SUDDEN DEATH PROTOCOLS

WITH SPECIFIC EMPHASIS ON

TANGATA WHENUA AND MANUHIRI,

WHANGANUI

(Reviewed July 2011)

This agreement is made in the Spirit of the Treaty of Waitangi. All parties recognise that commitment to working within the Articles and the principles of the Treaty of Waitangi are fundamental to the success of the agreement.

TE RUNANGA O TUPOHO

Atihaunui - A - Paparangi - Whanganui - Nga Hapu O Tupoho
This Agreement is

Between: New Zealand Police Whanganui
          Whanganui District Health Board Provider Arm
          Te Runanga o Tupoho Whanganui Iwi

Governing: Managing Whanganui Iwi matters relating to Sudden Death

1. Introduction

1.1 Representatives of Whanganui Iwi raised issues to both Whanganui Police and the Coroner, of their concern over Police dealing with sudden death.

1.2 This has resulted in a number of meetings in which their concerns have been discussed. Main points arising from these discussions are:

1.2.1 Continue and maintain communication between Police and Whanau.

1.2.2 Both the Whanganui Police and Iwi representatives acknowledge that a better understanding was required relating to sudden death.

1.2.3 The whakataumate whare was established on Whanganui Hospital grounds for use by grieving whanau.

1.2.4 This document does not attempt to describe in detail how every sudden death will be dealt with but instead provides a framework, which can be used to manage the process.

1.2.5 Owing to the centralisation of resources, Post Mortems are now carried out at both Palmerston North and Wellington hospitals.

2. Definitions

Karakia                                 process of prayer
Karanga                                 female voice of welcome or farewell
Manuhiri                                all others
Poroporoaki                             farewell process to the deceased
Ritenga                                 customary practices
Tangata Tiaki                           identified appointed person/s or representatives
Tangata Whenua                          local people of the land
Tapu                                    a medium of forbidden or sacred statement
Te Oranganui Iwi Health Authority      largest Maori health provider for Whanganui
Te Runanga o Tupoho                     Representative Body for lower Whanganui River
Tikanga                                 customary rules and processes
Tupapaku                                the deceased person
Wairua                                  spiritual significance of ones being
Whakapai                                process of blessing
3. Values

3.1 All parties agree that the following values will be maintained in accordance with this agreement:

- Maintain the highest level of integrity and professionalism
- Respect Whanau collective rights and freedoms
- Understand and respect cultural differences and diversity
- Manage any difference as quickly as possible

4. Consultation

4.1 Consultation in relation to this agreement has occurred between: Whanganui Police, Whanganui District Health Board Provider Arm, Te Runanga o Tupoho, Whanganui Iwi, Te Oranganui Iwi Health Authority PHO.

4.2 This document will be reviewed two yearly in consultation with all parties to the agreement.

4.3 Consultation is now required “internally” for each group and this protocol will come into effect on 2 September 2011.

5. Purpose of Agreement

5.1 To continue enhanced communication between Whanganui Police and Whanau relating to sudden deaths.

5.2 To consolidate understanding between Whanganui Police and Whanganui District Health Board’s Provider Arm, of Tikanga surrounding the care and treatment of tuakapa and the associated cultural practical spiritual practice.

5.3 To assist in building relationships between the parties to this agreement.

6. When someone dies

6.1 All deaths in New Zealand that meet criteria under the Coroners Act 2006 are required to be reported to the Coroner.

6.2 **Police acting on behalf of the Coroner** attend whenever there is something violent, unnatural, unexpected, or suspicious about a death, or where a doctor cannot issue a medical certificate as to cause of death. Police in turn report the death to the Coroner.

6.3 The Act identifies situations when a death must be reported to the Coroner.

These include:
- When a person seems to have died in a violent or unnatural way, such as drowning or a car crash, or poisoning
- When the cause of death is unknown
- When a person dies in prison
- When a person dies "in care", e.g. in a psychiatric hospital or a children’s home or while under CYFS care
- When a person appears to have taken his/her own life
- When a person dies while under anaesthetic or following a medical procedure, or as a result of anaesthetic or a medical procedure.

