around suicide reporting that the media have been following in New Zealand for the past several years".[161] In the third reading, Mr Seymour also commented that rules had been added to "balance privacy and responsible public reporting of death in accordance with other legislation".[162]

In my view, the End of Life Choice Act shows that Parliament considers that the current suicide reporting restrictions in s 71 of the Coroners Act are appropriate for the "responsible public reporting of death".

IV Conclusion

As can be seen from this chapter suicide and self-inflicted deaths have a long history of regulation. While the act of suicide is no longer criminalised, the acts of others concerning a person's suicide may still result in criminal charges.

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[154] At 4666.
[155] At 4667.
[156] At 4667.
[157] Coroners Act 2006 (currently in force), s 73(e).
[158] Section 36(5).
[159] Section 36(4).
[160] Supplementary Order Paper 2019 (259) End of Life Choice Bill 2019 (269-2).
[161] (25 September 2019) 741 NZPD 14160.
[162] (13 November 2019) 742 NZPD 15048.

Concern that media reporting causes imitative suicide is also long-standing. These concerns were the basis of the Wright Committee's recommendations, which in turn are reflected in New Zealand's coronial legislation. However, the suicide reporting restrictions have been controversial. Chapter Two will focus on the changes to the Coroners Act.

Chapter Two: The call for change and the Coroners Amendment Act 2016

Following the passage of the Coroners Act 2006, the debate about New Zealand's suicide reporting restrictions continued. The Chief Coroner, Judge MacLean, began to release annual suicide statistics and expressed his view that there was "room for some gentle opening up" of suicide reporting.[163]

Blackman's 2012 article was supportive of the suicide reporting restrictions in the Coroners Act, describing the media representatives as being "aghast" that the new Coroners Act contained any reporting restrictions.[164] He was of the view that the media overstated the benefits of unfettered suicide reporting. Citing the evidence for the harm that media reporting of suicide and the privacy interests of the families of the deceased, Blackman considered that the argument for removing the suicide reporting restrictions was not made out.

In contrast, Hollings argued in 2013 that the effect of media reporting on suicide was not large.[165] He considered that quality reporting guidelines were a more effective solution than censorship. Furthermore, Hollings argued that there was no research at the time on the benefits of media reporting on suicide.[166] It was his view that such research would show that the benefits of media reporting of suicide would outweigh the risks, if any, of such reporting.

In July 2013, the Law Commission undertook a review of the statutory rules governing the suicide reporting restrictions. It was asked to consider whether the approach set out in the Coroners Act struck the correct balance between freedom of speech and the public health aim of reducing suicide deaths. The report was completed in 2014 and recommended that the law of suicide reporting be changed.[167] The recommendations were implemented in the Coroners Amendment Act 2016 (the Coroners Amendment Act).

This chapter covers two topics. The first is the Law Commission's review of s 71 and suicide reporting, including the evidence of harm. In this section, I will discuss the Law Commission's review of the law and present up-to-date research, which lays out the necessary groundwork for addressing whether the evidence supporting suicide reporting restrictions remains justified.

The second topic is the Law Commission's recommendations and the Coroners Amendment Act, including submissions to the Justice and Electoral Committee. This section sets out changes to the law and the concerns raised by those submissions. Both topics will inform the discussions in Chapters Three and Four.

I The Law Commission report

In reviewing the suicide reporting restrictions, the Law Commission considered the scope of s 71 of the Coroners Act, the harm of reporting suicide, and media guidelines and how suicide is reported in New Zealand.

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[163] Rebecca Todd "Suicides outnumber road deaths" *Stuff (*online ed, 12 August 2010).
[164] Sam Blackman "Suicide and the media: whether New Zealand's statutory restrictions on the reporting of suicide are justified" (2012) 2 NZLSJ 746 at 746.
[165]. Hollings, above n 6.
[166] At 146.
[167] Law Commission *Suicide Reporting* (NZLC R131, 2014). Summarised in Linda McIver and Paul Comrie-Thomson "Suicide reporting" [2014] NZLJ 145".

A Scope of the suicide reporting restrictions

As part of their review of s 71, the Law Commission considered that the scope of the suicide reporting restrictions was unclear.[168] In their view, the Justice and Law Reform Committee thought the purpose of the suicide reporting restrictions was to prohibit the method of death from being published.[169] They formed this view based on the Justice and Electoral Committee's comment that the bill restricted people from publishing "specific details in cases of suspected or established self-inflicted death without the coroner's authority".

I do not agree with the Law Commission's interpretation, as the Justice and Law Reform Committee does not state that the statutory restrictions were only concerned with the manner of death. Rather, the Justice and Law Reform Committee did not change the statutory restrictions as they were "concerned about the implications for public safety and the possible consequences of such a change and support some restriction continuing in the interest of public safety".[170] Rather, as I set out below, the Law Commission's views reflect the lack of clarity about the scope of ss 71(1) and (2).

As shown in Chapter One,[171] the suicide reporting restrictions contained in ss 71(1) and (2) of the Coroners Act 2006 (as enacted) were similar to the statutory prohibitions from the 1988 Act. Sections 71(1) and (2) state:

> (1) No person may, without a coroner's authority, make public any particular relating to the manner in which a death occurred if–
>
> (a) the death occurred in New Zealand after the commencement of this section; and
>
> (b) there is reasonable cause to believe the death was self-inflicted; and
>
> (c) no inquiry into the death has been completed.
>
> (2) If a coroner has found a death to be self-inflicted, no person may, without a coroner's authority or permission under section 72, make public a particular of the death other than–
>
> (a) the name, address, and occupation of the person concerned; and
>
> (b) the fact that the coroner has found the death to be self-inflicted.

The suicide reporting restrictions are essentially a two-tier prohibition on publication. Section 71(1) applies before an inquiry has been completed. If a death is believed to be self-inflicted, then publication of particulars suggesting the "manner of the death" is prohibited without the coroner's authority. Section 71(2) applies when a coroner has completed their inquiry and determined a death to be self-inflicted. At that point publication of any particular, except for the details listed in s 71(2)(a) and (b), is prohibited without the coroner's authority. Publication is also permitted under s 71(2) of the Coroners Act, which relates to Independent Police Conduct Authority reports.

The term "particular", used in both ss 71(1) and (2), is defined in s 71(3) of the Coroners Act as "a detail relating to the manner in which the death occurred, to the circumstances of the death, or to an

[168] Law Commission *Suicide reporting* (NZLC R131, 2014) at 24.
[169] At 23 quoting Coroners Bill 2006 (228-2) (Select Committee report) at 3–4.
[170] Coroners Bill 2006 (228-2) (Select Committee report) at 3–4.
[171] See page 19.

inquiry into the death". A plain reading of ss 71(1) and (2) suggests that more details surrounding a self-inflicted death could be published before a coronial inquiry is complete, as s 71(1) applies to the "manner of death" only. However, given the broad nature of the term "particular", the Law Commission's view that the scope of the restrictions is unclear is correct.

A recent study of commentary about suicide reporting restrictions in New Zealand print media between 2010 and 2011 supports the Law Commission's views that the scope of the restrictions was unclear.[172] While this research has limitations, as only 30 articles were examined, it concluded that there was confusion about what media could report and that media conflated the reporting of individual suicides and discussion of suicide generally.[173]

Ultimately the Law Commission concluded that they did not need to determine the precise scope of the restrictions as they were enacted. In their view, if legislative restrictions on suicide reporting were to continue, then the scope of any such restrictions should be made significantly clearer.[174]

B Harm of suicide reporting

As noted above, one of the policy aims behind the suicide reporting restrictions was minimising or avoiding the harm of reporting suicide. In examining the risk of reporting suicide, the Law Commission was concerned with whether evidence of the harm, if any, was sufficient to justify statutorily restricting how suicide can be reported.[175] Certainly, as shown in Chapter One by media commentary in the 1800s and the Wright Report, concern over the effects of suicide reporting is not new.[176]

a. The Werther effect

In 1974, sociologist David Phillips analysed the effect of media reporting of suicides on the national rate of suicide.[177] What Phillips found, was an increase in the rate of suicide in the weeks and months following suicide reports. This spike was not subsequently followed by a decrease in the rate of suicide. For example, if the average rate of suicide was 10 per week, it may increase to 15 per week following media reporting. However, following that increase, the average rate of suicide would not decrease to 5 per week, rather it would return to a rate of 10 per week. In Phillips's view, this disproved the alternative, that the effect of suicide reporting would merely cause suicides to occur "a little sooner than it otherwise would have".[178] Phillips dubbed the increase in the rate of suicide following media reporting the "Werther Effect", after the protagonist of Goethe's 1774 novel, "The Sorrows of Young Werther", which was attributed to a rise in suicides in Vienna following its publication.

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[172] Jenkin, Slim and Collings, above n 8. The report notes that it is "the first study to examine the views of key stakeholders in the issue of suicide reporting from a news print media sample and to systematically document their framing of the issues".
[173] At 253.
[174] Law Commission, above n 168, at 24.
[175] At 11.
[176] See pages 11–12 and 13–17.
[177] David P Phillips "The Influence of Suggestion on Suicide: Substantive and Theoretical Implications of the Werther Effect" (1974) 39 American Sociological Review 340.
[178] At 350.

As the Law Commission noted,[179] since Phillps's study, a large body of research has emerged to show that media reporting can cause suicide contagion or "copycat suicide". Suicide contagion occurs when a person imitates another person's suicide. This person may have heard about the suicide through the media or their community. At the time of the Law Commission's report, over 80 studies showed that media reporting could produce copycat suicides.[180] The Law Commission's approach focused on meta-analyses of studies, which are systematic reviews of a group of studies. I have taken the same approach in updating the research, drawing on the recent meta-analyses of Niederkrotenthaler and Domaradzki.[181]

i. Mechanism of the Werther effect

The Law Commission considered that suicide contagion functioned via the theory of "social learning" where behaviour is learned through observation and then copied.[182] This process is stronger when the person identifies with the deceased in some way, whether due to celebrity status or sharing similar characteristics.

Niederkrotenthaler considered that the evidence indicated an increase in the number of suicides following the suicide of a celebrity. While this analysis did not necessarily support an increase in suicide following general suicide reporting, this was due to the small number of studies examined and because most studies of the Werther effect tend to involve celebrity suicides.[183]

Domaradzki, on the other hand, described two types of identification: vertical and horizontal.[184] Vertical identification occurs when a person identifies in some way with a celebrity's suicide. Horizontal identification occurs when the demographic or life circumstances are similar. For example, railway suicide increased by 44 per cent following publicity surrounding the death of a "non-prominent" person.[185]

Suicide contagion is also affected by whether the reporting normalises or glamourises suicide.[186] Normalisation occurs when suicide is presented as a reasonable or rational response to problems. Suicide is glamorised when it is presented sensationally or romantically, or when the reporting emphasises the positive qualities of the deceased.

The analyses of Niederkrotenthaler and Domaradzki support the Law Commission's view. Domaradzki concluded that studies showed that media "often depicted the victim as an extraordinary

[179] Law Commission, above n 168, at 11.
[180] At 12.
[181] Thomas Niederkrotenthaler and others "Association between suicide reporting in the media and suicide: systematic review and meta-analysis" [2020] BMJ m575; Jan Domaradzki "The Werther Effect, the Papageno Effect or No Effect? A Literature Review" (2021) 18 International Journal of Environmental Research and Public Health 2396.
[182] Law Commission, above n 168, at 12, citing Steven Stack "Suicide in the Media: A Quantitative Review of Studies Based on Nonfictional Stories" (2005) 35 Suicide and Life Threatening Behavior 121 and Thomas Niederkrotenthaler and others "Copycat effects after media reports on suicide: A population-based ecologic study" (2009) 69 Soc Sci Med 1085.
[183] Niederkrotenthaler and others, above n 181, at 6.
[184] Domaradzki, above n 181, at 2.
[185] At 10, citing Sabine Kunrath and others "Increasing railway suicide acts after media coverage of a fatal railway accident? An ecological study of 747 suicidal acts" (2011) 65 Journal of Epidemiology and Community Health 825.
[186] Law Commission, above n 168, at 14–15.

or popular personality", and their suicide was either inevitable or brave, with the deceased's motives being described in ways that might legitimise their act.[187] Niederkrotenthaler's analysis concurs, concluding that "increased media reporting of suicide leading to normalisation of suicide as an acceptable way to cope with difficulties".[188]

ii. Effect of advertising the method of death

Reporting the method of death, including details that suggest the method, is also a factor in suicide contagion. The Law Commission considered that reporting the method of death, particularly when the reader identified with the deceased, made that method appear "achievable".[189] While the information on methods of death is available should one wish to search for it, in the Law Commission's view, removing the "requirement" to search would make suicide more likely. Reporting "novel" methods of death also carries imitative risk, particularly if the method is seen as effective or painless.[190]

The effect of advertising the method of death is not limited to the media. For example, in 2011, Samsung Life Insurance, in an effort to reduce the rate of suicide, installed "heartwarming messages and photos" on the railings of a bridge, which would illuminate when people walked on by.[191] However, in the following years, the number of suicide attempts from this location increased up to 16 times.

Both Niederkrotenthaler and Domaradzki concur that advertising the method of death is a cause of suicide contagion.[192] They explain that reporting the method of death increases the "cognitive availability" of that method, with individuals considering suicide being more likely to select that method.

Niederkrotenthaler considers that the Werther effect increases the suicide rate by 8 – 18 per cent over two months, with an increase in the use of a reported method increasing by 18 – 44 per cent.[193] Domaradzki noted that in some cases, particularly highly reported celebrity suicides, the increase in the imitation of the method was as high as 60 per cent.[194]

Advertising the method of death can be seen even when the method is relatively well-known. An Australia. study on the reporting of Robin Williams's death showed an increase in the number of suicides of 11 per cent.[195] This increase was made up of largely accounted for by men aged between 30 and 64 who employed the same method.[196] This increase occurred despite high adherence to

[187] Domaradzki, above n 181, at 14.
[188] Niederkrotenthaler and others, above n 181, at 5.
[189] Law Commission, above n 168, at 13.
[190] At 13 citing Wai Sau D Chung and Chi Ming Leung "Carbon Monoxide Poisoning as a New Method of Suicide in Hong Kong" (2001) 52 Psychiatric Services 836.
[191] Haesoo Kim and others "Implementation and outcomes of suicide-prevention strategies by restricting access to lethal suicide methods in Korea" (2019) 40 Journal of Public Health Policy 91 at 96–97.
[192] Niederkrotenthaler and others, above n 181, at 6; Domaradzki, above n 181, at 11.
[193] Niederkrotenthaler and others, above n 181, at 7.
[194] Domaradzki, above n 181, at 11.
[195] Jane Pirkis and others "Suicides in Australia following media reports of the death of Robin Williams" (2020) 54 Australian & New Zealand Journal of Psychiatry 99.
[196] At 101. Similar results were reported in Canada (and the United States, see Rob Whitley and others "Suicide Mortality in Canada after the Death of Robin Williams, in the Context of High-Fidelity to Suicide Reporting Guidelines in the Canadian Media" (2019) 64 The Canadian Journal of Psychiatry 805; David S Fink, Julian

Australia's *Mindframe* suicide reporting guidelines, although that may be due to exposure to overseas reporting.[197]

b. The Papageno effect

In contrast to the Werther effect, recent research has also suggested that some types of media reporting can have a positive effect on suicide rates. First set out in 2010,[198] Niederkrotenthaler described the Papageno effect, after the character Papageno from Mozart's *Magic Flute*, who overcomes suicidal ideation following intervention from other characters. Reporting that engages the Papageno effect is reporting that focuses on those who overcome suicidal thoughts rather than those who act on them or reporting that increases awareness of resources to help when a person is in crisis.

This effect was demonstrated when the song "1-800-273-8255" by Logic gained significant attention in the United States.[199] During the periods studied, there was a decrease in actual suicides of 5.5 per cent and an increase in the number of calls to a suicide helpline of 6.9 per cent.[200]

In considering the evidence for the Papageno effect, Domaradzki concluded that while there is evidence supporting the Papageno effect, there was considerably more research done on the Werther effect, which created the risk of reporting bias.[201]

A similar point was made in Niederkrotenthaler's 2022 meta-analysis on the association between protective media reporting and suicidal behaviour.[202] The conclusion of the meta-analysis was that personal stories of hope had a small protective effect on vulnerable individuals, reducing their suicidal ideation for up to four weeks.[203] However, there was no evidence linking such personal stories of hope to help-seeking behaviour.[204] The meta-analysis concluded that:[205]

> The Papageno effect cannot replace media narratives about fatal suicides if the topic meets the media criterion of newsworthiness, but it provides a potentially novel and safe way forward to educate the public about suicide prevention that can help to shift the focus from narratives of despair to a more focused portrayal of how to cope with adversity. Many media guidelines are now rightfully cautious about reporting on suicide.

Santaella-Tenorio and Katherine M Keyes "Increase in suicides the months after the death of Robin Williams in the US" (2018) 13 PLOS ONE e0191405.

[197] Jane Pirkis and others "Coverage of Robin Williams' Suicide in Australian Newspapers" (2022) 43 Crisis 83. Suicide reporting guidelines are discussed below at pages 29–31.

[198] Thomas Niederkrotenthaler and others "Role of media reports in completed and prevented suicide: Werther v Papageno effects" (2010) 197 British Journal of Psychiatry 234.

[199] Thomas Niederkrotenthaler and others "Association of Logic's hip hop song '1-800-273-8255' with Lifeline calls and suicides in the United States: interrupted time series analysis" [2021] BMJ e067726.

[200] At 5.

[201] Domaradzki, above n 181, at 15.

[202] Thomas Niederkrotenthaler and others "Effects of media stories of hope and recovery on suicidal ideation and help-seeking attitudes and intentions: systematic review and meta-analysis" (2022) 7 The Lancet Public Health e156.At e165, the authors described the analysis as "the first systematic review and meta-analysis about media portrayals of stories of hope and recovery from suicidal crises on suicidal ideation and help-seeking attitudes and intentions".

