



New Zealand House of Representatives
Te Whare Māngai o Aotearoa

Justice Committee

Komiti Whiriwhiri Take Ture

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Petition of David White MNZM: Action to Prevent Family and Sexual Violence in New Zealand

Presented to the House of Representatives
by Hon Andrew Bayly, Chairperson

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Petition of David White MNZM

Recommendation

The Justice Committee has considered the petition of David White MNZM—Action to Prevent Family and Sexual Violence in New Zealand—and strongly recommends the Government examine the current approach to reporting coronial cases, so that searchability and accessibility is significantly enhanced.

Request for action to prevent family and sexual violence

This petition was signed by 1,124 people on the Parliament website and on paper. It was presented to the House by Hon Jo Luxton on 23 September 2025 and transferred to us on 23 October 2025, and requests:

That the House of Representatives urge the Government to take urgent action to establish a new nationwide adaptable program for the prevention of family and sexual violence, and to recognise and to include suicides linked to family and sexual abuse with violent deaths in official reporting.

Comments from the petitioner

The petitioner drew our attention to New Zealand's high rates of family and sexual violence. We heard that his daughter, Helen, was a victim of family violence.¹ This led to his advocacy for a system that is designed to prevent family violence, not just respond to it. He also wants official reporting about violent deaths to include suicides that are linked to family and sexual abuse.

According to the petitioner, only 20 percent of all crime is reported to the Police. He commented that the New Zealand Crime and Victims Survey makes it clear that these rates of violence are trending upward. The tables below show data from Cycle 7 of the survey.²

Table 1: Prevalence and incidence of sexual assault, 2018–2024

	2018	2019	2020	2021	2022	2023	2024
Prevalence (Number of victims)	80,000	79,000	71,000	84,000	81,000	76,000	90,000
Incidence (Number of offences)	167,000	184,000	169,000	200,000	290,000	193,000	217,000

¹ David White was made a Member of the New Zealand Order of Merit in 2023 for services to the prevention of family violence. His book, *Helen: The Helen Meads Tragedy*, is about the murder of his daughter.

² Ministry of Justice, [New Zealand Crime and Victims Survey](#).

Table 2: Incidence of all offences by a family member, 2018–2024

	2018	2019	2020	2021	2022	2023	2024
Number of adults experiencing one or more family offences	87,000	92,000	87,000	69,000	74,000	70,000	101,000
Number of family offence incidents	207,000	251,000	292,000	185,000	580,000	246,000	252,000

The petitioner told us the essence of “prevention” is action taken before any harm occurs. Prevention should be “a safety net on the banks of the river. It is not the ambulance at the bottom of the cliff because prevention has failed totally if all you do is pick up the casualties.” He feels that not enough is being done by government agencies to prevent family and sexual violence. In particular, the Centre for Family Violence and Sexual Violence Prevention has not managed its funding and work in a way that has brought down rates of family and sexual violence. The petitioner also feels that programmes to prevent family and sexual violence are too fragmented across government agencies, causing duplication.

Suggestions to prevent family and sexual violence

The petitioner suggested that the Government should establish a nationwide programme to prevent family and sexual violence. This programme should be administered by the Social Investment Agency because any programme that works to prevent family and sexual violence is by its nature a social investment. He told us that one management structure for multiple programmes would be more efficient than each government agency providing its own prevention programme. One government agency overseeing the prevention of family and sexual violence would also make it easier for community groups to access funding for local programmes.

We heard that a community-led approach to preventing family and sexual violence is effective. The petitioner told us that the establishment of the Ruapehu Whānau Transformation programme in 2012 by Ngāti Rangi is a good example. Every household in the community was asked what was needed to make their lives better and what skills the people in the household could offer that would benefit the community. The completed questionnaire enabled Ngāti Rangi to develop 23 initiatives under five groups—health, housing, education, employment, and social—with the aim of completing all of the initiatives within five years. Although reducing family violence was not one of the initiatives, the improved living conditions led to a decrease in family and sexual violence incidents.

Proposal to record suicides with links to family and sexual violence

The petitioner suggested that suicides linked to family and sexual violence should be included in official reporting of deaths that are a direct result of this form of violence. He told us that, on average, there are about 600 suicides per year, and it is estimated that half of these are linked to family and sexual violence. Linking suicides to deaths attributed to family and sexual violence would make family and sexual violence a major crime and, therefore, would need to be addressed as such.