6.4 Before a body can be buried or cremated, either:
- A Medical Certificate as to cause of a death must be signed by a doctor, or
- A Coroner must issue a Burial Order or order for cremation

6.5 To assist the Coroner to establish a cause of death a post mortem examination may be required. This requires the tupapaku to be taken to the Palmerston North Hospital mortuary for the post mortem examination. Occasionally the post mortem may need to be carried out in Wellington.

6.6 Responsibilities of the Whanganui District Health Board Provider Arm to ensure that all required documentation is available and is given a high priority.

7. Role of the Coroner

7.1 The Coroner is duty bound to carry out various obligations that are set out in the Coroners Act. The New Zealand Police Act as the Coroner’s agents.

7.2 When a death occurs within the criteria described in the Coroners Act (refer paragraph 5.2 above) the Police are required to notify the Coroner. In some cases doctors, hospitals and penal institutions also have notification obligations.

7.3 When notified of the circumstances of the death the Coroner will determine whether or not to take jurisdiction, and what initial investigations are required.

7.4 If the Coroner takes jurisdiction, he/she may order a post mortem (autopsy) to assist in establishing the cause of death. Depending on the outcome of the post mortem examination, and circumstances of the death, one of two things generally happens:
- The cause of death and circumstances of the death are resolved to Coroner’s satisfaction and no further inquiries are required; or
- A formal inquiry and inquest is required to establish the cause and circumstances of death.

7.5 Where a death has been reported to the Coroner and he/she accepts jurisdiction, the deceased person cannot be buried or cremated without a Coroner authorising the release of the body.

7.6 If a doctor who has treated the deceased before he/she dies is able and is willing to sign a certificate stating the cause of death, the Coroner will not normally be involved, unless the death falls within one of the categories outlined in paragraph 6.2 of this document.
7.7 If the death is one of the categories outlined in paragraph 6.2 the Coroner can in some cases accept a doctor's opinion as to the cause of death to help guide them in making a decision as to whether a post mortem examination is required.

8. Role of the Tangata Tiaki and Police Iwi Liaison Officer

8.1 Tangata Tiaki are as per attached Appendix A

8.2 Their role in relation to this agreement is:

- Advise on tikanga
- Advise Police of the appropriate whanau for the purpose of liaison
- Assist in communication with whanau
- Communicate any issues to Police

8.3 The Police Iwi Liaison Officer role in relation to this agreement is:

- Advise the Police Officers dealing with the death on tikanga
- Assist the officer in charge of a suspicious death with communication and tikanga
- Liaise with the whanau and appointed tangata tiaki
- Communicate the investigation procedure to the whanau and tangata tiaki
- Provide Police members with ongoing training on Tikanga Maori and recommended best practice.

9. Police Attendance at Sudden Deaths

9.1 To assist with this communication, Whanganui Police will rely on the services of the Tangata Tiaki and the Police Iwi Liaison Officer to mediate between Police and Whanau when appropriate.

9.2 Whanganui Police acknowledge that if they are called to deal with a death at night, they need to consider:

9.2.1 The need to remove the tupapaku from the address to the mortuary

9.2.2 Whether the tupapaku can remain with the whanau until the post mortem, depends on the following matters:

- circumstances of the death
- is the death suspicious
- the likelihood of criminal proceeding arising from the death
- if a post mortem examination is required, when it will be performed
- to maintain the dignity of the Tupapaku
- **If the Coroner agrees**

9.2.3 The need to remove tupapaku from the place of death to Whakataumate.

9.2.4 If the Coroner has jurisdiction in respect of the death the Coroner makes the final decision as to where the body is taken.

10. Role of the Pathologist

The role of the Pathologist is to act on the Coroner's instructions and to establish cause of death. The post mortem examination may involve a full external and internal
examination of the body, and the taking of tissue, blood, fluid and urine samples. Blood and urine samples are commonly sent away for toxicology tests. Small tissue samples may be taken for microscopic and/or toxicological examination to establish a diagnosis.

The Pathologist has to provide verification of tissues/blood samples taken from deceased, and the whanau must be informed when such samples are taken. They must also be advised that on request these samples be returned.

The Pathologist must produce a written report on their findings to the Coroner. This report is available to the Whanau on request.

Predominantly post mortems are conducted in Palmerston North, however the Coroner can refer matters to other areas for post mortems where the initial investigation reveals a need for specialist examination.

For the Whanau, this may cause delays in the release of the tupapaku, therefore it is essential that communication is ongoing.