[203] At e165.

[204] Thomas Niederkrotenthaler and others "Association of Increased Youth Suicides in the United States with the Release of *13 Reasons Why*" (2019) 76 JAMA Psychiatry 933 at e165–e166.

[205] Niederkrotenthaler and others, above n 202, at e166–e167.

It is clear from the discussion on the Werther and Papageno effects that suicide reporting guidelines form part of the public health response to reducing suicide contagion.[206]

c. Harm of prematurely reporting whether a death is suicide

Finally, the Law Commission also briefly considered whether reporting a death as a suicide before a coroner's finding, including by innuendo, harmed the integrity of the coronial process.[207] The reason for their view was that Parliament had determined that it was a coroner's role to legally determine the cause of death.[208] As such, public discussion on the cause of death may "usurp the role of the coroner or undermine the significance of that finding when made".[209] However, the Law Commission did not consider that reports that a death was suicide would impact witness recollection.[210]

As will be discussed below, due to the harm to the integrity of the coronial process, the Law Commission recommended retaining the restrictions on prematurely describing death as a suicide.[211]

C Suicide reporting guidelines

a. Generally

In their discussion on media reporting guidelines, the Law Commission considered both the Werther and Papageno effects, as described above, describing the latter as a "mastery of crisis stories".[212] They noted that media reporting guidelines have been developed by several countries, as well as the 2008 World Health Organisation (WHO) guidelines. At the time, the "quick reference" of the 2008 WHO guidelines recommended that media:[213]

a) Take the opportunity to educate the public about suicide.
b) Avoid language which sensationalises or normalises suicide, or presents it as a solution to problems.
c) Avoid prominent placement and undue repetition of stories about suicide.
d) Avoid explicit descriptions of the method used in a completed or attempted suicide.
e) Avoid providing detailed information about the site of a completed or attempted suicide.
f) Word headlines carefully.
g) Exercise caution in using photographs or video footage.
h) Take particular care in reporting celebrity suicides.
i) Show due consideration for people bereaved by suicide.
j) Provide information about where to seek help.
k) Recognise that media professionals themselves may be affected by stories about suicide.

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[206] See pages 29–30.
[207] Law Commission, above n 168, at 17–18.
[208] Coroners Act 2006, s 4(2) and 57.
[209] Law Commission, above n 168, at 17.
[210] At 18 citing *Beckett v TV3 Network Services Ltd* (2000) 6 HRNZ 84 (HC) at 90.
[211] See page 34.
[212] Law Commission, above n 168, at 26–27.
[213] World Health Organisation "Preventing suicide: a resource for media professionals" (2008) <www.who.int> at 3.

Media reporting guidelines emphasise the importance of avoiding elements that tend to be problematic, such as the use of language and photography, reporting the method or site of the suicide, and avoiding undue repetition of articles on particular suicides.[214] Guidelines from other countries, such as Australia or Canada are similar.[215]

The WHO guidelines were updated in 2017 and 2023. In respect of reporting the method of death, the 2023 guidelines state:[216]

> The greatest area of concern with regard to media reporting on suicide is when the reporting includes a discussion, image or description of a suicide method. These approaches are harmful and should be avoided whenever possible because they increase the likelihood that a vulnerable person will imitate the act. In reporting a suicide, it could be harmful to give details about the nature, quantity or combination of drugs taken or how they were obtained. For instance, the media should not publish the brand name of a drug used in suicide.
>
> Caution is also needed when the method of suicide is rare or unusual. While use of an unusual method may appear to make the death more newsworthy, reporting the method may lead other people to try it. New methods can spread easily as a result of sensationalist media reporting – an effect that can be accelerated via social media. However, if a decision is made to include a suicide method in the reporting, it is best to do this only once, and in the centre of the story, rather than in a headline, opening paragraph, nut graph or other prominent part of the story. Such reporting should always be done in terms that are as general as possible.

Reporting the site of suicide is cautioned against with similar wording, as doing so may promote such places as a "suicide site".[217] In addition, photography was potentially problematic as the images could either glamourise the deceased or, if the images suggested the method of death, remind a vulnerable person of previous attempts of self-harm.[218]

b. Suicide reporting guidelines in New Zealand

New Zealand's first suicide reporting guidelines were published in 1998 and subsequently revised in 1999.[219] Those guidelines "strongly discouraged" reporting the method of death.[220] Tully and Elsaka's 2004 study concluded that the 1999 guidelines were largely ignored by the media, who preferred to report suicide based on whether or not it was newsworthy.[221]

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[214] Media Roundtable *Reporting Suicide: A resource for the media* (2011).
[215] Canadian Journalism Forum on Violence and Trauma *Mindset: Reporting on Mental Health* (3rd ed, 2020); Everymind "Reporting suicide and mental Ill-health: A Mindframe resource for media professionals" (2020) <mindframe.org.au>.
[216] World Health Organisation "Preventing suicide: a resource for media professionals" (2023) <www.who.int> at 18.
[217] At 18.
[218] At 21–22.
[219] Ministry of Health *Suicide and the Media - The reporting and portrayal of suicide in the media - a resource* (1999).
[220] Everymind, above n 215, at 25.
[221] Jim Tully and Nadia Elsaka *Suicide and the Media - a study of the media response to Suicide and the Media: The reporting and portrayal of suicide in the media: A Resource* (Ministry of Health, 2004).

In 2010, a Ministerial Committee was established to review s 71 of the Coroners Act and the 1999 guidelines.[222] Although the Ministerial Committee concluded that the evidence justifying the suicide reporting restrictions was valid, it considered that the 1999 guidelines were outdated and did not account for social media.[223]

In response to the Ministerial Committee's report, the Associate Minister of Health convened a "roundtable meeting of media, mental health professionals and researchers" to draw up new guidelines.[224] This ultimately resulted in the 2011 suicide reporting guidelines, although, as noted by the Law Commission those guidelines were not endorsed by the Ministry of Health.[225] The 2011 guidelines simply state that the media should not specify "in detail the method or location of suicide".[226]

The Law Commission concluded, based on anecdotal evidence, that the 2011 guidelines were also largely ignored. In part, this was attributed to the conflation of s 71 of the Coroners Act with suicide reporting guidelines, along with the news media's view that statutory reporting restrictions were fettered their "right to freedom of expression and an attack on the quasi-constitutional role of the media as watchdog".[227] Given the fraught history of suicide reporting guidelines, the Law Commission recommended the creation of a new set of guidelines.[228]

The current suicide reporting guidelines were published in 2021,[229] along with a separate summary about the importance of adhering to those guidelines.[230] The 2021 guidelines are brief, at two pages, and emphasise the need to comply with ss 71 and 71A of the Coroners Act. As s 71 does not apply to overseas suicides, the "Dos" and "Don'ts" page recommends avoiding publishing the method of death for such deaths.

D How suicide is reported in New Zealand

a. The Law Commission report

The Law Commission also investigated how New Zealand media reported suicide. Despite the media's claim that the law prohibited *all* discussion of suicide,[231] discussion of suicide occurred regularly in the media. The Mental Health Foundation (the MHF) told the Law Commission that New Zealand media published,[232] on average, between 50 and 100 articles relating to suicide each week. Increased coverage would occur following a particularly newsworthy death.

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[222] Ministerial Committee on Suicide Prevention *Review of the restrictions on the media reporting of suicide* (2010).
[223] At [9].
[224] "Dunne to convene meeting of media, experts on suicide reporting" (press release, 21 December 2010).
[225] Law Commission, above n 168, at 28.
[226] Media Roundtable, above n 214, at 5.
[227] Law Commission, above n 168, at 28.
[228] At 50–55.
[229] Ministry of Health *Media Guidelines for Reporting on Suicide* (2021).
[230] Ministry of Health *The Importance of Media Guidelines for Reporting on Suicide* (2021).
[231] Law Commission, above n 168, at 30–31. citing Law Commission Harmful Digital Communications: The adequacy of current sanctions and remedies (NZLC, 2012) and comments by the chairman of the Media Freedom Committee.
[232] At 31, citing submissions from the Mental Health Foundation.

The Law Commission conducted a review, using a Google search, of mainstream media coverage of suicide between August and September 2013.[233] Their review found 104 items relating to suicide during that time, the majority (69) of which were articles relating to suicide prevention or policies. This was consistent with the Te Pou report, a 2010 report commissioned by the Ministry of Health, which found that 3,483 factual media items relating to suicide were published in New Zealand between 2008 and 2009. This figure was similar to research by the Media Monitoring Project in Australia, which has no legal restrictions on suicide reporting.[234]

The Law Commission also examined 83 articles relating to suicides that had received considerable media attention.[235] They found that a third of the articles did not comply with s 71 of the Coroners Act, or with coroners' rulings regarding publication and that 25 per cent of the articles described a death as a suicide before the coroner had completed their inquiry. Typically, this occurred when the person or their whānau were somehow newsworthy, the whānau had sought out media attention, or there was a perceived failure of a public agency.[236]

The articles generally complied with suicide reporting guidelines, consistent with the Te Pou report. However, those articles that did breach the guidelines, including by mentioning the method of death, usually drew their information from coroners' findings.[237]

b. Studies following the Law Commission's report

Since the Law Commission's report, there have been two studies on how suicide has been reported in New Zealand. While Dinsdale-Kingi's 2022 thesis discusses how media have reported Māori suicide, it does not address the Coroners Act or suicide reporting guidelines.[238] However, Colhoun's 2016 thesis compared suicide reporting in 1997 and 2009,[239] including adherence to suicide reporting guidelines and the Coroners Act and conducted interviews with members of the media regarding their views on suicide reporting. Although Calhoun incorrectly describes the Coroners Amendment Act as not relaxing suicide reporting restrictions, his data and conclusions remain valid.[240] His description may be the result of the confusion surrounding the scope of the restrictions.

Calhoun found that the method of death was reported in 48 per cent of articles in 1997 and 39 per cent of articles in 2006.[241] However, while the method of death was described explicitly in 1997, this was not the case in 2006, where the method of death was usually implied. In Calhoun's view, the rate of

[233] At 31, citing Brian McKenna and others *Reporting of Suicide in New Zealand Media: Content and Case Study Analysis* (Te Pou o Te Whakaaro Nui, June 2010).
[234] At 31, citing Katey Thom and others "Reporting of suicide by the New Zealand media" (2012) 33 Crisis 199 at 201.
[235] At 34–36.
[236] At 35.
[237] At 36.
[238] Terina Dinsdale-Kingi "Whakamate – Exploring media depictions of Māori suicide and its impacts on treatment and intervention" (MS Thesis, University of Auckland, 2022).
[239] Craig Colhoun "Suicide contagion: is the media placing the public at risk? An analysis of suicide reporting in New Zealand" (PhD (Clinical Psychology) Thesis, Massey University, 2016).
[240] At 32.
[241] At 60 and 92–97.

reporting the method of death suggested the Coroners Act was not being adhered to and that suicide reporting guidelines were not being followed.[242]

This view was further supported by interviews with members of the media.[243] Calhoun noted that, despite studies reporting the effect, interview participants had negative views, and were resistant to, the concept of suicide contagion.[244] While this resistance was considered, compared with international views, somewhat unique, this may be due to the history of suicide reporting guidelines.[245] With regards to the Coroners Act, members of the media argued that they generally adhered to the Act's restrictions, in contrast with Calhoun's findings.[246]

The New Zealand Media Council has considered the issue of reporting overseas suicides on two occasions,[247] both of which occurred before the 2021 guidelines were issued. The decision on Phillip Roberts' complaint was the most substantive. Mr Roberts complained that an article on an overseas suicide reproduced the deceased's suicide note, which had been posted online, and their method of death. He argued that the New Zealand Herald should have followed the suicide reporting guidelines. The Herald's editor disagreed, noting that the law in the United Kingdom did not prohibit such material from being published, and expressing their view that New Zealand's position on suicide reporting is "somewhat restrictive". The editor also noted that the Metal Health Foundation monitored suicide articles and had "no hesitation" in contacting the Herald should they have any concerns.

The Media Council did not uphold Mr Roberts' complaint. They were of the view that the Herald had followed suicide reporting guidelines by including a warning about the article's content at the top of the page and information on where to seek help at the bottom of the article.

The way New Zealand media reports suicide remains a live issue. A recent opinion piece in *Stuff* highlighted the risks of the Werther effect and the potential benefits of writing articles in line with the Papageno effect.[248]

Despite the 2021 guidelines, reporting overseas suicides potentially remains problematic. As an example, the reporting of the suicide of Thomas Kensington in March 2024 was explicit in both the method and circumstances of his death.[249] However, in the absence of a comprehensive study on media reporting, the extent of the issue is unclear.

Concerns about the potential for suicide contagion have been raised about the media reporting surrounding Phillip Polkinghorne's murder trial have been raised by both the Suicide Prevention Office and the Mental Health Foundation.[250] Mr Polkinghorne was accused and acquitted of killing his wife while making the death appear to be a suicide. Media coverage has included descriptions and

[242] At 175–177.
[243] At 184.
[244] At 186.
[245] At 194-195.
[246] At 196.
[247] *Matthew Farrell against New Zealand Herald* Case No. 2698 (August 2018) and *Phillip Roberts against New Zealand Herald* Case No. 2762 (March 2019).
[248] Jehan Casinader "Is our suicide conversation helping or harming?" *Stuff* (online ed, 17 September 2023).
[249] "Inquest opens into death of Lady Gabriella Windsor's husband Thomas Kingston" *New Zealand Herald* Auckland, online ed, 2 March 2024).
[250] See "Mental health experts issue warning over reporting of Polkinghorne trial" *Radio New Zealand* (online ed, 19 August 2024).

images of the method of the "apparent suicide". However, the Coroners Act did not apply at the time as there was no "reasonable cause" to suspect the death was self-inflicted, as required by s 71(1)(b) of the Coroners Act.

However, following Mr Polkinghorne's acquittal, it is open for the responsible coroner to conclude that the death may have been self-inflicted. If that is the case, then s 71 would apply from that point onwards.

II The Law Commission's recommendations and the Coroners Amendment Act 2016.

Given the suicide reporting restrictions' alleged lack of clarity and the fact those restrictions were not being complied with, the Law Commission considered that the Coroners Act was not working, particularly concerning what they termed "new media" such as social media.[251]

The Law Commission considered that the evidence for the Werther Effect, in terms of reporting the method of death, justified some sort of statutory limitation in the reporting of suicide.[252] However, other matters thought to contribute to suicide contagion, such as glorifying suicide or identification with the deceased were thought to be better suited to media reporting guidelines.[253]

However, the Law Commission's view was that certain aspects of s 71 should remain unchanged.[254] They considered that s 71 should continue to apply to "self-inflicted" deaths, rather than suicides, as it is the coroner's role to determine whether a person intended to die. Expanding the scope of s 71 to restrict reporting of overseas suicides was rejected due to the availability of overseas news on the internet. The definition of the phrase "make public" in s 73 of the Coroners Act was also left unchanged,[255] as that definition sufficiently captured types of publication that could cause harm.

The Law Commission recommended that s 71 of the Coroners Act be amended to prohibit the reporting of the method of death and describing the death as a suicide, as well as to provide a regime for granting an exemption to those restrictions. These recommendations were implemented in the Coroners Amendment Act 2016.

I discuss below the Law Commission's recommendations and how the recommendations were implemented in the Coroners Amendment Act 2016. Table 2.1 summarises the relevant submissions received by the Justice and Electoral Committee (the Select Committee).

Table 2.1: Submissions received by the Select Committee

Submitter	Position	Areas of concern
Michael Finucane.	Supported	Who made the decisions for exemption.
Graeme Edgeler.	Opposed	
James Hollings.	Opposed	

[251] Law Commission, above n 168, at 37–38.
[252] At 38.
[253] At 49.
[254] At 41.
[255] At 42.

Media Freedom Committee.	Neutral	., although they agreed with James Hollings.
Mental Health Foundation.	Supported	Consultation with whānau.
National Council of Women of New Zealand.	Supported	
New Zealand Law Society.	Supported	Consultation with whānau.
New Zealand Medical Association.	Supported	
New Zealand Nurses Organisation.	Supported	Suicide and media expert panel.
Southern District Health Board.	Supported	

A Scope of the new restrictions

As noted above, the Law Commission recommended that the publishing of the method of a self-inflicted death should remain prohibited. It was their view that this restriction should apply to everyone, regardless of the medium used,[256] as the Werther effect was not limited to the mainstream media. However, the Law Commission considered that the statutory exemption for reports of the Independent Police Conduct Authority in s 72 of the Coroners Act should remain unchanged. The Law Commission also recommended that the wording of the restriction should not distinguish between whether a coroner's inquiry was completed or not.[257] In their view, this distinction contributed to the confusion in the scope of the restrictions.

However, the Law Commission considered that the harm to the integrity of the coronial inquiry necessitated a distinction between a completed and uncompleted inquiry. As drafted, and ultimately enacted, ss 71(2)(c) and 71(3) address this recommendation. While s 71(2)(c) prohibits describing a death as a suicide, it is not an absolute prohibition. Section 71(3) allows a self-inflicted death to be described as a "suspected suicide" if a finding has yet to be made or, if a coroner has determined a death to be a suicide, describe the death as such. While the Law Society's submissions to the Select Committee supported the changes to s 71, they expressed particular support for retaining ss 71(2)(c) and 71(3), given the "high evidential threshold" for a finding of suicide.[258]

The Media Freedom Committee also supported this change, noting that it would end an "area of contention between coroners and the media".[259] However, the submissions of Edgeler, a barrister

[256] At 41.
[257] At 41–42.
[258] New Zealand Law Society "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014" at 3.
[259] Media Freedom Committee "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014" at 2.

