



LAW·COMMISSION
TE·AKA·MATUA·O·TE·TURE

Preliminary Paper 36

CORONERS
A REVIEW

A discussion paper

*The Law Commission welcomes your comments on this paper
and seeks your response to the questions raised.*

These should be forwarded to the Law Commission
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Preface

I N 1995 AND 1996 the Law Commission undertook extensive consultation with Māori for its Succession Law project. It was evident from that consultation that there are aspects of coronial practice which are of particular concern to Māori. We are also aware that many of the concerns which arise for Māori also arise for other communities for cultural, religious or personal reasons.

The Law Commission decided that it should separately consider the specific issues which had been raised in relation to coronial practice. Meetings were held with officials from the Ministry of Justice and the Department for Courts, as both are currently responsible for administering the Coroners Act 1988. The Law Commission also considered the extensive material held by the Ministry of Justice in relation to the Coroners Act 1988, which includes correspondence from the public about the coronial system. In addition, the Commission consulted a forensic pathologist, Dr K J Thomson, about the issues raised in this paper.

We have identified two categories of problems. The first category relates to broad concerns that the current coronial system is inadequate. These are:

- the procedures for the appointment, supervision and removal of coroners;
- the failure of government departments to act on coroners' recommendations;
- the lack of uniformity of coronial practice throughout New Zealand; and
- the absence of a method for systematic appraisal of coroners' reports to ensure that patterns of sudden death or factors predisposing to sudden death are identified and accorded an appropriate response.

The second category of concerns relates specifically to the conduct of the coronial office. Issues in this area are:

- the insensitive handling of the body and/or body parts by coroners and pathologists despite provisions in the Coroners Act 1988 which require coroners to have regard to cultural values or spiritual beliefs;
- practices which fail to take account of, or which conflict with, different cultural values, such as leaving the deceased unattended at a mortuary;
- the failure to inform the family when body parts are removed or samples taken;
- the absence of a specific provision requiring the return of organs or limbs removed during a post-mortem examination, and the consequent failure in some cases to return a specific body part with the body or to notify the family that a body part has not been returned; and
- unnecessary delay in the return of a body and/or body parts.

In this discussion paper we:

- consider the issues which were raised during the consultation process;
- review the relevant law both in New Zealand and overseas; and
- propose amendments to the Coroners Act 1988 to deal with the concerns which have been identified.

We have attempted to develop proposals which give weight to cultural values, particularly Māori cultural values, as well as recognise that determining the

cause of death is the important function of the coronial system. The Law Commission is interested in receiving submissions on issues discussed in this paper and especially on the proposals which the Law Commission makes for amending the Coroners Act 1988. The Law Commission will then publish a Final Report which will make recommendations for the amendment of the Coroners Act 1988.

The Commissioner in charge of preparing this report was Denese Henare. The research and writing was undertaken by Jason Clapham and Meika Foster.

Submissions or comments on this paper should be sent by 15 October 1999 to Meika Foster, Law Commission, PO Box 2590, DX SP23534, Wellington, or by email to MFoster@lawcom.govt.nz.

Glossary

The following definitions apply to the use of these terms in this paper. We do not intend to exclude the possibility that some of these terms can also have a wider meaning.

hapū	extended kin group, consisting of many whānau
iwi	tribe, descent group consisting of many hapū, the people of a place
kaiāwhina	assistant, agent
kaitiaki	guardian
karakia	prayers
kaumātua	elder
marae	(1) the open space in front of the meeting house (2) the modern marae complex, including open marae, meeting house, dining hall, kitchen facilities and toilet facilities, which functions as a meeting ground and symbol of identity for whānau and hapū, and sometimes also for communities formed on other bases, such as residence in the same town or suburb, or affiliation to a religious denomination
tangi/tangihanga	ceremony of mourning the dead
taonga	treasure
tikanga	law, custom, traditional behaviour, philosophy
tūpuna	ancestors
whānau	nuclear family, extended family, or a community with a common purpose or identity; in the definition of whānau, circumstances and context are important variables