11. Post Mortem Examination

11.1 Whanganui District Health Board Provider Arm provides post mortem services for the Whanganui catchment in Palmerston North or where directed by the Coroner.

11.2 Whanganui District Health Board’s Provider Arm, will endeavour to provide a timely service. However, a post mortem can only be conducted following receipt of appropriate documentation, including formal identification from the Police.

11.2.1 Whanganui District Health Board Provider Arm cannot guarantee immediate availability of a pathologist.

11.3 Where cases involve serious physical damage or decomposition especially in hot weather, Whanganui District Health Board’s Provider Arm, may have to remove the tupapaku to the mortuary for refrigeration to prevent further decomposition following discussion with the whanau representative. Without this measure post mortem would be difficult or impossible to carryout and also maintains the dignity and integrity of the Tupapaku.

12. Whakatau Mate (whare)

Whanganui District Health Board’s Provider Arm, guidelines for the use of the Whakatau Mate whare are as follows:

12.1 Whakatau Mate (whare) is where the tupapaku may rest whilst awaiting or following post mortem. This facility is available, in these circumstances:

- To all members of the community provided due respect is given to the cultural focus of the whare.
- An adult Whanau representative must be present with their Tupapaku at all times.
- In the circumstances that this is not carried out, the tupapaku will be transported to the Mortuary.

12.2 Specific guidelines to be followed are:
• Access to the Whakataumate whare is through a nominated key holder

The Whanganui District Health Board's Provider Arm, telephonist will contact the key holder. The key-holder will be responsible for the group using the whare, will collect the key and be responsible for the return of the key and will ensure the whare is left in a clean and tidy condition.

The key-holder must ensure that telephonist records their name when they collect the key. Refer to Appendix A.

Security

The Whakatau Mate house has a security alarm. The key holder will be given the combination number, which must remain confidential.

• Substances on the premises

Whanganui District Health Board's Provider Arm, practice a smokefree/auahi kore campus. Smoking is not permitted on Whanganui District Health Board's premises.

Alcohol must not be brought onto Whanganui District Health Board's Provider Arm, premises or consumed anywhere on the premises. Illegal substances are forbidden anywhere on Whanganui District Health Board's premises.

• Housekeeping

Each group using the Whakatau Mate whare is responsible for keeping it clean and tidy with the refuse removed.

• Enquiries contact person

All enquiries are to be directed to Kaiwhakahaere, Co-ordinator Maori Health, Whanganui Hospital, telephone 3481234. After hours contact is through the Hospital switchboard.

13. Communication

13.1 It is acknowledged by all parties to this agreement; communication is of the utmost importance when dealing with a death and the whanau.

13.2 Whanganui Police will identify an officer who will be responsible for communicating with the tangata tiaki in each case providing copies of the Sudden Death information pamphlet.

13.3 The Whanganui Police District Iwi Liaison Officer is available to assist with this protocol.

13.4 Whanganui Police also offer the services of Victim Support for Whanau should the need arise.

13.5 Whanganui Police acknowledges that the tangata tiaki is to be fully informed at all times, particularly if a post mortem is required.
13.6 Whanganui Police acknowledges that a member of the Whanau can accompany the tupapaku.

14. Deaths involving Foul Play

14.1 All parties to this agreement acknowledge that in exceptional circumstances, such as foul play:
   - The whanau will be treated with respect at all times
   - The whanau will be kept fully informed by the Police in relation to matters involving the tupapaku
   - The whanau will be able to practise tikanga regarding the tupapaku
   - The whanau is able to use the Whakatau Mate house at Whanganui Hospital for this purpose

15. Disputes Procedure

15.1 All parties to this agreement acknowledge that a disputes procedure is required involving Whanganui Police, Whanganui District Health Board Provider Arm, the Coroner, and Whanau.

15.2 The contact persons for this disputes procedure are as outlined as per the attached Appendix B.

16. Review

16.1 All parties to this agreement acknowledge that this agreement needs to be reviewed regularly and a quality assessment conducted.

16.2 It is agreed that a review and quality assessment will be conducted one year following the signing of this agreement and every year thereafter unless all parties agree otherwise.