"interested in law reform and freedom of expression", opposed this change.[260] In his view, no other type of coronial inquiry had such protections, and it was speculative to suggest that the coronial process was harmed by public comment about suicide.[261]

The use of innuendo in describing the method of death was also of concern.[262] The Law Commission considered that restrictions should apply to both direct and indirect reports of the method of death. They argued that it was the meaning of the report, rather than the "bare words" used that caused harm. Similarly, the Law Commission considered that reporting the site of a suicide carried sufficient risk that reporting such detail should also be prohibited.

As initially drafted, the Coroners Amendment Bill simply prohibited reporting the method of death and the site of the death.[263] However, due to the use of innuendo in describing the method of death, the Ministry of Justice recommended that the restriction of the site of death be broadened to details that suggest the method of death.[264] This recommendation was adopted, and as enacted, s 71(2)(b) of the Coroners Act prohibits the publication of any detail that suggests the method of a self-inflicted death.

Most of the submissions to the Select Committee regarding the changes to s 71 supported those changes. They considered that the Coroners Amendment Bill struck the right balance between freedom of expression and the health risks in reporting the method of death.[265] The views expressed that the changes made the law clearer and more capable of being enforced,[266] while suicide reporting guidelines were more appropriate to other factors related to the Werther effect, which would be difficult to legislate against.[267]

In contrast, the Media Freedom Committee struck a neutral position, as they disagreed that the research justified suicide reporting restrictions.[268] However, they did not argue that ss 71 and 71A should not be enacted,[269] as they considered that the Law Commission's report tried to balance preventing deaths from suicide and freedom of speech.

Both Hollings, a journalism academic, and Edgeler opposed ss 71 and 71A and considered that there should be no suicide reporting restrictions in the Coroners Act.[270] Like the Media Freedom

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[260] Graeme Edgeler "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014" at 4–5.
[261] I discuss Edgeler's view in Chapter Four at page XX.
[262] Law Commission, above n 168, at 42.
[263] Coroners Amendment Bill 2014 (239-1) (explanatory note) at 3-4, and cl 30.
[264] Ministry of Justice "Briefing to the Justice and Electoral Committee on the Coroners Amendment Bill 2014" at 1–2; Ministry of Justice "Coroners Amendment Bill Departmental Report" at 18.
[265] Mental Health Foundation "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014"; National Council of Women of New Zealand *Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014*; Southern District Health Board "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014"; New Zealand Medical Association "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014"; New Zealand Law Society, above n 258; Michael Finucane "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014".
[266] Finucane, above n 265, at 1.
[267] Mental Health Foundation, above n 265, at 3–4.
[268] Media Freedom Committee, above n 259, at 3.
[269] At 2.
[270] Edgeler, above n 260; James Hollings "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014".

Committee, Hollings submitted that the research has never justified New Zealand's suicide reporting restrictions, while Edgeler's submissions were related to the practicality of the exemption regime and the use of criminal law.

Hollings also considered that there were good arguments for the use of voluntary suicide reporting guidelines and that sections in the Coroners Act regarding describing a death as suicide should be retained as they were consistent with suicide reporting guidelines. However, given the consistent message from suicide reporting guidelines described earlier, the same logic applies to restricting the publication of the method of self-inflicted deaths.

The Ministry of Justice's Departmental Report did not support the submissions of Hollings, Edgeler, or the Media Freedom Committee,[271] stating that while the Coroners Act was restrictive, the scientific evidence supported restricting the publication of the method of death.

B Exemption regime

In addition to significantly narrowing the suicide reporting restrictions, the Law Commission also proposed a new exemption regime.[272] They considered that while rare, an exemption could only be granted under circumstances where the public interest outweighed the risk of further suicides, giving the example where publication may force an institution to restrict access to a ready means of self-harm. The Law Commission also expressed the view that exemptions for describing a death as a suicide would also be similarly rare, primarily because the proposed changes would permit the media to describe a death as a suspected suicide.[273]

As proposed, and enacted as s 71A(3), the Coroners Amendment Bill set out a two-step test. The Chief Coroner must first be satisfied that granting an exemption does not present an "undue risk that other people will attempt to copy the behaviour of the dead person concerned". If that step is satisfied, then the Chief Coroner must consider whether any risk that person may copy the behaviour of the deceased is "outweighed by other considerations that make it desirable, in the public interest, to allow the publication".

The Southern District Health Board were of the view that the test lacked clarity and was not balanced correctly. In their submission, the test should be weighed towards being satisfied that *no* further self-inflicted deaths would occur.[274] The Ministry of Justice did not support this submission.[275] While they acknowledged that decisions under s 71A would not always be straightforward, the Suicide and Media expert panel, discussed below, was better placed to provide advice suited to a particular exemption.

Finucane, a lawyer who had previously written about s 71, supported the test for an exemption, expressing the view that it balanced the risks of harm with freedom of expression.[276] In his submission, he noted that copycat suicide and suicide contagion had wider meanings in academic

[271] Ministry of Justice, above n 264, at 18.
[272] Law Commission, above n 168, at 43–44.
[273] At 43.
[274] Southern District Health Board, above n 265, at 2.
[275] Ministry of Justice, above n 264, at 17.
[276] Finucane, above n 265, at 1–2.

literature. He suggested that the phrase "copy the behaviour of the deceased" should be retained and that coroners should be able to take a broad view of its meaning.[277]

As noted above, Hollings was of the view that any suicide reporting restrictions and, by extension, exemption regimes were unnecessary. Despite this, he submitted that if s 71A were to be retained the test set out in s 71A(2)(a) should be removed,[278] as that was not a matter a coroner could make such a determination and that the purpose of the exemption test could be solely met by the test in s 71A(2)(b).

Unlike previous suicide reporting prohibitions, the Law Commission considered that the Chief Coroner, or Deputy Chief Coroner, would be best placed to determine whether an exemption should be granted. The reason for this change was that different coroners would have varying views on the risk of harm, leading to a diverse range of practices. The Law Commission considered this to be undesirable and contrary to the policy aim of educating the public and media about the risks of reporting suicide. To assist the Chief Coroner, the Law Commission recommended the creation of an expert panel, discussed in more detail in a separate section below.

In his submission, Finucane disagreed with the Chief Coroner being the sole decision maker for exemptions. In his view, it was inappropriate as the Chief Coroner would be required to "reach into" matters before another independent judicial officer. Finucane submitted that if the goal was consistent practices, that could be achieved through practice notes or consultation with the Chief Coroner.[279]

In response to concerns by journalists about the difficulties and impracticalities of applying to a coroner for permission under the Coroners Act, the Law Commission considered that any exemption regime should be timely, particularly given the need for swift reporting of breaking news.[280] Although the narrower restrictions would remove much of the difficulties described, the Law Commission recommended that applications for exemptions should be given priority, citing s 107 of the Care of Children Act 2004 as a legislative precedent.[281]

As drafted, and enacted, s 71A(2)(a) of the Coroners Act requires that the Chief Coroner give priority to considering the application. To ensure an application is "dealt with promptly", s 71A(4) allows the Chief Coroner to carry out any communications necessary for processing the application. No time frames are set out.

Finucane submitted that there was no particular need for exemption applications to be considered promptly, as the suicide reporting restrictions were significantly narrower.[282] He considered s 71A(4) was too informal and that exemptions should require a formal application, such as a template form.[283] While no legislative changes were made, an application form can be found on the Coronial Services website.[284]

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[277] At 2.
[278] Hollings, above n 270, at 2.
[279] Finucane, above n 265, at 2–3.
[280] Law Commission, above n 168, at 44.
[281] At 44, footnote 87.
[282] Finucane, above n 265, at 3.
[283] At 3–4.
[284] "Application for an Exemption Under Section 71A of the Coroners Act 2006" Coronial Services <www.justice.govt.nz>.

Edgeler was particularly critical of the requirement to seek an exemption and how much time seeking permission could take.[285] In his experience, seeking approval had on one occasion taken five months, attempting to seek permission from both the coroner investigating the death and the Chief Coroner. In his view, the requirement to seek "pre-approval" was unworkable.[286]

Finally, the Law Commission considered that the right to review a refusal to grant an exemption, contained in s 75 of the Coroners Act, should be retained, although modified to reflect the exemption regime.[287] While they considered the right of review to be essential, the Law Commission recommended that the decision should not be judicial reviewable, as the delay and expense would be incompatible with the need for timeliness.[288]

However, as amended, s 75 does not restrict the possibility of other reviews. As discussed in the section on the views of the deceased's whānau, the courts treat s 75 effectively as a judicial review in any event.[289]

C Suicide and media expert panel

The Law Commission considered that, when considering applications for exemptions, the Chief Coroner would be assisted by a suicide and media expert panel (the Panel).[290] The Panel would assist the Chief Coroner by providing up-to-date information about the role of media in suicide reporting and the associated risks. The Law Commission did not consider that the Chief Coroner should be required to consult with the Panel. Rather, it should be available for particularly difficult cases.

The Law Commission's recommendations are reflected in s 116A of the Act. The Chief Coroner may consult with the Panel as a whole or may choose to consult with particular members. The Panel is made up of up to four members, appointed by the Director-General of Health, and must have expertise in:[291]

a) suicide prevention;
b) media;
c) tikanga Māori;[292] and
d) Māori youth suicide.

The creation of the Panel was supported by three submissions, with the MHF's submission simply noting their support.[293] The Southern District Health Board submitted that the Panel also include a member with mental health expertise,[294] while the National Council of Women of New Zealand submitted that "the chief coroner seek advice from panel members with expertise in tikanga Māori,

[285] Edgeler, above n 260, at 2–3.
[286] At 2.
[287] Law Commission, above n 168, at 44.
[288] At 44.
[289] See pages 42–43.
[290] Law Commission, above n 168, at 44.
[291] Coroners Act 2006, s 116A(3).
[292] Tikanga Māori refers to Māori customary values and laws. As recognised by the Supreme Court in *Ellis v R* [2022] NZSC 114, [2022] 1 NZLR 239, tikanga forms part of both Aotearoa (New Zealand) common law and is recognised in some statutes and regulations.
[293] Mental Health Foundation, above n 265, at 4.
[294] Southern District Health Board, above n 265, at 3.

especially in the instance that Tūpāpaku is Māori".[295] The Ministry of Justice considered the National Council of Women of New Zealand's submission to be unnecessary given the requirement that the Panel have expertise in both tikanga Māori and Māori youth suicide.[296]

Hollings did not consider it necessary to create the Panel.[297] In his submission, the Panel would be time-consuming and a constraint on journalists and the Chief Coroner. While timeliness is a separate issue and is addressed in Chapter Three,[298] Hollings' submission is incorrect as the Panel's views are not binding on either journalists or the Chief Coroner.

D Enforcement of the suicide reporting restrictions

The Law Commission considered whether publishing information in breach of s 71 should remain an offence, noting that there were no known prosecutions.[299] Given that s 71 had narrowed considerably, they considered that a breach of s 71 should remain a criminal offence, as the restrictions were specifically linked to evidence of harm.[300] The Law Commission also considered it would be straightforward to bring prosecutions.

The Law Commission recommended that the provisions in s 71(2) would set out that unless "the Chief Coroner has granted an exemption, no person may directly or indirectly make public the method of death".[301] This implies that the Law Commission considered that once an exemption was granted, it would apply to the world at large. However, the Coroners Amendment Act states that "No person may, unless the person is granted an exemption under section 71A or has permission under section 72" publish the prohibited information. This is a significant difference, which I discuss in detail in Chapters Three and Four,[302] and was not the subject of submissions. However, I consider that as written, exemptions only apply to the applicant, which means that any other reporting remains unlawful.

The fines for a breach of s 71 were increased in line with the Law Commission's recommendation, with a person liable for a fine of up to $5,000, and a body corporate liable for a fine of up to $20,000.[303] They considered that this would bring the penalty in line with similar offences. Section 139 of the Coroners Act reflects those recommendations. The definition of "make public" in s 73 of the Coroners Act remained unchanged.

Hollings submitted that the law should not criminalise families who wish to speak to the media about suicide.[304] However, this view is not correct as only the restrictions on the method of death and reporting a death as suicide were subject to criminal sanctions.[305]

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[295] National Council of Women of New Zealand, above n 265, at 4. Tūpāpaku means the body of a deceased person.
[296] Ministry of Justice, above n 264, at 21.
[297] James Hollings "Submission to a review of the Coroner's Act 2006" 11 at 2.
[298] See pages 49–50.
[299] Law Commission, above n 168, at 44.
[300] At 45.
[301] At 39.
[302] See pages 53 and 74–75.
[303] Law Commission, above n 168, at 45.
[304] Hollings, above n 297, at 2.
[305] Law Commission "Submission to the Justice and Electoral Committee on the Coroners Amendment Bill 2014" at 2.

As noted earlier, Edgeler's primary criticism of the suicide reporting restrictions was the use of criminal sanctions. He was concerned by the potential criminalising of families or friends of the deceased who talk about suicide on social media.[306] In that context, Edgeler considered the idea that people would seek pre-approval from the Chief Coroner as "laughable" and that the argument that the criminal law would likely not be enforced in such cases did not justify its use.

In Edgeler's view, the combination of an automatic prohibition, the need to seek permission, and the criminal law created a chilling effect, which would prevent people from seeking permission in the first place.[307] While he accepted that evidence did suggest that there were harms associated with publishing the method of death, he noted that overseas suicides were not subject to criminal sanction. Given that New Zealand is unique in its approach, he described the use of the criminal law in that context as "odd".

While I discuss this point in more detail in Chapter Four,[308] Edgeler's view overlooks the fact that there are similar default suppression or non-publication laws in New Zealand.[309] These laws function in the same way as s 71, where the default position is softened somewhat by the ability to seek permission to publish.

Edgeler also did not accept the Law Commission's justification for prohibiting describing a death as a suicide, as other deaths before a coroner were not afforded the same protection.[310] Describing coroners as being made of "sterner stuff", his view was that the integrity of the coronial process could be maintained without the use of criminal sanctions.

Edgeler submitted that the regulation of suicide reporting, if any, would be best left to a media regulator, such as the Broadcasting Standards Authority.[311] The Coroners Act is concerned with particular deaths and any restriction would not apply to methods of suicide in general. While acknowledging that media regulation was outside the scope of the Select Committee and that the amendments to the Coroners Act were an improvement, Edgeler submitted that the suicide reporting restrictions and criminal sanctions were unnecessary.

As part of the Select Committee process, the Ministry of Justice prepared three regulatory impact statements. The third of the regulatory impact statements (the Third RIS) discussed whether breaches of s 71 of the Coroners Act would be enforceable.[312] The statement noted that the restrictions were more explicit and, therefore, more enforceable, and the increased penalties were comparable to similar provisions, which would underscore the importance of the narrower reporting restrictions. However, it was uncertain that the public would have sufficient awareness of the restrictions in s 71. The Third RIS concluded that prosecutions would only be made in cases of substantial breaches.

[306] Edgeler, above n 260, at 2.
[307] At 3-4.
[308] See page 69.
[309] For example, Criminal Procedure Act 2011, ss 201, 203–204, Family Court Act 1980, s 11B.
[310] Edgeler, above n 260, at 4–5.
[311] At 5–6.
[312] Ministry of Justice *Regulatory Impact Statement Coroners Act 2006: Proposals for Reform Paper 3* at 8.

E Interests of the deceased's whānau[313]

As the Law Commission's report noted, one of the policy aims of the suicide reporting restrictions was to protect the privacy of the whānau of the deceased.[314] It also noted that publication carried with it the potential for further harm, including a greater risk of self-harm, including suicidal behaviour.[315] While the Law Commission did not make any recommendations regarding the privacy of the deceased's whānau, it noted the existence of s 74 of the Coroners Act, which would allow a coroner to prohibit the publication of evidence in cases of suicide.[316]

While the Law Commission Report was silent on the issue of consultation, it did discuss whether the exemption decision could be reviewed.[317] However, the interests of the deceased's whānau featured in two submissions to the Select Committee. The New Zealand Law Society recommended that the Chief Coroner should be required to consult with interested parties, as well as the suicide and media expert panel when considering granting an exemption.[318] They argued that this would be consistent with the then-proposed requirement to consult with interested parties on significant matters.[319]

The Law Commission explained its rationale for not requiring the Chief Coroner to consult with the interested parties. In their view, consultation was unnecessary. The restrictions in s 71 were concerned with the risk of copycat suicide,[320] and interested parties were unlikely to have any relevant comments regarding the risk of publication.

The MHF submitted that the suicide reporting restrictions and exemption regime did not allow the Chief Coroner to restrict the publishing of suicide details at the request of the deceased's whānau.[321] They argued that this would enable the whānau to manage their bereavement and raise any concerns about the impact that reporting would have on them. The MHF also suggested that any publication restrictions could be subject to review by the Panel, who would consider freedom of expression and any public interest in the death.

The Law Commission explained that any relevant privacy interests could be met through s 74 non-publication orders.[322] However, while the Law Commission is correct that personal privacy, including that of the deceased, is a ground for making an order for non-publication, those powers apply to either evidence or submissions made during an inquiry, or to the identification of witnesses. Making such orders is a matter for the responsible coroner, and granting the Chief Coroner powers to make such orders would impinge on their judicial independence.

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[313] Whānau refers to a person's family, although it is broader than their immediate family. Whānau is multi-generational and consists of grandparents, parents, parental siblings, a person's siblings, children (including adopted children) and their spouses, and grandchildren. Definitions of te reo Māori words come from the Legal Māori Resource Hub "Dictionary" <www.legalmaori.net>. I also note that the definition of "immediate family" in s 9 of the Coroners Act 2006 recognises that the differing cultural forms that families can take.
[314] Law Commission, above n 168, at 11.
[315] At 16 citing John R Jordan "Is Suicide Bereavement Different? A Reassessment of the Literature" (2001) 31 Suicide and Life-Threatening Behavior 91–102.
[316] At 45.
[317] Law Commission, above n 168, at 44.
[318] New Zealand Law Society, above n 258, at [11]-[13].
[319] Coroners Act, ss 23 and 24.
[320] Law Commission, above n 305, at 3.
[321] Mental Health Foundation, above n 265, at 5.
[322] At 3.