1 Introduction

THE PURPOSE OF CORONIAL INQUIRIES

- 1 **T**HE STATE TAKES A VITAL INTEREST in ascertaining, as precisely as possible, the cause of all deaths so that suspicions of foul play, homicide or neglect of human life can be fully investigated. The underlying objective is to allow dangerous or negligent practices that have cost human lives to be identified and then modified or eliminated. These interrelated aims provide the foundations of twentieth century coronership.¹
- 2 The vast majority of deaths in New Zealand do not require a coroner's inquiry or investigation to establish the cause or manner of death. Rather, a death certificate is issued by a registered medical practitioner and mourning and funeral arrangements can proceed without delay. There is no State involvement apart from requirements relating to burial, cremation, the registration of the death and, in particular cases, police inquiries to locate the doctor concerned who is able to issue a certificate.
- 3 In some circumstances, however, the State is required by law to become more closely involved. Under the Coroners Act 1988, certain deaths must be reported to the Police and then to a coroner. These are: deaths without a known cause, unnatural or violent deaths, suicides, deaths occurring while the person concerned was undergoing a medical, surgical or dental operation or procedure, and deaths in a prison or mental hospital (s 4). These cases necessitate an inquiry by the coroner to establish the cause and manner of death. In nearly every such case, the cause of death is established by a post-mortem examination.
- 4 With the authority of a coroner, a pathologist may perform a post-mortem examination of a body. A post-mortem examination typically involves a gross examination of the exterior of the body for any abnormality or trauma and a careful inspection of the interior of the body and its organs. Small samples of tissue are invariably taken from each important organ for microscopy and analysis. Blood and urine samples may also be taken.
- 5 The post-mortem may be performed where the coroner is to hold an inquest into death or has opened but not completed an inquest, or to enable the coroner to decide whether to hold an inquest (*Laws NZ, Coroners*, para 17). In deciding whether to authorise a post-mortem examination, the coroner must consider the extent to which the information already available addresses the matters that an inquest considers and the extent to which the post-mortem is likely to answer the questions raised at an inquest.
- 6 A coroner's inquest is a judicial hearing presided over by a warranted judicial officer who has most of the powers of a District Court Judge. It is a fact-finding

¹ For the historical development of the office of the coroner, see the Appendix.

exercise rather than a method of apportioning guilt. Consequently, it is a process of investigation unlike a trial.

- 7 The purpose of an inquest is to establish that a person has died, that person's identity, when and where that person died, and the causes and circumstances of the death (s 15(1)(a)(i)–(v) of the Coroners Act 1988). In addition, if the death appears to have been unnatural or violent, the coroner must consider whether this appears to have been due to the action or inaction of any person.
- 8 A further important objective of an inquest is to enable the coroner to make recommendations or comments on avoiding circumstances similar to those in which the death occurred or on how people should act in such circumstances to reduce the chances of similar deaths occurring. For this to be achieved, the inquiries of the coroner should not be limited to matters of mere formality, but should be of social and statistical relevance to a modern community (*Re Hendrie* (HC Christchurch, 12 January 1988, CP445/87, Hardie Boys J)).
- 9 Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what is seen as the immediate cause of an accident: the primary causes can and frequently do lie much deeper.² In this context, it has progressively become evident that the fundamental causes of accidents, and therefore the measures required to avoid recurrence, can require a much broader perspective than that which is currently adopted by coroners.
- 10 With certain notable exceptions,³ deaths tend to be considered without any system for broad appraisal of the background factors contributing to the death to establish whether it is an isolated episode or a symptom of a deep-seated problem. The Commission considers it imperative that the possibility of fundamental causes is a regular exercise of the coroner's function. A true appraisal of apparently insignificant incidents can remove or reduce the prospect of disaster. This is made difficult at present, however, because there is no system for the collation and appraisal of a particular coroner's finding in relation to others.
- 11 This paper makes a number of recommendations to address the inadequacies of the current coronial system,⁴ with a particular focus on:
 - the procedures for the appointment, supervision and removal of coroners;
 - the failure of government departments to act on coroners' recommendations;
 - the lack of uniformity of coronial practice throughout New Zealand; and
 - the absence of a method for the systematic appraisal of coroners' reports to ensure that patterns of sudden death or of factors predisposing to sudden death are identified and accorded an appropriate response.

In addition to proposing such wide-ranging recommendations, this paper also addresses the specific concerns that particular coronial practices are culturally inappropriate.

² The Law Commission will be releasing a discussion document on general systems safety in the near future.

³ For example, the report of the coroner at Taumarunui delivered on 16 April 1999 into the deaths resulting from the Raurimu shootings.

⁴ See in particular our proposal for the establishment of the institution of Chief Coroner beginning at paragraph 105.

