Coronial Inquiries: What to know?

Responding to and managing critical incidents while supporting learner wellbeing and safety is difficult. This is especially true when a learning or residential community experience the sudden or unexpected death of a learner.

In some cases, the unexpected death of a learner may be subject to a Coronial Inquiry. The more information providers have access to in these situations, the better positioned they may be to provide an appropriate level of care and support to their learners, staff and communities.

This resource provides information to providers on coronial inquiries and how to stay informed of key information through the process.

Requirements under the Code

The Education (Pastoral Care of Tertiary and International Learners) Code of Practice 2021 (the 'Code') states that providers must gather and communicate relevant information across their organisation (including student accommodation) and from relevant stakeholders to accurately identify emerging concerns about learners' wellbeing and safety or behaviour and take all reasonable steps to connect learners quickly to culturally appropriate social, medical and mental health services (clause 10(1)).

While the Code does not specifically require providers to follow coronial inquiries, doing so can support an effective and responsive learner wellbeing and safety system.

What is a Coronial inquiry?

Any sudden death that is unexpected, violent or suspicious may be investigated by a coroner. A coroner holds an inquiry to find out more about who a person was and where, when and how they passed. Inquiries also help coroners make recommendations or comments that might prevent a similar death happening in the future.

At the end of an inquiry, the coroner will release their findings. A finding is a report written by the coroner about the facts of the death and can include comments or recommendations. The findings and recommendations of a coronial inquiry are open to the public.

Release of Coroner's Findings

The release of coroner's findings can have an impact on a provider and the wider learning or residential community. Sometimes, findings or media reporting may come with no prior indication for your organisation. This can have impacts on learner wellbeing and safety and the support providers are able to offer to those affected.

Coroners do not usually speak to media about individual cases they manage or findings they issue. However, a coroner may send a findings report directly to the media if it has been requested or if there is an issue of national significance.

Staying informed of coronial updates and findings can assist a provider in supporting learners or their communities after an unexpected death of a learner, even if it occurred years prior.

What can you do?

1. Stay informed

There are several ways a provider can stay informed about the progress of a Coronial Inquiry or its findings. These include:

Quarterly recommendations recap— these are a summary of coroners' findings that have been made over a three-month period.

Findings of public interest— these are published findings from cases that are of significant public interest.

Annual reports—these reports provides information about the work of the Coroners Court.

Request information—immediate family, the general public and the media may request information from a coroner.

Applying to become an interested party

To learn more about or access findings, visit the Coronial Services website.

2. Become an interested party

Interested parties in a Coronial Inquiry are people or organisations the coroner considers having particular interest in the inquiry. This interest needs to be more than, or different to, the interest of a member of the general public. They are notified of significant matters during an inquiry and receive relevant information.

Providers navigating the impacts of an unexpected death of a learner are not automatically considered interested parties. However, there are certain actions a provider can take to be registered as an interested party and kept informed about key updates and findings from a Coronial Inquiry. These include:

Informing Police —in the event of a sudden/unexplained death, Police take on responsibilities as agents of the coroner. A provider may make a request to the officer leading the investigation to be informed about key developments in the case and to be listed as an interested party. The officer will make note of this and include contact details in their report to the coroner. The coroner may then contact the provider directly to inform them of the outcome or next steps or instruct the Police to do so.

Making an application —To apply to become an interested party, contact the regional Coroner's office responsible for the case by email or telephone and inform them of the application you would like to make to the coroner. In this case, it would be an application to be registered as an interested party. For contact details of regional coroner's offices, please visit the Coronial Services website.

It is at the discretion of the coroner leading the inquiry to approve an application to become an interested party. If you are not approved to be listed as an interested party, you may request that you be informed of and sent a copy of the coroner's findings at the end of an inquiry.

For more information about Coronial Inquiries, please visit the Coronial Services website.

For resources to support critical incident response and management, visit the NZQA website.