The Ministry of Justice did not support the New Zealand Law Society or MHF's submissions. In their view,[323] it would be the media that would most likely be seeking an exemption from the Chief Coroner. As one of the purposes of the exemption regime was to produce a quick decision, a broad consultative requirement would introduce delay and be counterproductive. Moreover, the purpose of the amendment was to "liberalise the reporting of suicides".[324] The MHF's submission would result in differing publishing restrictions for some suicides and difficulties in enforcing publishing restrictions.

As enacted, ss 71 and 71A do not require consultation with the whānau of the deceased. However, in practice, the whānau are routinely consulted as part of s 71A applications.[325]

F To which deaths do ss 71 and 71A apply?

The Law Commission did not consider whether any changes to the Coroners Act should apply retroactively. However, the Ministry of Justice's Departmental Report recommended that the provisions of the Coroners Amendment Act should not apply to coronial investigations of deaths that were reported to the coroner before the Act came into force.[326] While not the subject of submissions, the Select Committee inserted Schedule 2 into the Coroners Amendment Bill.[327] The report recommended inserting the schedule to provide for the transition to the amended Coroners Act, setting out the pre-amendment Act applies:

> …if a death occurs and is reported to the coroner before the commencement date, the current Act largely applies, with a few technical amendments. If the death is reported to the coroner after the commencement date, but the date of death is before the commencement date, then the amended Act would apply.

Schedule 2 sets out that the pre-amendment version of s 71 applies if the death was reported to the coroner before the 2016 Amendment came into force. The pre-amendment version of s 71 also applies if the death is reported to the coroner after the commencement of the 2016 Amendment, but the date of death is earlier than the commencement date.

The definition of date of death also includes situations where the date of death is unknown, for example where the deceased person was missing, and it may have been many years before their body was discovered. In such cases, the date of death is defined as the date the death is first discovered. Should that date be after the commencement of the 2016 Amendment, then the current version of s 71 would appear to apply. However, a coroner could later determine a more precise date of death and, in the absence of any case law suggesting otherwise, determine that the pre-amendment version of s 71 applies.

III Conclusion

In this Chapter, I set out the Law Commission's review of s 71 of the Coroners Act, which led to the passage of the Coroners Amendment Act 2016. I discussed how research continues to show that

[323] Ministry of Justice, above n 264, at 18.
[324] At 27.
[325] See pages 51–52.
[326] Ministry of Justice, above n 264, at 29.
[327] Coroners Amendment Bill 2014 (239-2).

suicide reporting can lead to an increase in the rate of suicide and an increase in the use of particular methods. I also set out the use of suicide reporting guidelines in New Zealand and discussed how suicide is reported.

The changes to s 71 reflected the Law Commission's view that the scope of any suicide reporting restrictions needs to be clear. As such, s 71 restricts publishing the method of death, details that suggest the method of death, and a premature description of a death as a suicide.

However, the restrictions in s 71 are not absolute. A new regime, s 71A of the Coroners Act, allows the Chief Coroner to grant an exemption to the restrictions in s 71. An exemption may only be granted if the Chief Coroner is satisfied that the risk of imitation is low, and that publication is in the public interest.

In Chapter Three, I will set out how the exemption regime has worked in practice. This will include discussing whether the regime is timely, and the extent to which the whānau of the deceased are consulted.

Chapter Three: Sections 71 and 71A in practice

In Chapter Two I discussed the reform of s 71 of the Coroners Act and the creation of the exemption regime in s 71A. This chapter discusses how ss 71 and 71A have worked in practice.

I first discuss the exemption decisions and set out the general reasons for exemption applications and which applications have been granted. As one of the purposes of the s 71A regime was timeliness, I then discuss whether that has been achieved. Finally, this part of Chapter Three will discuss the extent to which the suicide and media expert panel has been consulted and the extent of consultation with the deceased's whānau.

The second part of this chapter will examine the criminalisation of publication set out in s 139 of the Coroners Act. It will discuss the scope of the exemption regime and whether the language of s 71 leads to unnecessary criminalisation, as well as examine the Police investigations of two potential breaches of s 71.

Considering the above, I will then examine particular s 71A exemptions in detail as case studies`. This will include discussing the deaths and the exemption applications, and the extent and lawfulness of any reporting.

I Section 71A exemptions

A Methodology

For this section, I have analysed s 71A exemption decisions between 22 July 2016 (the date the Coroners Amendment Act 2016 came into force) and December 2023. Where the coronial inquiry was complete, the s 71A decisions and the associated coronial findings were provided under Official Information Act requests.[328] In one instance, the s 71A exemption decision was provided with the leave of the responsible coroner, as they had yet to complete their inquiry. Although the number of applications is, for statistical purposes, small, the section on general findings summarises the decisions as a group and identifies trends and themes.

The case studies analyse those themes, such as the pre-existing reporting of the method of death, and examine the articles published in response to the death. For this analysis, I have utilised the Newztext Plus database, which offers a full-text search of New Zealand newspapers, magazines, blogs, and newswires. For each death, I confined the date range from the date of the self-inflicted injury to 31 December 2023 and performed keyword searches for either the name of the deceased, their method of death, or a combination of both.

As noted in Chapter 2, there have been no studies regarding how suicide has been reported in New Zealand, including compliance with ss 71, for the period following the 2016 Amendment Act. The case studies will show how a particular death has been reported. Unlike the study of *felo de* se articles in Chapter One, articles that have been published in multiple sources, such as various regional papers, will be counted to show the spread of suicide reporting.

[328] Provided by email on 4 April 2022, 9 May 2023, and 4 March 2024.

B General findings

Table 3.1 summarises the number of decisions made under s 71A of the Coroners Act, the number of applications per year and what exemptions those applications sought, whether those applications were granted, whether the coronial inquiry was ongoing at the time of the application, and whether the Panel or whānau were consulted by the Chief Coroner.

Table 3.1: Section 71A Exemptions

Year	Applications made	Applications granted	Method of death	Description of death as suicide	Inquiry ongoing	Consultation with the expert panel	Consultation with whānau
2016	3	1	1	2	3	2	1
2017	4	2	3	3	4	1	4
2018	1	0	1	1	0	0	0
2019	1	0	1	0	1	0	1
2020	2	2	2	0	0	0	2
2021	3	3	2	1	2	0	3
2022	1	0	1	0	1	0	1
2023	2	2	2	0	1	1	2
Total	17	10	13	7	12	4	14

As can be seen in Table 3.1 above, 17 decisions have been made under s 71A since the Coroners Amendment Act came into force. Seven decisions were declined, while the remaining decisions were granted, either fully or in part. Most of the applications, 12 out of 17, were made while the coronial inquiry was ongoing. Most of the applications relate to a single deceased person, with four decisions relating to multiple deceased people.

Applications for exemptions are infrequent, ranging between one and four applications annually. This would appear to bear out the Law Commission's view that the need for exemptions would be rare.[329]

The arguments raised by the applications are detailed below. Most of the applications were to report either the method of death or to describe the death as a suicide, with only three applications seeking both. For statistical purposes, I have included those applications in both categories.

C Applications to describe a death as a suicide

There were seven applications to describe a death as a suicide. One application was declined as the death had been determined to be a suicide, and as such, the application was unnecessary.[330] Five applications were declined as the investigations were in their early stages, and there was insufficient evidence to describe the death as a suicide.[331] The Chief Coroner did not consult with the responsible coroner before declining the applications.

[329] Law Commission, above n 168, at 37.
[330] *Re: An exemption from restrictions on making public details of the death of Sinan Joschka Saglam* CSU-2016-CCH-551, 28 February 2018.
[331] See the discussion surrounding Zdenek Hanzlik's death below.

Only the application to describe Reid O'Leary's death as a suicide was granted.[332] The applicant, Mark Story, a journalist for NZME, had already published an article describing Mr O'Leary's death as a suspected suicide.[333] However, Mr Story applied for an exemption as Mr O'Leary's whānau had been "emphatic about their wish to be open about Mr O'Leary's death and to discuss the issue".[334]

As the inquiry into Mr O'Leary's death was ongoing, the Chief Coroner consulted with the responsible coroner, Coroner Ryan.[335] Coroner Ryan confirmed that if the application were granted, it would not interfere with his inquiry. The Chief Coroner also consulted with Mr O'Leary's whānau, who confirmed that they supported the application and that it was "their desire to raise awareness of the issues surrounding men's mental health".[336] In granting the application, the Chief Coroner noted Depression New Zealand's comments that men are less likely to ask for help with depression.[337]

D Applications to publish the method of death

Table 3.2: Applications to publish the method of death					
Method of death already in the public domain		**To bring attention to an issue**		**The death is somehow newsworthy**	
Granted	**Declined**	**Granted**	**Declined**	**Granted**	**Declined**
6	1	4	0	0	2
Total		**Granted**		**Declined**	
13		10		3	

As shown in table 3.2 above, 13 applications sought to publish either the method of death or a detail that would suggest the method of death. In contrast with applications to describe a death as suicide, three applications have been declined. The reasons for the applications fall into three broad categories, discussed below.

a. Method of death already in the public domain

Of the seven applications made on the basis that the details of the method of death were already in the public domain, six were granted. The deaths of Zdenek Hanzlik and Sinan Saglam, both of which resulted in two applications, are discussed in detail as case studies.

Five applications were granted because the method of death had been made public before the person's death had been reported to the coroner.

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[332] Re: A*n exemption from restrictions on making public details of the death of Reid Keady O'Leary* CSU-2020-HAS-265, 9 March 2021.
[333] At [6], citing Mark Story "Hastings man's 'silent' death spurs sister to speak out on mental health" *Hawke's Bay Today* (online ed, 6 March 2021). Note, this article no longer appears online, however, see Mark Story "Hastings mechanic's death 'rocked a community'" *Hawke's Bay Today* (online ed, 17 March 2021) and Gianina Schwanecke "Mate's 'raw' suicide sparks Havelock North man to action" *Hawke's Bay Today* (online ed, 22 March 2021). Both articles note the Chief Coroner's exemption to describe the death as suicide.
[334] At [5](b).
[335] At [16].
[336] At [17].
[337] At [21], citing Depression New Zealand "You don't have to tough it out" <www.depression.org.nz>.

The application to report Neil Vaughan's death noted that the method of his death had been published before his death was apparent and had been reported to the coroner.[338] The circumstances of Mr Vaughan's death, along with the prior reporting, were sufficient to satisfy the Chief Coroner that the application did not pose an undue risk that people would imitate Mr Vaughan's behaviour.

The application to report the method of Alaric Eccleston-Brown's death was granted as his death had occurred following a police pursuit.[339] The pursuit and its outcome had been widely reported before the death had been reported to the coroner, and the Police had issued statements about the death. While not considered by the Chief Coroner, Mr Eccleston-Brown's death was also subject to an IPCA investigation.[340] Section 72 of the Coroners Act allows publication of the method of death if it forms part of an ICPA report.

However, despite s 72 and the granting of the s 71A exemption, the method of Mr Eccleston-Brown's death cannot be made public. The Coroner was of the view that s 71 only applies to suicides, rather than to all self-inflicted deaths. However, they made non-publication orders under s 74, prohibiting publication of the method of his death, or any detail that may suggest the method of his death, on the grounds of interests of justice and decency.[341]

Section 72 was considered relevant in determining the application to report the manner of Matu Reid's death.[342] In that decision, the Deputy Chief Coroner noted the public interest in matters where death or serious harm occurs as part of an interaction with the Police. In her view, s 72 represented Parliament's view that the public interest in the publication of the method of death outweighed the risk of harm.

b. To bring attention to an issue

Four applications fall into this category, all of which have been granted. Two of the applications, Kenneth Crawford and "Hannah Marble",[343] argued that it was not possible to bring attention to a coroner's recommendation without mentioning the method of death. I discuss the application about Hannah Marble's death in detail below as a case study.

The application in respect of Kenneth Crawford sought to publish a particular that suggests the method of death, rather than the method itself.[344] The applicant argued that Mr Crawford had taken his own life after watching a film and that anyone who had viewed the film would be aware of the method of death. The application sought to bring publicity to the Coroner's recommendations

[338] *Re: An exemption from restrictions on making public details of the death of Neil Peter Vaughan* CSU-2020-HAS-1, 14 July 2021.
[339] Re: a*n exemption from restrictions on making public details of the death of Alaric Dylan Eccleston-Brown* CSU-2016-AUK-1102, 9 September 2016.
[340] *Re:* a*n inquiry into the death of Alaric Dylan Eccleston-Brown* CSU-2016-AUK-1102, 30 May 2018 at [3]. Independent Police Conduct Authority "Death of Alaric Eccleston following a Police pursuit in Auckland" 7 September 2017 <www.ipca.govt.nz>.
[341] At [57].
[342] *Re:* A*n inquiry into the death of Matu Tangi Matua Reid* CSU-2023-AUK-902, 28 July 2023 at [21]–[22].
[343] In this thesis I have honoured the family's wishes not to disclose the name of the deceased.
[344] Re: a*n exemption from restrictions on making public details of the death of Kenneth Raymond Eric Crawford* CSU-2018-CCH-806, 9 December 2020.

regarding the fictional depiction of suicide. The Chief Coroner agreed, citing the Chief Censor's views on detailed depictions of suicide in fiction.[345]

The application regarding Neil Vaughan's death, also discussed above, argued that granting the application was in the public interest as the focus of the article was not Mr Vaughan's method of death, but euthanasia. At the time of the application, the debate surrounding euthanasia was particularly topical due to the End of Life Choice Act 2019 coming into force.

In contrast to the above, the application for publishing the method of Paul Rowe's death was made while the inquiry was still open.[346] Mr Rowe had died while an inpatient at Palmerston North Hospital's mental health ward.[347] The application argued that it was in the public interest to report the concerns of Mr Rowe's whānau, including issues surrounding his care and safety.[348]

As with the application regarding Mr O'Leary, the Deputy Chief Coroner consulted with the responsible coroner, who confirmed that granting the application would not interfere with their inquiry.[349] In granting the application, the Deputy Chief Coroner noted that it would be unlikely that knowledge of the location and method of Mr Rowe's death would spur imitation.[350] The public interest test was met given the previous media coverage of issues with patient care at Palmerston North Hospital.

c. The death is somehow newsworthy

Two applications were made, in effect, because the deaths themselves had an element of newsworthiness.[351] Both applications were made while their respective inquiries were open and concerned inquiries into the deaths of multiple people. The applications, which were not granted, argued an exemption was necessary for closure, or to address rumours.

One of the factors relevant to a coroner's decision to open an inquiry into a death is the existence of rumours, allegations or other public concerns.[352] While an inquiry into a self-inflicted death is mandatory, the existence of such allegations or rumours, to the extent they are relevant, may very well form a part of the inquiry.

However, elements of speculation or the need for closure are matters of public curiosity, rather than public interest. Moreover, addressing rumours or providing closure are matters that fall within the circumstances of the death, which is firmly the role of the responsible coroner.

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[345] At [20] citing Classification Office "Media and suicide – Don't Look Away" (26 August 2019) <www.classificationoffice.govt.nz>.
[346] *Re: An exemption from restrictions on making public details of the death of Paul Anthony Rowe* CSU-2021-WGN-218, 22 December 2021. Note that Mr Rowe's death is an active inquiry before Coroner Greig. In a Minute dated 22 May 2023, Coroner Greig authorised the release of the s 71A decision to me, stating that its release would not interfere with their investigation.
[347] At [6](a) and (b).
[348] At [6](c) and (d).
[349] At [17].
[350] At [21].
[351] *Re: An exemption from restrictions on making public details of the death of Kevin Douglas Maulder and Patricia Anne Maulder* CSU-2017-HAS-8 and CSU-2017-HAS-9, 17 January 2017 and *Re: An exemption from restrictions on making public details of the deaths of Timothy Kerr Hamilton and Tanya Grace Ellwood* CSU-2018-AUK-259 and CSU-2018-AUK-260, 31 January 2019.
[352] Coroners Act, s 63(d).

E Timeliness

As mentioned in Chapter Two, the Law Commission considered that timeliness was essential for s 71A exemptions, which is reflected in s 71A(2)(a) and (4) of the Coroners Act. The Office of the Chief Coroner provided the dates of the applications for exemption.[353] Table 3.3 sets out how long decisions under s 71A have taken.

Table 3.3: Time taken for s 71A Exemptions	
Working days for decisions	**Number of decisions**
0 (same day)	3
1 day	2
2 days	4
3 days	1
4 days	3
5 days	1
6 days	1
34 days	1
Total	16

Edgeler was concerned that the exemption regime in s 71A was unworkable due to the potential for delay. Table 3.2 shows that, in practice, delay has not proved to be an issue. Decisions on 14 applications were issued in five working days or less, with three decisions being issued on the same day as the application.

The one exception, which took 34 days, is discussed in detail as part of the case study for Sinan Saglam. However, as that application was made for the purposes of this thesis, rather than for journalistic reasons, timeliness could be considered less of an issue.

F Use of the Suicide and Media expert panel

As noted in Chapter Two,[354] the Panel was established by s 116A of the Coroners Act to advise the Chief Coroner. The Panel is made up of up to four members, appointed by the Director-General of Health, and must have expertise in:[355]

a) suicide prevention;
b) media;
c) tikanga Māori; and
d) Māori youth suicide.

[353] Data provided by email on 7 June 2024. The application date for one decision was not able to be provided.
[354] See pages 39–40.
[355] Coroners Act 2006, s 116A(3).

The Chief Coroner may consult with the Panel as a whole or may choose to consult a particular member. However, the Chief Coroner is not required to do so. As shown in Table 3.1, the Panel has been consulted on four occasions, twice in 2016, and once each in 2017 and 2023.