17. Costs

17.1 Unless it is otherwise agreed all parties to this agreement and any other contractual arrangements, will meet their own costs, unless the specific parties agree otherwise.
18. Signatories

18.1 All parties acknowledge that the people listed are signatories to this agreement.

*Sudden Death Agreement*  
*With Specific Emphasis on Maori*

Protocol reviewed and signed by the following authorised signatories:

**Julie Patterson**  
Chief Executive Officer  
Whanganui District Health Board  

Date: 2/9/11.

**Inspector Duncan Macleod**  
New Zealand Police  
Whanganui  

Date: 02/09/11.

**John Maihi**  
Kaiwhakahaere  
Te Runanga o Tupoho  
Whanganui  

Date: 2/9/2011.

**Adrian Rurawhe**  
Chairperson  
Te Oranganui Iwi Health Authority PHO  
Whanganui  

Date: 2-9-11
### APPENDIX A

#### TANGATA TIAKI, AND KEYHOLDERS FOR THE WHAKATAU MATE (WARE)

<table>
<thead>
<tr>
<th>NAME</th>
<th>WORK PHONE</th>
<th>HOME PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon McKenzie</td>
<td>Key holder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(027) 467 7087 (cell)</td>
<td></td>
</tr>
<tr>
<td>John Maihi</td>
<td></td>
<td>(027) 269 5689</td>
</tr>
<tr>
<td>Susan Osborne</td>
<td>(If above can't be contacted can assist if required)</td>
<td>(06) 348 3377</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(027) 4914809</td>
</tr>
</tbody>
</table>

#### TAIWI REPRESENTATIVES AND KEY HOLDERS FOR THE WHAKATAU MATE (WARE)

<table>
<thead>
<tr>
<th>NAME</th>
<th>WORK PHONE</th>
<th>HOME PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rev. Graham Juden, Chaplain – WDHB PA</td>
<td>(06) 348 1234</td>
<td></td>
</tr>
<tr>
<td>Switchboard main entrance – WDHB PA</td>
<td>(06) 348 1234</td>
<td></td>
</tr>
</tbody>
</table>
# APPENDIX B

## DISPUTES PROCEDURE CONTACTS

In the event of a dispute involving this protocol document the following persons are to be contacted to resolve the dispute:

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>CONTACT PERSON</th>
<th>WORK PHONE</th>
<th>HOME PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coroner</td>
<td>District Coroner</td>
<td>(06) 350 0083</td>
<td></td>
</tr>
<tr>
<td>Whanganui Police</td>
<td>Area Controller Whanganui</td>
<td>(06) 349 0600</td>
<td></td>
</tr>
<tr>
<td>Whanganui Police</td>
<td>Te Rangi Maniapoto Kai Takawaenga</td>
<td>(027) 2335104</td>
<td></td>
</tr>
<tr>
<td>Whanganui District Health Board Provider Arm</td>
<td>Julie Patterson Chief Executive Officer</td>
<td>(06) 348 1234</td>
<td></td>
</tr>
<tr>
<td>Whanganui District Health Board Provider Arm</td>
<td>Gilbert Taurua Director of Maori Health</td>
<td>(06) 348 1234</td>
<td>(021) 702 706</td>
</tr>
<tr>
<td>Te Runanga O Tupoho</td>
<td>John Maihi Kaiwhakahaere</td>
<td></td>
<td>(027) 269 5689</td>
</tr>
<tr>
<td>Tangata Tiaki</td>
<td>Sharon McKenzie Te Oranganui Iwi Health Authority PHO Maori Liaison Officer</td>
<td>(06) 348 1234</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

FLOW DIAGRAM OF SUDDEN DEATH PROCESS

Doctor issues death certificate (refer to diagram 1)

SUDDEN DEATH OCCURS
- No Certificate as to cause of death

Police notified – est. enquiry – whanau advised
- Scene considered
- Identify deceased, etc.
- Consider foul play

Coroner decides on Post Mortem – Pathologist advised

Coroner decides on Post Mortem – Pathologist advised
- Forms completed:
  - Coroner 47
  - ID
  - Life extinct

PM completed – Coroner decides if inquest necessary

Yes

Body released via undertaker to next of kin

No

Police advised – next of kin notified

Inquest mandatory:
- Prison/police custody
- Violent/suicide
- Mental health
- Medical
- Surgical/Dental
- Not satisfied everything covered

No

Body released via undertaker to next of kin