Comments from the Centre for Family Violence and Sexual Violence Prevention

The Centre for Family Violence and Sexual Violence Prevention acknowledges the petitioner's advocacy for improvements to the family violence system following the tragic loss of his daughter. The centre agrees that the rates of family and sexual violence remain unacceptably high and too many people are being harmed and killed.

We asked why family and sexual violence is so prevalent in New Zealand. We heard that a range of historical and current problems, when combined, lead to violence. In addition to harmful drug and alcohol use and untreated mental health conditions, systemic factors such as gender inequities, racism, ableism, and homophobia also create conditions for violence to continue. The centre told us that when the family and sexual violence system tries to respond to these problems, it quite often can cause harm by not providing the right social and economic support that would enable people to live thriving lives.

The centre told us that family and sexual violence are intergenerational issues, which need sustainable long-term solutions that are not subject to political changes or budget cycles. In 2023, the centre developed an outcomes and measurement framework to track its progress and help it understand its contribution towards reducing family and sexual violence. The framework identified 20 short-term and 12 long-term outcomes that are needed to realise its 25-year strategy: *Te Aorerekura: National Strategy to Eliminate Family Violence and Sexual Violence*.³ The centre indicated that more people have sought help over the short term, and this is reflected in the data—32 percent of sexual assault victims reported their assault to the Police, which is up from 7 percent in 2018.

Community-led approaches to prevent and reduce violence

The centre agreed that community-led approaches to prevent and reduce family and sexual violence are effective. It told us that one of Te Aorerekura's objectives is to "build collective ownership for solutions, and support and resource integrated, community-led responses". To do this, the centre has established a framework to support multi-agency responses to family violence to make sure people who are affected by violence are appropriately supported. The centre said it also distributes funding grants to local organisations, that enable communities to coordinate their own efforts in helping groups disproportionately affected by family and sexual violence.

Linking suicides to family and sexual violence in official reporting

In response to the petitioner's request that suicides linked to family and sexual violence be included in official reporting of deaths, the centre told us there is no centrally recorded data that shows whether family or sexual violence causes or contributes to suicides. We asked the centre about models it could use to gather more data on suicide and its correlation with family and sexual violence. It said all family violence deaths are investigated and reviewed by the National Mortality Review Committee. The aim of the review is identifying system-level failures and inequities, and opportunities for prevention or improvement.

³ <https://preventfvsv.govt.nz/national-strategy>.

We are aware that, under the Coroner's Act 2006, coroners investigate any unexpected death, including suspected suicide, and make recommendations to prevent similar deaths from occurring in the future. However, these recommendations are not binding. The centre brought to our attention that the register of recommendations is not set up in a way that enables recommendations that refer to family and sexual violence and suicide to be collated and made accessible.

The centre explained that it does not have the resources to collate or analyse data relating to family and sexual violence in the context of suicide. The centre thinks this sort of analysis would require a robust methodology and would need to use data held by the Police, the Ministry of Justice, and the courts. Currently, there are restrictions on how this data can be accessed.

We asked the centre how it works with other agencies on suicide associated with family and sexual violence. It told us that the Ministry of Health consulted the centre when it developed the Suicide Prevention Action Plan 2025–2029. The plan recognises suicide as the leading cause of death in pregnant women and new mothers. It includes a maternal mental health programme across government that integrates mental health support with maternity care.

Comments from the Coroners Court

The role of the coroner is to investigate the types of death listed in sections 13–15 of the Coroners Act. They include deaths that are self-inflicted, unexpected or unnatural, violent, childbirth-related, or that occur in official custody or care. The Chief Coroner told us that coroners are independent judicial officers who conduct inquiries for the purposes set out in section 57 of the Act. One purpose is to establish, as far as possible, matters including the causes of the death, and the circumstances of the death. The Chief Coroner explained that the Act gives coroners broad inquisitorial powers. Coroners determine the scope of the inquiry, but the matters to be explored must have some expected connection with the death.

The Chief Coroner told us that, where appropriate, coroners make recommendations or comments for the purpose of preventing further deaths in similar circumstances. We note that, under section 7 of the Act, the Chief Coroner is required to maintain a publicly available register of recommendations, or summaries of recommendations or comments. The Chief Coroner told us that the register currently takes the form of a "Recommendations Recap". The recap is a summary of coroners' findings that have been made over a three-month period.