In a 2022 memorandum, the Ministry of Health noted the small number of consultations.[356] The only recent question had been an inquiry from the Office of the Chief Coroner about the panel itself in May 2022.[357] The memorandum noted that appointments to the panel were for three-year terms, but as the panel's membership had not been actively monitored in recent years, the terms of its members had expired.[358] At the time of my application for an exemption, the Panel members were being reappointed, which caused some small delay.[359]

The small number of consultations begs the question of whether the Panel serves a useful function, putting to one side the fact that disestablishing the Panel would require an amendment. Despite the small number of consultations, the Panel still has a useful function to play. As can be seen from the applications discussed, there are various reasons why it may be in the public interest to describe the method of death. As the applications are to be given priority, it seems practical to have ready access to expert knowledge, especially given the ongoing research into both the Werther and Papageno effects.

G Involvement of whānau and privacy

As noted in Chapter Two, consultation with the whānau of the deceased was featured in submissions from the New Zealand Law Society and MHF.[360] In practice, while not expressly required by s 71A of the Coroners Act, consultation with the whānau occurred in 14 out of 17 exemption applications. There is one example where an exemption was granted where the whānau has not responded,[361] and one exemption decision that was not provided to the deceased's whānau.[362]

Table 3.4 summarises the whānau's responses to the applications for exemption.

Table 3.4: Consultation with whānau

	Opposing views		**Supporting views**		**Not consulted**	**Granted**	**Declined**
	Impact of publication	9	Support reasons for the application	5	3	9	6
	Distress	2	Privacy	1			
	Privacy	3	Public interest	1			
	Harm to public	1					
Total		9		6			

As can be seen from the table above, most responses opposed the application being granted. All of the responses cited the effect that publication would have on the deceased's whānau. Two responses also

[356] Memorandum "Suicide and Media Expert Panel – Update and Process for New Appointments" (22 August 2022) at [3] and [13] (Obtained under Official Information Act 1982 request to the Ministry of Health).
[357] At [13].
[358] At [7]–[8].
[359] *Re: An exemption from restrictions on making public details of the death of Sinan Joschka Saglam*, above n 459 at [4].
[360] See pages 42–43.
[361] *Re: An inquiry into the death of Matu Tangi Matua Reid* CSU-2023-AUK-902, 28 July 2023.
[362] *Re: An inquiry into the death of Sinan Joschka Saglam* CSU-2016-CCH-551, 2 October 2017.

specifically noted that publication would cause the whānau distress, while three applications were concerned with the impact on their privacy. The effect of publication was also noted in one application where the deceased's whānau were not consulted.[363] One application was opposed on the basis that the risk to the public was greater than the applicant had made it out to be.[364] The Chief Coroner agreed and declined the application.

Of the responses supporting publication, five responses supported the exemption being grant for the reasons put forward by the applicant. As noted above the case study concerning Ms Marble's death, while the interested parties supported the application being granted, they also asked for privacy. Finally, one interested party put forward reasons why the application was in the public interest, as the deaths under investigation were believed to be a murder-suicide. However, the Chief Coroner did not consider that public speculation about the deaths in question met the statutory test and declined the application.

The Coroners Act requires the responsible coroner to consider the views of the deceased's whānau before directing a post-mortem investigation.[365] Similarly, under s 23 of the Coroners Act, the responsible coroner must give interested parties notice of "significant matters". However, a failure to do so does not affect the validity of the coroner's actions.[366] However, as s 23 only applies to the responsible coroner, it does not impose a statutory consultation requirement on the Chief Coroner.

Despite the above, it is arguable that natural justice requires that interested parties be consulted on any coroner's decisions that affect them, and a statutory requirement of consultation is unnecessary. Interested parties, particularly the whānau of the deceased, are directly affected by publication, as anyone the subject of media attention would be.

To date, there have been no reviews of any of the exemption decisions, whether under s 75 of the Coroners Act or by way of judicial review. However, the High Court has reviewed decisions on non-publication under s 74 and the scope of s 75. In *B v Coroners Court in Auckland*,[367] Davison J considered that the wording of s 75 was unambiguous and only applies to those affected by a refusal to grant a s 71A exemption or a s 74 non-publication order.[368] To widen the scope of s 75 to allow for a review of a decision not to grant a non-publication order would "require the court to read in words to the section which are not there".[369]

Justice Davison noted that the above effectively created two separate processes for reviews, either a review under s 75 or a judicial review.[370] This was not considered problematic as the High Court has treated reviews under s 75 as if they were judicial reviews in any event, albeit with different remedies. The reasoning in *B* would apply with equal force to a decision granting an exemption under s 71A. As a judicial review, the High Court would need to "be satisfied that there was an error of law, that the

[363] This decision cannot be cited due to non-publication orders.
[364] This decision cannot be cited due to non-publication orders.
[365] Coroners Act 2006, ss 33–35. Consultation is not required should a coroner direct an immediate post-mortem, see s 37.
[366] Section 23(2).
[367] *B v Coroners Court at Auckland* [2020] NZHC 2278.
[368] At [49]–[50].
[369] At [49].
[370] At [50]–[51] citing *Matenga v Coroner's Court at Dunedin* [2014] NZHC 2994 and *Fardell v Coroner's Court at North Shore* [2007] NZAR 122 (HC).

Coroner took into account irrelevant considerations, failed to take account of relevant considerations, or reached an unreasonable decision".[371]

However, the statutory test only requires the Chief Coroner to be satisfied that the harm of reporting is outweighed by the public interest in making the method of death, or whether a death is a suicide, public. For a judicial review to succeed, the affected party would need to show that the Chief Coroner did not consider a particular risk of harm. This could be, for example, evidence that the deceased's whānau is at a particular risk of self-harm or suicide.

II Criminal offence

A Generally

As noted in Chapter Two,[372] it is an offence, under s 139 of the Coroners Act, to publish any information in contravention of s 71(2). Section 71(2) states that "No person may, unless the person is granted an exemption under section 71A or has permission under section 72" make public the method of death, a particular that suggests the method of death, or describe the death as a suicide.[373].

As set out in s 73 of the Coroners Act, "make public" means to publish by means of:

a) broadcasting (within the meaning of the Broadcasting Act 1989); or
b) a newspaper (within the meaning of the Defamation Act 1992); or
c) a book, journal, magazine, newsletter, or other similar document; or
d) a sound or visual recording; or
e) an Internet site that is generally accessible to the public, or some other similar electronic means.

On conviction, a person is liable for a fine of up to $5,000, and a body corporate is liable for a fine of up to $20,000. As noted in Chapter Two,[374] the Third RIS considered that one of the issues with s 139 was that a lack of awareness of the statutory prohibitions could lead to a lack of compliance by the public on social media.

My view is that the scope of s 71 remains unclear. A strict interpretation of s 71(2) means that the exemptions granted under s 71A apply only to the applicant. The language in s 71(2) states that a person may not publish the prohibited information "unless the person is granted an exemption under section 71A". Section 71A(1) states a "person may apply to the chief coroner for an exemption from the restrictions" in s 71(2). This can be contrasted with the phrase "has permission under section 72". Section 72 gives permission to make public the details of self-inflicted deaths in IPCA reports. In particular, s 72(c) permits "the making public by a person of a particular of the death".

When read together, a strict interpretation would be that the "person" referred to in s 71(2) is the same "person" referred to in s 71A(1). However, as the definition of person includes legal persons,[375] journalists' applications could be considered to be on their organisation's behalf. The consequence of

[371] At [61].
[372] See pages 40–42.
[373] A death can however be described as a "suspected suicide".
[374] See pages 41–42 and Ministry of Justice, above n 312, at 8.
[375] See the definition of "person" in the Legislation Act 2019, s 13.

this interpretation is that any publishing by media organisations not covered by the exemption would be unlawful.

To date, there have been no prosecutions under s 139.[376] Except for Crime Scene Cleaners' Facebook page and Max Key's podcast, which are discussed below, the Police have been unable to provide any other examples of complaints or investigations regarding potential breaches of ss 71 or 139 of the Coroners Act.[377] This may be because there have simply never been any other complaints that the s 71 restrictions have been breached, or that due to the variety of ways people may make such complaints, it is difficult to find such complaints.

The lack of prosecutions may also be due to difficulty meeting the required standards of the Solicitor General's Prosecution Guidelines (the Guidelines).[378] The Guidelines set out a two-stage test, an evidential test and a public interest test.

The evidential test means that there is enough evidence to identify and convict the person who committed the offence.[379] For a prosecution under s 139 to satisfy this test, there must be sufficient evidence to show that the elements of s 71(1) and (2) are met, namely:

a) the death occurred in New Zealand;
b) the death is, or reasonably suspected to be, self-inflicted;
c) publishing, as defined in s 73, has occurred; and
d) publishing that information is prohibited by s 71(2).

Should the evidential test be met, the public interest test requires consideration of whether a prosecution is in the public interest.[380] The Guidelines set out several factors that may be relevant to the decision of whether to prosecute. For a prosecution under s 139, the following factors may be relevant:

a) the seriousness of the offence;
b) whether there is any risk of the offence being repeated;
c) the risk of harm created by the offence;
d) the offence is an abuse of a position of authority or trust; and
e) whether the Court will impose a minimal penalty.

While it can be argued that once the information about the method of death is lawfully in the public domain, publication would be seen as merely a technical breach of s 71(2) and prosecution would not meet the public interest test. However, those without an exemption would still be unnecessarily criminalised.

The Law Commission recommended that the provisions in s 71(2) would set out that unless "the Chief Coroner has granted an exemption, no person may directly or indirectly make public the method

[376] Ministry of Justice response to Official Information Act 1982 request (30 September 2022).
[377] Police responses to Official Information Act 1982 requests (22 October 2022) and (10 March 2023).
[378] Crown Law "Solicitor-General's Prosecution Guidelines" (1 July 2013) <www.crownlaw.govt.nz>.
[379] At [5.3]–[5.5].
[380] At [5.5]–[5.11].

of death".[381] Had the Coroners Amendment Act been drafted this way, the unnecessary criminalisation discussed above would be avoided.

B Crime Scene Cleaners

On 8 February 2022,[382] Radio New Zealand reported that Crime Scene Cleaners (CSC), a specialist cleaning company, had been posting graphic photos on their social media pages, Facebook and Instagram. While specific dates for the images were not given, they had been posted since April 2020. The images included the aftermath of suspected suicides and self-harm.

The CEO of CSC, Carl Loader, apologised later that day.[383] CSC also took down its Facebook and Instagram accounts. Mr Loader claimed that CSC was "raising awareness of some important social issues" but conceded that he "should have kept a closer eye on the content that was being shared".

On 11 February 2022, the Deputy Chief Coroner asked Police to investigate whether CSC had breached the Coroners Act.[384]

In their response to my Official Information Act request regarding Crime Scene Cleaners,[385] Police described the request to investigate a potential breach of s 71 as a "generic review based on a media report and social media posts and not a direct referral or complaint". Despite the investigation specifically considering whether s 71 of the Coroners Act has been breached, this response highlights the difficulty in researching the frequency of such complaints.

As part of their investigation, Police interviewed Mr Loader, who was described as a "colourful character".[386] While taking responsibility, he was also described as unaware of the law. Police also noted that Mr Loader minimised "the potential effect" of posting the images.[387] However, this is not elaborated on in any detail.

Four images were identified as being from suspected suicides, with two captions directly mentioning the method of death.[388] The images did not show any deceased people or identify the location. However, for some of the images, Mr Loader was able to identify the source of the image.[389]

While recognising that these images were taken during the normal course of CSC's business, the Police described the photos as "repugnant" and would "invoke disgust in many members of the public because of their very nature".[390]

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[381] Law Commission, above n 168, at 39.
[382] Sam Olley "Cleaners post crime, suspected and attempted suicide scene photos on social media" *Radio New Zealand* (online ed, 8 February 2022).
[383] Sam Olley "Trauma cleaning business apologises for graphic social media posts" *Radio New Zealand* (online ed, 9 February 2022).
[384] This also included considering whether s 74 of the Coroners Act had been breached. While such orders are not the subject of the thesis, I note that s 74 applies to evidence given in an inquiry, or the identity of a witness, neither of which would apply to images taken by CSC.
[385] Police response to Official Information Act 1982 request (10 March 2023).
[386] Police response to Official Information Act 1982 request (10 March 2023) at 8. The interview with Mr Loader was withheld on privacy grounds.
[387] At 8.
[388] At 5–6.
[389] At 6.
[390] At 7.

Police noted that no one had come forward to complain about the four suspected suicide images, no victims had been identified, and the images had been immediately removed from Facebook and Instagram.[391] The comments on the four images were "short and very generic".

The Police considered that the images technically breached the restriction in s 71(2)(a) and (c) of the Coroners Act.[392] CSC would have known that when being hired to clean a property, the scene was a suspected suicide. However, in their view:[393]

> a coronial process would have determined suicide as the cause and a certificate issued. Without the ability to easily identify the victim and check the Coroner *had* completed a certificate of findings, it is logical to assume that would have or was going to, occur in due course.

Regarding the two captions describing the method of death, the Police considered that the methods of death that were described were common knowledge. As such the breach of s 71 was not considered "significant enough to warrant a prosecution in this case" and would not meet the Public Interest test. In reaching this view, the Police also considered Mr Loader's cooperation and implementing new processes would avoid further breaches.[394]

Following the completion of an investigation by the Deputy Privacy Commission, the outcome of the Police investigation was reported in December 2022.[395] The articles included comments by a victims' advocate, who criticised the Police's decision not to attempt to speak with potential victims. The article also noted that the Police did not investigate possible charges under the Crimes Act.

In my view, it would have been illogical for the Police to expect anyone affected by CSC's actions to come forward. The images were quickly taken down following Radio New Zealand's reports, making it impossible for people to discover whether pictures that relate to a loved one's death were published online. Moreover, as discussed above, the offence is that of publishing prohibited information. The Police must ascertain whether the death in question is a suspected suicide that occurred in New Zealand, and that a publishing has occurred. In other words, the offence is breaching a statutory prohibition, rather than an offence against a specific person.

The Police considered that CSC "technically" breached the Coroners Act, or in other words, the Evidential Test was met. That is, CSC published photos on an internet site generally accessible to the public, and these photos included a description of four deaths as suicides and the method of death for two suspected suicides.

However, it was the Police's view that the Public Interest test was not met. They considered that a coroner would have ultimately decided that the deaths in question were suicides.[396] While this was not elaborated on, it may be that the Police considered that this made the breach of s 71(2)(c) less serious.

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[391] At 6 and 8.
[392] At 7.
[393] At 7.
[394] At 9.
[395] Sam Olley "Crime Scene Cleaners broke the law - but dodged prosecution - with 'morally repugnant' social media posts" *Radio New Zealand* (online ed, 23 December 2022) and Sam Olley "Crime Scene Cleaners broke the law but no prosecution" *New Zealand Herald* (online ed, 23 December 2022).
[396] Meaning that the deaths could be called suicides, rather than suspected suicides.

However, that argument would render breaches of s 71(2)(c) essentially meaningless. It would become a complete defence to describe a death as a suicide before a coroner has released their findings to say, "That was going to be the outcome anyway".

The rarity, or lack thereof, of the method of death, is not relevant to the Public Interest test. The restrictions in s 71 make no distinction between common or rare methods of death. As discussed in Chapter Two, the harm of reporting the method of death is not just from a novel or easily replicated method. Reporting the method of death increases the cognitive availability of that method.

Finally, CSC's ignorance of the law is not an answer to any offence.[397] It may be that the above considerations, along with the corrective actions taken by CSC to avoid further offending,[398] may have led the Police to form the view that the Courts would only impose a minimal fine. However, if that is correct, the Police do not appear to have considered the length of time the photos were online, the number of people who had viewed or shared the images, or the conduct's repeated nature over several years. Such considerations would be relevant to considering whether a minimal fine would be imposed.

C Key'd Up podcast

The decision not to prosecute CSC can be contrasted with a similar decision made concerning Max Key's podcast, "Key'd Up".[399] In an episode of the podcast, published on 21 May 2023, Mr Key interviewed a journalist, Dom Harvey. During the interview, the pair discussed men's mental health, and Mr Harvey mentioned the suicide of a friend and detailed the method of death.

The podcast attracted media attention and was reported to the Police.[400] By 30 May, the podcast was taken down. When spoken to by Police, Mr Key told them he was unaware of the Coroners Act's reporting restrictions, and that he had taken steps to "educate himself" and removed the podcast. Given that the podcast was no longer available, the Police considered that "a prevention conversation was all that needs to take place regarding this matter".[401]

As the podcast named the deceased, their whānau were identifiable.[402] However, they were unaware of the podcast until after it had been taken down. In comments to the media, although the whānau supported discussing men's mental health, they considered describing the method of death as a "step too far".

While the podcast breached s 71(2), the breach can be distinguished from CSC as it was comparatively short-lived. The episode of the podcast was up for no more than 9 days before being taken down once Mr Key was made aware of the law. The breach could be seen as inadvertent, as it occurred during an unscripted interview. Finally, the breach occurred in the context of a discussion on

[397] Crimes Act 1961, s 25.
[398] Itself a factor arguing against prosecution.
[399] Caroline Williams and Simon Plumb "No police charges for Max Key over podcast which broke suicide law, 'educational discussion' had instead" *Stuff* (online ed, 30 May 2023).
[400] Police response to Official Information Act 1982 request (4 July 2023).
[401] At 2.
[402] The articles do not identify the deceased's whānau.

men's mental health, and while it is unclear what relevance the method of death would have, it is arguable that some public interest was being met and that an exemption may have been granted.

However, a breach of the Coroners Act by a podcast could be seen as more serious than a company's social media site. Podcasts are a form of journalism,[403] although some podcasts would more precisely be considered amateur journalism. It would be expected that a journalist is aware of their legal obligations concerning statutory suppression or non-publication orders.[404]

In comparison to the podcast, CSC's breaches of s 71(2) were repeated and occurred over two years. The act of taking and publishing photographs could be seen as more deliberate. Given the nature of the images and posts, it would be difficult to argue that there is a public interest in publishing the images.

However, what is absent from either of the Police's decisions is an analysis of the reach of CSC's Facebook page or the Key'd Up podcast. How many times the images were viewed or how many people listened to the podcast is not mentioned. Without such information, the potential for harm, which is relevant to the Public Interest Test, cannot be evaluated. Ultimately, both cases illustrate the Regulatory Impact Statement's comments about the difficulties arising with social media.

III Case studies

The deaths of Zdenek Hanzlik, Hannah Marble, and Sinan Saglam are discussed below. The methods of their deaths are mentioned. I have been granted s 71A exemptions in respect of the method of their deaths. The exemption for Mr Saglam's death was granted in 2023 and has been included in the statistics above. However, the exemptions for Mr Hanzlik and Ms Marble were granted in 2024,[405] and have not been included. The exemptions are limited to this thesis only and do not permit further publication of the methods of their deaths.

I selected the deaths of Mr Hanzlik and Mr Saglam as case studies because the applications argued that previous publication of the method of death justified an exemption. The two case studies differ in the fact that Mr Hanzlik's self-harm received considerable media attention prior to his death, while Mr Saglam's did not. Ms Marble's death was selected as a case study because it serves a good example of a self-inflicted death and illustrates both the need for exemptions to be granted after a coronial inquiry has been completed and the positive changes that can result from allowing publication.

A Method of death already in the public domain – Zdenek Hanzlik

a. Mr Hanzlik's death

[403] With respect to s 68(1) of the Evidence Act 2006, see *Slater v Blomfield* [2014] NZHC 2221, [2014] 3 NZLR 835 at [140], noting that the definition of "journalist" does "not impose quality requirements and does not require the dissemination of news to be in a particular format. The focus is on the medium disseminating new or recent information of public interest".
[404] I return to this point in Chapter Four, see page 77.
[405] *Re: An exemption from restrictions on making public details of the death of Zdenek Hanzlik* CSU-2017-WGN-377, 3 May 2024 and *Re: An exemption from restrictions on making public details of the death of [Hannah Marble]* CSU-2017-DUN-185, 3 May 2024.

In 2017, Zdenek Hanzlik's marriage to V ended.[406] As a result of Family Court orders, he was unable to see his children, which upset him greatly. Mr Hanzlik would occasionally travel to Wellington to protest outside Parliament about the treatment of fathers in the Family Court, typically holding placards.

On the afternoon of 21 September 2017, Mr Hanzlik was protesting outside Parliament, when witnesses observed him setting himself alight. Members of the public intervened and contacted emergency services. Mr Hanzlik was subsequently taken to the hospital, where he died the next day. Given the time and location, Mr Hanzlik's actions were observed by many people and widely reported.

Coroner Ryan completed his findings into Mr Hanzlik's death on 28 March 2019.[407] In determining that Mr Hanzlik's death was a suicide, the Coroner noted Mr Hanzlik's views that he had been "murdered" by the legal system,[408] and that he was distressed over the lack of access to his children.[409] The Coroner found that Mr Hanzlik would have known that his actions were likely to be fatal and, as such, had intentionally and deliberately caused his death.[410]

b. The applications for exemption

Mr Hanzlik's death was the subject of two s 71A applications. The first, granted on 22 September 2017, was from a lawyer for publication on a blog,[411] who argued that the method of Mr Hanzlik's death had already been publicised by the Police, the MHF and in news reports.[412] Mr Hanzlik's death was described as being of public interest, and there was "no risk that the additional publicity may add appreciably to any risk of suicide contagion".[413] Mr Hanzlik's former partner,[414] was consulted. She opposed the application as media coverage could cause adverse effects on her children.

In granting the application, the Chief Coroner noted that Mr Hanzlik's death was witnessed by members of the public and had received media attention. The articles included the method and location of his death, and the presence of placards.[415]

The second application was from a journalist for Fairfax Media and was partially granted on 28 November 2017. The application sought to make public the method of death and a description of the death as a suicide.[416]

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[406] V's identity was subject to interim non-publication orders, see *Stuff v Coroner's Court at New Plymouth* [2018] NZHC 2556, [2019] 3 NZLR 243. On 9 May 2019, those orders were made permanent by Coroner Ryan. I have used the same identifier as the High Court and the Coroners Court.
[407] *Re: An inquiry into the death of Zdenek Hanzlik* CSU-2017-WGN-377, 28 March 2019.
[408] At [30] and [36](a).
[409] At [26], [33], and [36](b).
[410] At [36](c)–(d) and [37].
[411] Although the blog remains online and searchable, no articles mention Mr Hanzlik.
[412] *Re: an exemption from restrictions on making public details of the death of Zdenek Hanzlik* CSU-2017-WGN-377, 22 September 2017 at [5](b) and (c).
[413] At [5](d).
[414] At [6].
[415] At [15].
[416] *Re: An exemption from restrictions on making public details of the death of Zdenek Hanzlik* CSU-2017-WGN-377, 28 November 2017 at [4].

V was consulted and opposed the application on the same grounds as the first application.[417] V also opposed the application as she had been interviewed by the Applicant and had later withdrawn her consent for the information to be published. However, this information was considered to be "outside the boundaries" of s 71A.[418]

The Suicide and Media expert panel was consulted, noting that self-immolation was rare in New Zealand.[419] However, publishing novel methods of suicide can potentially increase the risk of similar suicides.[420] Doubt was expressed as to whether the method of death was relevant to the key message, Mr Hanzlik's struggles with the Family Court, and the possibility that people in similar situations may engage in self-immolation as a form of protest.[421]

The Chief Coroner granted the application in respect of the method of Mr Hanzlik's death, noting that this information had been the subject of considerable media reporting and was already in the public domain.[422]

However, permission was not granted to describe Mr Hanzlik's death as a suicide.[423] The Chief Coroner explained that while Mr Hanzlik's death may be self-inflicted, whether his death was intentionally inflicted needed to be established, and as the investigation into his death was in its early stages, it was not appropriate to describe the death as a suicide.

c. How Mr Hanzlik's death was reported

Table 3.5 sets out the articles published about Mr Hanzlik's death, as retrieved from the Newztext Plus database, as described at page 45 above.

Table 3.5: Articles about Mr Hanzlik's death	
Year	**Articles published**
2017 (prior to death)	20
2017 (following death)	24
2018	1
2019	6
Total	51

There have been 51 news articles about Mr Hanzlik's death. Twenty articles were published before Mr Hanzlik's death. As such, s 71 did not apply at the time, and the method and location of Mr Hanzlik's self-harm could be legally reported. Once Mr Hanzlik died, his death was reported to the coroner as it appeared to be self-inflicted and s 71 applied. At that point, reporting the method of his death became

[417] At [7]–[9]. However, V's claims of personal privacy were addressed in *Stuff v Coroner's Court at New Plymouth*, above n 3.
[418] At [9].
[419] At [21].
[420] At [18], citing Liu and others "Charcoal burning suicides in Hong Kong and urban Taiwan: an illustration of the impact of a novel suicide method on overall regional rates" Journal of Epidemiology and Community Health 61 (2007) 248.
[421] At [20]–[21].
[422] At [23] and [26].
[423] At [24]

unlawful. Regardless of the lawfulness of reporting Mr Hanzlik's method of self-harm, reporting detailed descriptions of the method and location of self-harm is not in keeping with suicide reporting guidelines at the time.[424]

While I discuss the Werther and Papageno effect in terms of freedom of expression in Chapter Four,[425] I do not agree that the ability to report self-harm, as occurred in this example, should be restricted. Survival of suicide attempts, depending on how it is reported, could very well engage the Papageno effect. Whereas reporting on those who have died by suicide, particularly reporting the method, is more likely to be associated with imitative suicide.

There were 24 articles published in 2017 following Mr Hanzlik's death. However, this reporting occurred before the second exemption to Fairfax Media was granted on 28 November 2017. The articles varied between short news briefs and more substantive articles. The substantive articles discussed the context surrounding his experiences with the Family Court and included interviews with Mr Hanzlik's friends. The articles continued to mention the method of his death. The lack of any exemption to a media organisation means that, on the interpretation of s 71(2) discussed earlier, that reporting was unlawful.

The only article published in 2018, was a press release by "Families 4 Justice" about an upcoming protest about the impact of the Family Court on families and the treatment of fathers. The press release quoted a member of the group who had been interviewed saying that Mr Hanzlik had "torched himself" outside parliament.[426] This article was not published by Fairfax Media.

Six articles were published in May 2019, following the release of the Coroner's findings. Two articles were short briefs noting the Coroner's findings.[427] The remaining articles were substantive and, by including detailed interviews with friends, focused on Mr Hanzlik as a person. In doing so the articles can be seen as consistent with reporting guidelines, as they avoided oversimplifying the reasons for Mr Hanzlik's actions or glamorising Mr Hanzlik's actions. Only three of the 2019 articles were published by Fairfax Media.

B Reporting a coroner's recommendations – Hannah Marble

a. Ms Marble's death

On 9 June 2017, Hannah Marble contacted her former partner while she was quite upset.[428] She told him she had taken a large amount of paracetamol. He later told Police that it was not uncommon for Ms Marble to make such calls. Ms Marble's flatmates checked on her, but she did not appear unwell. Over the following days, Ms Marble behaved normally.[429]

[424] Media Roundtable, above n 214, at 5.
[425] At page 69-70.
[426] Families 4 Justice "Black Friday continues for NZ Law Society" *Scoop* (online ed, 18 April 2018) <scoop.co.nz>.
[427] "Coroner rules death of man outside Parliament a suicide" *Radio New Zealand Newswire* (online ed, New Zealand, 7 May 2019) and "Protest over 'injustices'" *The Dominion Post* (online ed, 8 May 2019) at 10.
[428] *Re: An inquiry into the death of [Hannah Marble]* CSU-2017-DUN-185, 30 July 2020 at [31].
[429] At [32]–[34].

A similar conversation occurred on 17 June 2017,[430] and Ms Marble was encouraged to alert her flatmates. One of Ms Marble's flatmates later told Police that although she appeared unwell on the evening of 17 June, Ms Marble appeared well the following morning.[431]

However, from 19 June 2017 onward, Ms Marble became progressively unwell and was often vomiting.[432] On 20 June, Ms Marble's parents, who were aware of Ms Marble's ill health and had become concerned, contacted her flatmates and asked them to check on her.

Ms Marble was found unresponsive in her bed and was quickly taken to hospital. However, despite medical intervention, Ms Marble passed away on 21 June 2017.[433] Based on the medical evidence, the Coroner determined that the cause of Ms Marble's death was massive hepatic necrosis, presenting as acute liver failure secondary to a paracetamol overdose.[434]

Although the Coroner found that Ms Marble had "deliberately taken an excess quantity of paracetamol", he was not prepared to find that she had done so intending to die.[435] The Coroner noted that Ms Marble had other means of inflicting her death and was future-focused in the days before her death.[436]

In deciding to make recommendations about the availability of paracetamol, the Coroner outlined the risks of a paracetamol overdose.[437] Paracetamol, which is available without a prescription, is safe when taken as recommended. However, as paracetamol is metabolised in the liver, some of it is converted into a toxic compound.

Following a normal dose, the liver ultimately detoxifies this compound. However, when paracetamol is taken to excess, the liver is unable to cope with the toxic compound and is damaged as a result.

The symptoms of an overdose of paracetamol are not readily apparent. As the Coroner noted, this may lull a person into a "false sense of security".[438] However, between 12 and 24 hours later, symptoms resulting from liver failure, such as abdominal pain and nausea develop. Although there is an antidote to a paracetamol overdose, the antidote is ineffective by the time symptoms appear, as liver damage has already occurred.

The Coroner considered New Zealand research that paracetamol overdoses accounted for 23 per cent of overdoses treated at the Wellington Hospital Emergency Department.[439] The United Kingdom had, via regulations, limited the maximum size of paracetamol packs, with research showing a 43 per cent reduction in paracetamol-related deaths in England and Wales.[440]

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[430] At [37]–[40].
[431] At [46].
[432] At [50]–[52].
[433] At [53]–[54]
[434] At [126].
[435] At [76]–[84].
[436] At [55]–[56] and [82].
[437] At [95]–[100].
[438] At [98].
[439] At [102], citing Nadia Freeman and Paul Quigley "Care vs convenience: Examining paracetamol overdose in New Zealand and harm reduction strategies through sale and supply" (2015) 128 NZMJ 28.
[440] At [105], citing Keith Hawton and others "Long term effect of reduced pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales: interrupted time series analyses" (2013) 346 BMJ f403.

Coroner Robinson made recommendations to the Chair of the Medicines Classification Committee (the Chair) and the Food and Grocery Council regarding restricting the availability of paracetamol without a prescription.[441] The Chair responded to the Coroner's recommendations, stating that they were unaware of any new evidence that would cause them to reconsider the current availability of paracetamol. However, the Chair supported the recommendation to the Food and Grocery Council.

b. The application for exemption

An application to report the method of Ms Marble's death was granted on 1 September 2020.[442] The applicant, a journalist for The Press, part of Fairfax Media, argued that the media could not report the Coroner's recommendations without reporting the method of death.[443] Moreover, the applicant argued that the public also needed to be aware of the dangers of paracetamol overdose.

The Chief Coroner consulted with Ms Marble's father and her former partner. While they supported the application, they also requested that Ms Marble's name, and that of her acquaintances, be kept private. The Chief Coroner noted that this was outside the scope of the application but would forward the request to the applicant.[444]

In granting the application, the Chief Coroner considered the "public health message that prompted Coroner Robinson's recommendations and the fact he considered her death accidental".[445] In addition, the Chief Coroner stated that given the need to seek immediate medical attention, it was in the public interest to report the dangers of paracetamol poisoning.[446]

c. How Ms Marble's death was reported

Table 3.6 sets out the articles published about Ms Marble's death, as retrieved from the Newztext Plus database, as described at page 45 above. The column of titled "Unlawful articles" refers to articles published by people who did not have a s 71A exemption.

Table 3.6: Articles about Ms Marble's death			
Year	**Articles published**	**Lawful articles**	**Unlawful articles**
4–11 September 2020	28	22	7
12 September – 31 December 2020	2		2
2022	1	1	
Total	31	23	9

There have been 31 articles that directly refer to Ms Marble's death, 28 of which were published between 5 September and 11 September 2020. Two articles were published in October and December

[441] At [120]–[125]. Note the Food and Grocery Council did not respond to the Coroner's recommendations.
[442] *Re: An exemption from restrictions on making public details of the death of [Hannah Marble]* CSU-2017-DUN-185, 1 September 2020.
[443] At [5].
[444] At [16]–[17].
[445] At [19].
[446] At [20].

2020 in a specialist pharmacology publication. The final article was published in 2022, in the context of a report about a similar death overseas. In terms of lawful reporting, 23 articles were published by Fairfax Media.

While the initial articles, published on 5 and 6 September, discuss the circumstances of her death,[447] the primary focus was on the risks of paracetamol overdoses and the Coroner's recommendations. The articles mentioned the Medicine Classification Committee's rejection of the recommendations and the Food and Grocery Council's view that purchasing limits would not have prevented Ms Marble's death.

However, on 8 September, it was reported that the Medicine Classification Committee and Medsafe would discuss limiting the total paracetamol in a packet in response to the Coroner's recommendations.[448] On 11 September, Countdown announced that it would limit sales of paracetamol to one packet per customer.[449]

The Medicines Classification Committee considered the Coroner's recommendation at their meeting on 27 October 2020. While the Committee did recommend that paracetamol be reclassified, they requested that Medsafe "further consider options for addressing both the issues raised by the coroner and broader issues relating to both single active ingredient paracetamol and combination products".

The reporting of Ms Marble's death and Coroner Robinson's recommendations are notable for two reasons. First, they serve as an example of the impact of publicity on organisations implementing a coroner's recommendations. The second reason is that it shows there is a need to consider applications for an exemption after a finding is completed.

C Method of death already in the public domain – Sinan Saglam

a. Mr Saglam's death and how it was reported

In August 2016, Sinan Saglam was living in the Marlborough region. He was from Germany and travelling around New Zealand on a working holiday. In the early hours of 4 August 2016, he sent an email to his family, which was described as a suicide note.[450] In the late afternoon, Mr Saglam was seen by multiple people taking his own life. The Coroner determined that his death was suicide.[451]

Unlike the above examples, Mr Saglam's death was not widely reported, appearing in two articles around the time the death occurred. More importantly, both articles contain the method of death, the location in which it happened, and, when they were published, no exemptions had been granted.[452]

b. The applications for exemption

[447] For example, see Sam Sherwood "Coroner wants cap on paracetamol sales in supermarkets after student's fatal overdose" *Stuff* (online ed, New Zealand, 5 September 2019).
[448] Sam Sherwood "Health officials to discuss Panadol restrictions after student's death" *Stuff* (online ed, New Zealand, 8 September 2019). Ultimately this did not result in any changes.
[449] Sam Sherwood "Coroner wants cap on paracetamol sales in supermarkets after student's fatal overdose" *Stuff* (online ed, New Zealand, 11 September 2019).
[450] *Re: An inquiry into the death of Sinan Joschka Saglam* CSU-2016-CCH-551, 2 October 2017 at [20].
[451] At [39].
[452] At the time of writing, both articles remain online.

As with Mr Hanzlik's death, Mr Saglam's death has also been the subject of two s 71A applications. The first application argued that it was necessary to report the method and location of Mr Saglam's death in connection with an article about a proposal to improve public safety.[453] The application also stated that the location of the death had previously been published and that the method of death was obvious from the location.[454] The decision does not cite the previous articles, and from the description, it is possible they were not provided.