While the recap meets the legislative requirement to maintain a register, the Chief Coroner acknowledged that it is not easily searchable by type of death without looking through each published recap issue. They indicated that it would be possible to create a new database without making any legislative change. The new database could include a search function to make it easier to search for recommendations, but the Coroners Court would need additional funding for its development.

The Chief Coroner explained that other online sources are available. The National Coronial Information System in Australia (NCIS) is a repository of coronial data from Australia and New Zealand. Due to changes in Australian legislation, the agreement for New Zealand to share Coroners Court information with NCIS is currently being renegotiated. Pending this, no

New Zealand data can be accessed via NCIS, except for requests for information that are considered on a case-by-case basis by Coroners Court staff. The Chief Coroner told us that summaries of coroners' recommendations are also published on the New Zealand Legal Information Institute website.

The Chief Coroner told us that, under section 60 of the Act, the coroner is required to open and conduct an inquiry for deaths that appear to be self-inflicted. We asked whether the coroner investigates whether a suicide was caused by family or sexual violence. The Chief Coroner explained that the scope of a coronial inquiry could include whether sexual or family violence was a circumstance that contributed to a self-inflicted death under inquiry. Comments or recommendations may be made by a coroner where evidence obtained during the inquiry shows that family or sexual violence has contributed to the death.

Our response to the petition

We acknowledge the tragic passing of the petitioner's daughter, Helen Meads, and we thank him for his long-standing advocacy to reduce family and sexual violence in New Zealand. We agree that the rates of family and sexual violence in this country are too high, and we think more attention should be shown to this problem. We would like to see more work done on preventing family and sexual violence through an all-of-government approach.

We agree with the petitioner's comments that a community-led approach to reducing and preventing family and sexual violence has been successful. We were impressed by the Ruapehu Whānau Transformation's success in completing all 23 initiatives and its additional effect on reducing family and sexual violence incidents in the community. We consider that Te Aorerekura, as the national strategy to eliminate family and sexual violence, should prioritise community-led initiatives that work to support victims of family and sexual violence. The centre should also increase its funding for local communities to better enable them in their efforts to prevent and reduce family and sexual violence.

We think the petitioner's proposal to include suicides that are linked to family and sexual violence in official reporting of deaths could be valuable in understanding the bigger picture. Attributing these suicides to family and sexual violence would better highlight the severity of this problem.

We note that having the National Mortality Review Committee investigate and review family violence deaths is a step in the right direction. However, we think more could be done to collate and analyse data relating to family and sexual violence in the context of suicide. We strongly recommend that the Government examine the current approach to reporting coronial cases, so that searchability and accessibility is significantly enhanced, particularly for research and reporting purposes. We see a responsibility for the coroner to more fully consider whether family or sexual violence contributed to a suicide and provide a way for this data to be recorded. This would mean that organisations such as the Centre for the Prevention of Family Violence and Sexual Violence can analyse the data and use it to inform the future direction of their programmes. Consideration would need be given to protect the identity of the deceased and appropriate ethics framework for in-depth research.

Appendix

Committee procedure

The petition was signed by 1,124 people on the Parliament website and on paper. It was presented to the House by Hon Jo Luxton on 23 September 2025 and transferred to us on 23 October 2025. We met between 3 November 2025 and 21 May 2026 to consider it. We received written submissions from the petitioner, the Centre for Family Violence and Sexual Violence Prevention, and the Chief Coroner. We heard oral evidence from the petitioner and the Centre.

Committee members

Hon Andrew Bayly (Chairperson)
Hon Ginny Andersen (to 25 March 2026)
Jamie Arbuckle
Carl Bates
Camilla Belich (from 25 March 2026)
Tākuta Ferris
Rima Nakhle
Dan Rosewarne (from 25 March 2026)
Tom Rutherford
Todd Stephenson
Vanushi Walters (to 25 March 2026)
Hon Dr Duncan Webb
Dr Lawrence Xu-Nan

Helen White participated in some of our work on this petition.

Related resources

The documents we received as evidence in relation to this petition are available on the [Parliament website](#).

A recording of our hearing can be accessed online on [the Parliament website](#).