The Chief Coroner did not consult with Mr Saglam's family. The application was declined as there was no link between the method of death and the reason for the application, as Mr Saglam's death was deliberate rather than accidental.[455] Moreover, the articles about Mr Saglam's death had been published 18 months before the application.[456] In such circumstances, the Chief Coroner considered that people would be freshly exposed to the details of the death and that granting the application would "present an undue risk that people would copy the behaviour of Mr Saglam".[457]

The second application was made by me for the purposes of this case study. While researching articles relating to the Mr Saglam's death, I found the articles referred to in the first exemption application. While the articles could be found on the Newztext database, they could also be found on the publisher's website and via a Google search. As both the titles and content of the articles reference the location and method of Mr Saglam's death and citing them would breach s 71(2) of the Coroners Act,[458] I applied for a s 71A exemption. The application sought to describe the method of death or details suggesting the method and supplied the articles in question. I argued that the risk that others would copy Mr Saglam's behaviour is limited by the narrower audience academic writing would have over news media and that publication was in the public interest due to the lack of research into this topic and its potential uses in informing future law reform.[459]

On 7 July 2023, the Chief Coroner partially granted the application. The immediate whānau were consulted, who supported the application. The Chief Coroner also consulted the Panel, who were split on whether the application should be granted, given the purpose of the application was to further research.[460] However, the Panel also pointed out that while the potential audience may be smaller, this does not insulate those people from risk or vulnerability.[461]

The Panel noted that *all* publicly available information can contribute to the risk of suicide contagion, particularly for uncommon methods of death.[462] The publication of the location of Mr Saglam's death, which would also suggest the method, was considered to carry the most risk.[463]

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[453] *Re: An exemption from restrictions on making public details of the death of Sinan Joschka Saglam* CSU-2016-CCH-551, 28 February 2018 at [5](d) and (e).
[454] At [5](a)–(d).
[455] At [15].
[456] At [16]. Mr Saglam died in August 2016 and the application was in February 2018.
[457] At [5](a) and (b) and [16]–[17].
[458] Publishing in the sense of being on a publicly available internet site, as set out in s 73(e) of the Coroners Act.
[459] *Re: An exemption from restrictions on making public details of the death of Sinan Joschka Saglam* CSU-2016-CCH-551, 7 July 2023.
[460] At [20](a).
[461] At [20](c).
[462] At [20](b).
[463] At [20](d).

The Chief Coroner granted the application in respect of the method of death but agreed with the panel and declined the application in respect of the location.[464] The decision applies only in respect of this thesis, which reflects the law as discussed below. A consequence of the decision is that the articles cannot be cited. Even if they were taken down, their titles convey the location and method of Mr Saglam's death.

IV Conclusion

In examining the s 71A exemptions, this chapter has shown that generally, most applications sought to publish the method of death. Most of those applications were granted and were made while the inquiry into the death was ongoing. In contrast, six out of seven applications to describe a death as a suicide were declined.

The reasons for exemption applications were varied but fell into three broad categories. Where the method of death was already in the public domain, six out of seven applications were granted. The sole exception was the first application to publish the method of Mr Saglam's death. Similarly, applications that sought to bring attention to a broader issue, such as the Werther effect from fiction or euthanasia, were all granted. However, applications for what could be termed "newsworthiness" were all declined, as the applications did not meet the public interest test in s 71A(3)(b).

The Law Commission's view that applications for exemptions would be rare was borne out, with between one and four applications per year. Applications were decided in a timely manner, with 14 out of 16 applications decided in five or fewer working days. However, the Panel was rarely consulted, with four consultations between 2016 and 2023.

With respect to the criminal offence set out in s 139 of the Coroners Act, I argued that s 71 applies to the applicant, rather than the public at large. This has the effect of unnecessary criminalisation in situations where one particular media outlet has an exemption, and another does not. If s 71 had been drafted in a similar manner to the Law Commission's recommendation, then this would not be the case.

I also discussed how Police approached complaints about Crime Scene Cleaners Facebook posts and Max Key's podcast, both of which received media attention. I noticed that there was no consideration of the spread of publication. Rather, the approach of the Police was to ensure that the material was taken down. As both cases involve social media and amateur journalism, they illustrate the difficulties of enforcing s 71.

Finally, I examined the deaths of Mr Hanzlik, Ms Marble, and Mr Saglam, and the applications to report the method of their deaths. Mr Hanzlik's death was notable as there was a large spread of articles over multiple years, with a mixture of both lawful and unlawful publishing. It also illustrated the need for multiple exemptions.

Mr Saglam's death was discussed as a contrast to that of Mr Hanzlik. It is an example of pre-existing unlawful publication, which does not, in and of itself, make publication a matter of public interest.

Ms Marble's death was examined as it served as an example of a self-inflicted death, rather than a suicide. It also illustrated the use of the exemption regime to bring attention to a coroner's

[464] At [22] and [23].

recommendations, the beneficial changes that can be brought about as a result, and the need for the exemptions to be considered once a coronial inquiry is complete.

Chapter Four: Freedom of expression

Chapter Two discussed the harm of suicide reporting and the reforms to ss 71 and 71A of the Coroners Act, while Chapter Three discussed how those reforms have worked in practice. This chapter examines whether the restrictions and exemption regime in ss 71 and 71A are a justified exception to freedom of expression, taking into account Chapters Two and Three.

I also discuss whether the current exemption regime balances the goal of reducing imitative suicide with freedom of expression. As part of that discussion, I examine the extent that s 71 prevents public attention from being drawn to coroners' recommendations, the scope of s 71A exemptions, and whether the criminal offence is properly formulated. Finally, I consider what amendments to the Coroners Act would be required to make ss 71 and 71A less restrictive on freedom of expression.

I Freedom of expression

Section 14 of the New Zealand Bill of Rights Act 1990, which affirms New Zealand's commitment to the International Covenant on Civil and Political Rights (ICCPR), states that everyone "has the right to freedom of expression, including the freedom to seek, receive, and impart information and opinions of any kind in any form". However, as noted by the Law Commission, this right is not absolute, a point accepted by the Media Freedom Committee in their submissions to the Select Committee.[465] As noted in the ICCPR, International Covenant on Civil and Political Rights, freedom of expression can be limited to protect "national security or of public order (ordre public), or of public health or morals".[466]

The law impacts freedom of expression in several ways. For example, official information may be withheld to protect the privacy of natural persons,[467] or the law of defamation being used to protect a person's reputation from untrue public statements. Freedom of expression can also be limited to protect a person's right to a fair trial.[468]

Harm to the public can justify limitations to freedom of expression. The Films, Videos, and Publications Classification Act allows the Chief Censor to classify works as objectionable that, for example, promote terrorism, acts of torture, or sexual exploitation of children.[469] Possession of material classified as objectionable is an offence, although an exemption from the Chief Censor can be obtained.[470] Likewise, advertising and display of tobacco products is prohibited, with some exceptions, by the Smokefree Environments and Regulated Products Act 1990.[471]

The law also limits freedom of expression through the use of automatic suppression or non-publication. In the criminal jurisdiction, victims of sexual offending are automatically granted name suppression, as are child victims or witnesses.[472] Children and vulnerable people are afforded similar

[465] Media Freedom Committee, above n 259, at 2.
[466] International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 19(3)(b).
[467] Official Information Act 1982, s 9(2)(a).
[468] See for example Criminal Procedure Act 2011, s 200(2)(d) and 205(2)(d).
[469] Films, Videos, and Publications Act 1993, s 3.
[470] Sections 44–46.
[471] Smokefree Environments and Regulated Products Act 1990, part 2.
[472] Criminal Procedure Act, ss 201, 203, and 204.

protection under the Family Court Act and Oranga Tamariki Act.[473] All of these acts allow for publication with the leave of the court.

When viewed in the context of the automatic suppression above, s 71 of the Coroners Act is not particularly unusual as it simply represents the default position of non-publication, with an exemption regime set out in s 71A and automatic permission to publish granted by s 72. However, this does not necessarily mean that s 71 is a justified limitation on freedom of expression.

In reaching the view that s 71 was a justified limitation on freedom of expression, the Law Commission considered the 2001 edition of the Legislation Design and Advisory Committee's guidelines.[474] These guidelines set out a two-stage inquiry into whether the limit has a significant and important objective and whether the proposed limit is rational and proportional.

In considering whether s 71 is a justified limitation on the right to freedom of expression, I have considered the 2021 edition of the Legislation Design and Advisory Committee's guidelines.[475] The two-stage inquiry articulated in these guidelines is slightly different to the 2001 guidelines. The inquiry asks whether the purpose of the proposed limitation is sufficiently important to justify such a limitation, and if so whether the proposed limitation is connected to the purpose of the limitation, limits the right no more than is necessary, and is proportionate to the importance of the objective. I turn to these questions below.

A Purpose of limiting the reporting of self-inflicted death

The policy justification for the restriction is the public health concern about the impact that reporting the method of death of a suicide can have on a vulnerable person. The Supreme Court has held that in certain situations, identifiable health and safety concerns can justify a restriction of freedom of expression.[476] As discussed in Chapter Two,[477] the Law Commission considered that the evidence for the harm of reporting the method of death justified legislative restriction.

The research into the Werther and Papageno effects is clear that it is the nature and manner of suicide reporting that can have a positive or negative effect on a vulnerable person. Recent research continues to provide evidence that the Werther effect, in particular reporting the method of death, can be harmful. Reporting that engages the Papageno effect, or "mastery of crisis" reporting, would rarely, if ever, require publication of the method of death.

The reasoning for the policy of prohibiting describing a death as suicide is different. As noted, the Law Commission considered that such a publication harms the integrity of the coronial process. Edgeler was particularly critical of this view, noting that no other type of death, such as motor vehicle

[473] Family Court Act 1980, s 11B and Oranga Tamariki Act 1989, s 438.
[474] Law Commission, above n 168, at 47; Legislation Advisory Committee "Legislation Advisory Committee Guidelines: Guidelines on Process and Content of Legislation 2001 edition and amendments" (May 2001) Ministry of Justice at [4.4.1].
[475] Legislation Design and Advisory Committee "Legislation Guidelines" (September 2021) <www.ldac.org.nz> at [6.1].
[476] *Moncrief-Spittle v Regional Facilities Auckland Ltd* [2022] NZSC 138, [2022] 1 NZLR 459 at [101]–[102]. See also *Make It 16 Inc v Attorney-General* [2022] NZSC 134, [2022] 1 NZLR 683, where the Supreme Court held that setting the voting age at 18 had not been justified, and as such, was not a justified infringement to be free from discrimination based on age.
[477] See page 34.

collisions, drowning, or homicide has such a prohibition. However, reporting such matters is the reporting of a fact that is typically apparent due to the nature of the death. For the same reason, reporting a death as self-inflicted, or suspected suicide, is a permitted reporting of a fact that may be readily apparent due to the nature of the death.

As noted, both in Chapter One,[478] a finding of suicide requires an examination into whether a person understood the consequences of their actions and intended to take their own life. That is purely a matter to be determined as part of the coroner's inquiry and is not necessarily readily apparent. Ascertaining suicidal intent requires examining evidence from people who knew the deceased, such as whānau, friends, and colleagues, as well as the deceased person's medical and mental health history. It may also involve an inquiry into a person's online activity. Also, unlike other deaths before a coroner, the finding that a person's death is self-inflicted or suicide may have other consequences, such as ACC or life insurance entitlements.

Based on the evidence for harm of suicide reporting and the policy rationale for restricting describing a person's death as a suicide, I consider that the "importance" test is met. Given that s 71(2) prohibits publication of these details, it also follows that the "purpose of the limitation" limb of the second stage of the inquiry is met.

B Whether s 71 is a proportionate response to the policy objective

Whether s 71 is a proportionate response to its objective depends on the alternatives. As set out in the Third RIS there are effectively three options.[479] The first would be automatic suicide reporting restrictions that are broad in scope, similar to s 71 as originally enacted. The second would be s 71 as currently in force, while the third would be to have no restrictions.

As discussed in Chapter Two, the suicide reporting restrictions originally in the Coroners Act were broad and unclear in scope. While a coroner could permit details to be reported, the test could also be considered unclear as it required a consideration of whether publication would "unlikely to be detrimental to public safety".[480]

Although the research surrounding the Werther effect may very well support some sort of restriction, many of the harms are caused by how suicide is reported, rather than the content. Simplification or glorification of suicide can be considered subjective and is not necessarily capable of the precise definitions required for a statutory restriction. It is reasonable to conclude that a broad restriction is not a proportionate limitation on freedom of expression.

The research into the Papageno effect further supports this conclusion. While it is true that reporting celebrity suicides is associated with an increase in imitative suicides, it is not a universal truth and is entirely dependent on how those deaths are reported.[481]

Having no restrictions on reporting suicide represents the opposite extreme. It does not restrict freedom of expression at all. However, this does not address any of the potential harms that some

[478] See pages 4–6.
[479] Ministry of Justice, above n 312, at 4–5.
[480] Coroners Act 2006 (as enacted), s 71(3).
[481] Ministry of Justice, above n 312, at 4–5.

suicide reporting can pose to vulnerable people. While reporting guidelines may assist with this issue, it is entirely reliant on voluntary compliance.

I consider the current restrictions the most proportionate of the possible responses. The legislative restrictions are narrow, and unlike other aspects of the Werther effect, readily capable of articulation. This makes compliance more straightforward than restrictions on subjective matters, such as identification with the deceased.

As I noted in Chapter Two,[482] Hollings' argument that restricting reporting a death as a suicide should be retained, as such a restriction reinforced the intent of "reputable media guidelines" is equally valid for restricting reporting the method of death. The suicide reporting guidelines from the World Health Organisation,[483] Canada,[484] Australia,[485] and the United Kingdom are consistent in their advice to refrain from advertising the method of death.[486]

C Whether s 71 limits freedom of expression no more than necessary

As noted above, and consistent with other legislation, s 71 represents a default position, that of non-publication, tempered by an exemption regime and circumstances in which publication is automatically permitted. On the face of it, this would seem to be the least possible restriction to freedom of expression that would achieve the public health goal.

However, I consider that there are aspects of ss 71, 71A, and 139 which could be less restrictive. First is that s 71 hinders a coroner's ability to publicly make comments and recommendations. This connects to two other issues: the restriction of the power to make an exemption to the Chief Coroner and the scope and defences of the criminal offence. The remainder of this chapter discusses these points.

II Effect of s 71 on recommendations and comments

One of the purposes of the Coroners Act is to prevent death by "the making of recommendations or comments that, if drawn to public attention, may reduce the chances of further deaths occurring in circumstances similar to those in which the deaths occurred".[487] This creates an inherent tension with the mandatory prohibition of s 71,[488] which potentially prevents recommendations or comments being drawn to public attention.

The purpose of examining the extent to which s 71 prevents coroners' comments or recommendations from being published is twofold. The first is to show whether the reforms in the Coroners Amendment Act have improved publicity. The second purpose is to understand how mandatory non-publication currently hinders the protective aspect of the coroners' role.

A Methodology

[482] See page 37.
[483] World Health Organisation, above n 216, at 18.
[484] Canadian Journalism Forum on Violence and Trauma, above n 215, at 40.
[485] Everymind, above n 215, at 15.
[486] "Samaritans' media guidelines for reporting suicide" (April 2020) <samaritans.org>.
[487] Coroners Act 2006, s 3(1).
[488] "Chief Coroners Annual-Report 2021/22 and 2022/23" Coronial Services <www.justive.govt.nz> at 18.

To analyse whether s 71 has restricted the publication of coroners' recommendations, I adopted the approach taken by Moore and Henaghan and obtained details of coroners findings where recommendations were made.[489] This was provided in the form of a spreadsheet that contained findings between 01 July 2007, when the Coroners Act 2006 came into force, and 31 December 2023.[490] The data came from the Case Management System and included the content of a finding's comments and recommendations.

The data was analysed in two groups, based on the date the death was reported to the coroner, which would determine whether the death was subject to the revised s 71. Each death was tagged to indicate whether there were no comments or recommendations, the death was not self-inflicted, or the death was self-inflicted.

Self-inflicted deaths were also tagged on whether the comments or recommendations were publicly available. This was done by comparing the data in the spreadsheet with recommendations published in the *Recommendations Recap* on the Coronial Services website and individual recommendations on the New Zealand Legal Information Institute website.[491]

B Results

a. Tables

Table 4.1: Pre-amendment recommendations	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**
No recommendations made	1	0	4	4	6	3	0	7	21	28	73
Not relevant	106	199	201	185	168	148	103	68	97	44	1014
Self-inflicted recommendations	16	47	41	33	28	17	17	21	31	15	266
Recommendations not published	11	31	33	26	20	15	7	5	21	9	178 (66.92%)

Table 4.1 covers the period from 1 July 2007 to 21 July 2016, before the Coroners Amendment Act 2006 came into force.

Table 4.2: Post-amendment recommendations	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**
No recommendations made	39	73	50	60	54	28	40	5	349
Not relevant	41	119	118	132	97	57	19	7	590
Self-inflicted recommendations	5	28	32	32	29	5	6	0	137

[489] Jennifer Moore and Mark Henaghan *New Zealand Coroners' Recommendations, 2007-2012* (2014) at 75.
[490] Provided by email on 12 February 2024.
[491] Coronial Services "Recommendations Recap" <www.justice.govt.nz> and New Zealand Legal Information Institute "New Zealand Coroners Court" <www.nzlii.org>.

Recommendations not published	2	11	10	9	11	0	2	0	45 (32.85%)

Table 4.2 covers the period from 22 July 2016 to 31 December 2023.

b. Limitations

There are limitations to the data used. The data is more complete for the pre-amendment recommendations. While timeframes are similar, Table 4.1 covers a period of nine years, while Table 4.2 covers a period of eight and a half years. However, it is important to note that the average time it takes to close a coronial file is 510 days.[492] This explains the lower number of recommendations made for deaths occurring from 2021. If the data from 2021–2023 were excluded, the rate of non-publication would rise slightly to 34.13 per cent.

There are also fewer comments or recommendations in Table 4.2, 727 compared to 1280. In part, this can be explained by the time to complete coronial inquiries or a change in coronial practice. However, the Coroners Amendment Act also inserted s 57A to the Coroners Act, which limits the power to make comments or recommendations to, amongst other things, factors that "contributed to the death".[493]

Detailed commentary on s 57A is out of the scope of this thesis. However, I do note that this would prevent relevant comments or recommendations about matters which may not have contributed to a person's death. For example, a person in a mental health facility dies by suicide. The coroner's investigation may reveal systemic issues regarding the monitoring of inpatients. However, if the death would have occurred even if the person had been regularly monitored, those systemic issues would not have contributed to the death and the coroner cannot make comments or recommendations.

Finally, it is possible that recommendations have not been entered into the Case Management System. However, in comparing the published self-inflicted recommendations to the data provided, I have not found any instances of this occurring.[494]

While it was possible to determine whether the method of death had been mentioned, comments and recommendations were often truncated. A detailed analysis of the content of the comments and recommendations was not possible.

C Discussion

As can be seen from Tables 4.1 and 4.2, before the Coroners Amendment Act came into force, 178 out of 266, or 66.92 per cent, of self-inflicted comments or recommendations were not published. However, after the Coroners Amendment Act came into force, 45 out of 137, or 32.85 per cent, of self-inflicted comments or recommendations were not published.

Given the clearer, narrower scope of s 71, an improvement in the publication of recommendations is to be expected. However, what the data cannot show is the number of deaths where comments and recommendations were not made by a coroner due to the inability to authorise publication.

[492] "Chief Coroners Annual-Report 2021/22 and 2022/23", above n 488, at 25–26.
[493] Coroners Act 2006, s 57A(3)(a).
[494] In other words, there were no instances of published comments or recommendations that did not exist in the data provided.

Alternatively, there may very well have been deaths similar to Ms Marble, where the media may have wished to draw attention to comments or recommendations but have decided not to make an application for exemption.

III Who should make exemption decisions?

Section 71A limits the exemption-making power to the Chief Coroner. However, due to their knowledge of the death, I consider that exemption decisions should be made by the responsible coroner, rather than the Chief Coroner. In this section, I set out how the Law Commission's concerns about consistency can be addressed, the scope of exemptions, and how a broader exemption-making power addresses other concerns raised about ss 71 and 71A.

A Consistency

As set out in Chapter Two,[495] the Law Commission's reasoning for this change was that letting individual coroners decide on exemptions would lead to a variety of approaches, which would be undesirable. In their view, limiting exemptions to the Chief Coroner would lead to consistent decision-making. However, rather than limiting who can make exemption decisions, the existing power to create practice notes addresses concerns about consistency.

One of the Chief Coroner's functions is to help achieve consistency in coronial decision-making.[496] This can be achieved by issuing practice notes, as set out in s 132 of the Coroners Act. A coroner must "have regard" to any practice notes when exercising either a power, duty, or function.[497] Practice notes must be regularly reviewed. The Chief Coroner must make "every effort" to consult the coronial bench on proposed practice notes.

The Law Commission's report did not discuss why practice notes were not seen as an answer to the issue of consistency. As enacted, s 71(4)(b) of the Coroners Act required coroners to have regard to relevant practice notes when deciding whether to grant an exemption. This requirement was in addition to the requirement under s 6 mentioned above. Parliament considered the use of practice notes to be an appropriate measure to ensure consistency, which makes the Law Commission's lack of discussion on this point puzzling.

There also appeared to be some confusion on who would make exemption decisions in the submissions to the Select Committee. The Media Freedom Committee commented that practice notes would lead to consistency, which suggests they did not understand that the exemption power would be limited to the Chief Coroner.[498]

If consistency is not an issue, there is no reason for the power to grant exceptions to be limited to the Chief Coroner. It could also be argued, as Finucane did, that having the Chief Coroner grant exemptions is an intrusion into judicial independence.[499] There is some force to this view, as the manner of death is part of the cause and circumstances of a person's death, which are matters for the

[495] See page 46.
[496] Coroners Act 2006, ss 7(1)(b)(ii) and 7(2)(b).
[497] Section 6.
[498] Media Freedom Committee, above n 259, at 3.
[499] Michael Finucane "Media Reporting of Suicide: The Risks of Suicide News Stories and How Responsible Reporting can be Achieved" (2015) 3 NZLSJ 35 at 515; Finucane, above n 265, at [3.3].

responsible coroner to determine.[500] Describing a death as a suicide also falls squarely into matters to be decided by the responsible coroner.

I also note that one of the roles of the coroner, as set out in s 4(1)(e)(ii) of the Coroners Act is deciding whether to authorise making public aspects of self-inflicted death. While it is probable that this section was overlooked when s 71 was amended in 2016, restoring the ability of coroners to grant exemptions would be consistent with s 4.

As shown in Chapter Three, 12 out of 17 applications, or 70.58 per cent, were made while an inquiry was underway. While in practice, the Chief Coroner does consult with the responsible coroner, there is no requirement to do so, and the practice is not universal, even when granting exemptions.[501]

Given the consultation that the Chief Coroner must make before issuing a practice note, which would address any concerns as to judicial independence. The use of practice notes would also suggest another role for the suicide and media expert panel, which could provide input into such a practice note. This would allow coronial practice to be informed by the latest evidence into harmful suicide reporting.

B Scope of exemptions

As discussed in Chapter Three the language of s 71(2) restricts granting an exemption to a particular person or organisation.[502] If the language of s 71(2) were changed to be consistent with the Law Commission's recommendation, so that exemptions apply to all people, then unnecessary criminalisation would not occur.

However, the issue of scope is broader than criminalisation. When referring to the scope of an exemption, I am referring to the need for an application, how broadly the exemption applies, and the effect that would have on the public interest test.

Section 71A does not allow for exemptions without an application. In other words, should the responsible coroner consider that publication of the method of death meets the criteria set out in s 71A(3), they cannot issue an exemption as part of their findings. Even if the broader wording of the Law Commission had been adopted, under the current regime, the responsible coroner would have needed to apply to the Chief Coroner for an exemption. Such an arrangement would support Finucane's view that the exemption regime infringes on judicial independence.

However, if the responsible coroner were the decision maker, there would also need to be the power to grant an exemption without an application. As noted above, 32.85 per cent of comments and recommendations have gone unpublished due to the restrictions in s 71. While the responsible coroner would still need to be satisfied that the test in s 71A(3) is met, this would allow exemptions to be made proactively.

In the present regime, the risk of harm and public interest considerations in s 71A(3) is confined to the exemption application. A nuanced approach may be taken by broadening the exemption's scope as described above. For example, the risk of imitation and the public interest may be met by limiting the

[500] Coroners Act 2006 s 57(2)(d) and (e).
[501] As an example, see the case study into Mr Hanzlik's death.
[502] See page 53.

exemption to professional publications, such as medical journals. This would allow target recommendations to reach their intended audience. However, given my proposed wording for s 71(2), the exemption would need to be explicit in its limitation.

Section 71A's wording would need to change to reflect the change in decision maker, including the power to seek advice from the Suicide and Media Expert Panel. However, s 71A would otherwise remain unchanged. The need for timeliness is already reflected in the statutory language, and given the rarity of applications, there is no reason to expect that to be an issue in practice.

Finally, I consider that the Chief Coroner should continue to maintain a register of exemptions. It would allow a potential applicant to know whether an exemption had been granted and under what conditions. It would also be consistent with the Chief Coroner's function to maintain a publicly accessible register of comments and recommendations.[503]

C Consultation with whānau

The responsible coroner has the requirement to consult with interested parties on significant matters, an application for an exemption would fall into this category. As discussed in Chapters Two and Three, this was a concern raised by several submissions.

The most common concern of families of the deceased was the impact of publication and privacy. Section 74 of the Coroners Act allows a coroner to make non-publication orders on several grounds, including decency, the interests of justice, and personal privacy. The Law Commission argued that the coroner's powers under s 74 were sufficient to address any concerns families may have about privacy.[504]

However, those powers relate to evidence given during inquiry proceedings or to witness identification. As such, they are not available to s 71A applications as the decision maker, the Chief Coroner, is not the responsible coroner.

There are potential alternatives to s 74 orders. As the Supreme Court has commented, courts have an inherent power to suppress information, and "safety concerns, if sufficiently grave, may be enough to justify such an order".[505] However, given the importance of open justice, the party seeking such an order must show that the specific adverse consequences are sufficient to justify such an order. In any event, under the current exemption regime, such an order would also be contrary to judicial independence.

It could also be argued that a s 71A exemption could be granted subject to the condition that the whānau is not identified. In such a scenario, there would need to be a sufficient risk that the whānau would imitate the deceased's behaviour. However, that would more likely be a reason to decline an application.

If the responsible coroner were deciding s 71A exemptions, this issue would not arise, as they can make orders under s 74. While this power must be exercised consistently with freedom of expression, this nevertheless can allow, if justified, any concerns to be potentially addressed. Any practice note

[503] Coroners Act, s 7(2)(e).
[504] Law Commission, above n 305, at 3.
[505] See the Supreme Court's comments in *Erceg v Erceg* [2016] NZSC 135, [2017] 1 NZLR 310 at [21](c).

regarding s 71A exemptions could also address the use of s 74 non-publication orders in respect of suicide reporting.

D Post-inquiry exemptions

Generally, the exemption decisions have been made before the responsible coroner has concluded their inquiry. However, 29.4 per cent were made after the inquiry had been completed,[506] at which point the responsible coroner would be functus officio. This raises the question of who, if anyone, should have the power to grant an exemption in such circumstances.

This issue does not currently arise as the exemption regime is separate from a coronial inquiry. From a practical sense, there is a need for exemptions to be granted after an inquiry is complete. In terms of journalism, it will not be until an inquiry is complete that comments and recommendations are known.

There may be other reasons for the delay, such as the use of a particular death as a part of research or another inquiry, such as a Royal Commission. Such exemption applications could occur years after an inquiry has concluded.

A simple solution would be for s 71A to specify that for open inquiries, the applications are to be determined by the responsible coroner. Applications that are made following an inquiry could be determined by the Chief Coroner, who should have the power to assign an application to another coroner.

While s 74 orders would not be available to post-inquiry applications, I do not consider that this would necessarily be a problem. Applications from journalists would decrease, as proactive exemptions would allow for the publication of more comments or recommendations. The exemptions for research or other inquiries could be limited in scope to that particular use.[507]

IV The defences to the criminal offence

As discussed in Chapters Two and Three, a breach of s 71 is a criminal offence, as set out in s 139(1). While there have been no prosecutions to date, the two identified referrals to the Police show the difficulty with enforcement.

In essence, s 139(1) creates either a strict or absolute liability offence, which does not require knowledge or recklessness. The Legislation Design and Advisory Committee's guidelines note that when strict liability offences are justified, any defences should be specified in the statute.[508] At present, the only available statutory defence is s 139(3), which states that s 139(1) does not apply if a person is "hosting" the material on an internet site unless they are the one that has placed the material on the site.

Section 139 can be compared to s 211(2) of the Criminal Procedure Act 2001, which creates a strict liability offence of publishing information in breach of a suppression order.[509] Unlike the Coroners Act, the Criminal Procedure Act explicitly sets out that the prosecution does not need to prove intent,

[506] Five out of 17 applications. See Table 3.1.
[507] As is the case for the exemptions granted for this thesis.
[508] Legislation Design and Advisory Committee, above n 475, at [24.4].
[509] Knowingly or recklessly breaching a suppression order is a separate offence, with higher penalties, see Criminal Procedure Act 2011, s 211(1).

and that it is a defence if they can prove they did not know that the information was suppressed and that they removed the suppressed material as soon as possible.[510]

As illustrated in *Police v Bolton*, breaches of s 211(2) cover a wide spectrum of people, from the media, who are obliged to be aware of suppression orders, to those who inadvertently breach suppression orders.[511]

Section 139 should contain equivalent provisions to s 211(6) and (7) of the Criminal Procedure Act. This would be consistent with the Legislation Design and Advisory Committee's guidelines. The statutory defence, which focuses on removing infringing material, is consistent with the policy aim of preventing harm. As discussed in Chapter Three, the existence of possible defences is relevant to decisions on whether a prosecution is in the public interest. Finally, such a change would reflect the approach the Police have taken and guide decisions on prosecution.

V Changes to the Coroners Act

The changes discussed above would require the Coroners Act to be amended. In summary, those changes are:

a) Section 71(2) should be amended to specify that unless a coroner has granted an exemption, no person may make public the method of death, details that suggest the method of death, or describe a death as a suicide.
b) Section 71A should be amended to specify that:
    a. exemptions apply to all people, unless the exemption states otherwise; and
    b. the responsible coroner may grant an exemption without the need for an application.
c) specify that applications for exemptions are considered by:
    a. the responsible coroner; or
    b. when a coronial inquiry has been completed, the Chief Coroner, who may delegate the application to any other coroner.
d) Section 116A should be amended to reflect that any coroner can seek advice on s 71A exemptions, and that advice can be sought about any relevant practice notes.
e) Section 139 amended to include:[512]
    a. that it is not necessary for the prosecution to prove that the defendant intended to commit an offence; and
    b. a defendant has a defence to s 139(1) if they can show that they:
        i. did not know or could not reasonably have known that the information published was suppressed; and
        ii. removed the suppressed material as soon as practicable after becoming aware the information was suppressed.

However, I do not consider that the remaining parts of s 71A should be amended. The test set out in s 71A(3) is appropriate, as are ss 71A(2) and (4), which address the need for exemptions to be considered promptly.

[510] Section 211(6) and (7).
[511] *Police v Bolton* [2019] NZDC 5271 at [11].
[512] Based on the Criminal Procedure Act, s 211(6) and (7).

VI Conclusion

In this chapter I discussed whether ss 71 and 71A are a justified limitation on freedom of expression. Automatic non-publication regimes, which permit exemptions, are not uncommon in New Zealand. However, the 2021 edition of the Legislation Design and Advisory Committee's guidelines propose a two-stage inquiry into the importance of any proposed limitation and whether that limitation is proportionate.

I agreed with the Law Commission that the research into the Werther and Papageno effects justified a continued restriction. I also considered that the current restrictions represent a proportionate middle ground between the extremes of unfettered publication and complete prohibition on publication.

However, I did not agree that ss 71, 71A, and 139 were formulated in such a way that they restricted freedom of expression consistently with the policy objectives. In reaching this view, I noted that more coronial comments and recommendations had been published, although, it was not possible to consider whether there were recommendations that could have been more effective if they had been published.

Ultimately, my view was that the decision-making power in s 71A should not be limited to the Chief Coroner. The primary reason for this limitation was the Law Commission's concerns about consistency, which could be met using practice notes issued by the Chief Coroner. Given that most exemption applications occurred while a coronial inquiry was active, it would make more sense for the responsible coroner to make the decision, as they would be able to consider the views of the deceased's whānau. However, there is still the need for applications to be considered after an inquiry is complete. In such cases, the Chief Coroner could make the decision, or they could assign it to another coroner.

I also considered that the criminal offence provision in s 139 of the Coroners Act required statutory defences. This would accommodate the policy goal of reducing harm caused by publicising the method of death. It would also provide clearer guidance for Police in deciding whether to prosecute potential breaches of s 71.

Finally, I summarised the amendments that would need to be made to the Coroners Act. I noted that certain aspects of s 71A would not need to change, in particular the statutory test for an exemption.

Conclusion

This thesis sought to answer two questions. The first is whether the mandatory publication restrictions and exemption regime in ss 71 and 71A of the Coroners Act 2006 unnecessarily restrict the reporting of suicide. The second is whether the exemption regime strikes the right balance between competing public and private interests.

Since the passage of the Coroners Act 1951, the publication of details about individual suicides has been prohibited. The reason for this prohibition is to reduce the potential for imitative self-harm and to protect the privacy of those bereaved by suicide. These restrictions were controversial, and media have long held the view they were an unnecessary limitation on freedom of expression.

Following the 2014 report from the Law Commission, the Coroners Act 2006 was amended to become clearer and less restrictive on what matters are prohibited from publication and to create an exemption regime. Without an exemption, it is an offence to publish the method of death, details that suggest the method, or to describe a death as a suicide.

Concerns about how media report suicide, and its potential for influencing future deaths are long-standing. Since the 1970s a growing body of research has concluded that certain types of media reporting can cause imitative suicides, dubbed the Werther effect. This thesis has examined the evidence for harm from suicide reporting, as well as the emerging evidence of suicide reporting that decreases incidents of self-harm.

The evidence remains clear that how suicide is reported can be harmful to vulnerable people. However, unlike the method of death, certain aspects of the Werther effect, such as glamorising suicide, are subjective and not suited to statutory restriction.

I concluded that the restrictions in s 71 of the Coroners Act, tempered by an exemption regime, are a justifiable limitation on freedom of expression. However, the exemption regime can be less restrictive as the exemptions are limited to the applicant. In my view, exemptions should apply to all people unless specified. While there may be occasions where limiting who may publish the method of a person's death may be in the public interest, that is a matter that should be up to the decision-maker.

The criminal enforcement of s 71 also requires changes. A statutory defence should be available if the prohibited material is taken down promptly. This would be consistent with other legislation and with the policy aim of preventing further suicide.

There is also no compelling reason to restrict the power to grant exemptions to the Chief Coroner. It is my view that this should be exercised by the coroner inquiring into the suspected suicide. In doing so, this addresses the second question of the thesis, the balance between public and private interests.

While the whānau of the deceased are consulted under the current regime, there are no powers to restrict the publication of details of the death should the whānau wish for privacy. If the coroner responsible for the inquiry had the power to grant exemptions, they would have the power to prohibit publication under s 74 of the Coroners Act.

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