THE CORONERS ACT 1988 AND CULTURAL CONCERNS

- 12 The Coroners Act 1988 came into force on 1 January 1989. One of its primary purposes was to address concerns that some of the practices under the 1951 Act were culturally insensitive.⁵ These concerns were noted by the Working Party on Delays in the Release of Bodies for Burial, which was set up in 1983 by the then Minister of Justice. Their Final Report identified two coronial practices as particularly problematic, namely: the performance of post-mortem examinations and the delay in releasing bodies for burial.
- 13 In its Final Report, the Working Party found that “unreasonable delays [in the release of bodies for burial] have continued to occur”. It therefore recommended that:
- the Coroners Act 1951 be amended to provide that a Coroner or, in his absence, a Justice shall, in exercising any power or authority conferred upon him by the Act, have regard, as far as is reasonably practicable, to the ethnic traditions and spiritual beliefs of a deceased and the family. (p 10)
- 14 In response to these recommendations, the Government enacted the Coroners Act 1988.⁶ Section 8 of the Act provides that a coroner must have regard to spiritual beliefs and customary values in deciding whether or not to authorise a doctor to perform a post-mortem. Section 9 provides that a coroner shall direct a doctor to perform a post-mortem forthwith if the family of the deceased require the body to be available as soon as possible.
- 15 Notwithstanding these provisions, concerns in relation to the operation of the Act have continued to be expressed in relation to:
- the insensitive handling of a body and/or body parts by coroners and pathologists notwithstanding ss 8 and 9 of the Act;
 - practices which fail to take account of, or which conflict with, different cultural values, such as leaving the deceased unattended at a mortuary;
 - the failure to inform the family when body parts are removed or samples taken;
 - the absence of a specific provision in the Act requiring the return of organs or limbs removed during a post-mortem examination, and the consequent failure in some cases to return a specific body part with the body or notify the family that a body part has not been returned; and
 - unnecessary delay in the return of a body and/or body parts.
- 16 In the following chapters, we propose various amendments to the Coroners Act 1988 to address these specific concerns as well as the more general concerns about the coronial system discussed earlier.

⁵ See the speeches made during the various readings of the Coroners Bill: (27 July 1982) Vol 444 NZPD 1450–1460; (14 April 1983) Vol 450 NZPD 121–137; (14 July 1987) Vol 482 NZPD 10430–10434; (19 April 1988) Vol 488 NZPD 3412–3416; (14 June 1988) Vol 489 NZPD 4361–4371; (19 July 1988) Vol 490 NZPD 5156–5165.

⁶ For a detailed review of the law in relation to this Act, see *Laws NZ, Coroners* (1992–).

2

Cultural values – the body and body parts

INTRODUCTION

- 17 **P**EOPLE HAVE DIFFERING VIEWS and practices regarding death. For example, both Jewish and Islamic beliefs entail the need for a speedy burial of the deceased (Brennan 1992). Jewish customary law also requires a specially appointed guardian to attend the deceased until burial. The guardian is required to spend the night with the deceased reciting prayers (Hirsh 1986, 49). Cook Islanders believe the deceased should not be interfered with (Kiriau 1986, 16). Traditionally, Fijians view post-mortems as unthinkable and believe that the dead should not be tampered with (Curulala 1986, 21). Niueans generally consider post-mortems to be a strange practice (Sipeli 1986, 24–25). Samoans and Tongans regard post-mortems as an indignity to the deceased (Pesio 1986, 29; Falemaka 1986, 30).
- 18 Māori are no exception. Differences between Māori beliefs and western philosophy regarding death have caused Māori to raise a number of concerns regarding the Coroners Act 1988. In particular, these concerns relate to powers under the Coroners Act 1988 being exercised without due regard to Māori customs and spiritual beliefs as is required by ss 8 and 9 of the Act. In this paper, we consider Māori cultural values concerning death, particularly as they relate to the body and body parts. We also discuss how the law treats issues concerning the body and body parts. Particular difficulties arise in respect to the removal and retention of body parts during a post-mortem examination, an area where the law in New Zealand is silent.

WHĀNAU AND RESPECT FOR THE DEAD

- 19 In Māori culture, the whānau has an intimate connection with the deceased and is usually closely involved with the preparations leading up to the deceased's burial. The deceased is "cared for, cherished, mourned, spoken to [and] honoured" (Dansey 1992, 108). Respect continues to be shown in this manner because, although the physical remains of a person are lifeless, the spirit continues to live on (Barlow 1996, 97; Oppenheim 1973, 15).
- 20 In making its Final Report to the Minister of Justice, the Working Party on the Delays in the Release of Bodies for Burial noted the significance of death in Māori culture. The Working Party noted:

[Māori] spiritual and cultural traditions require the immediate availability of the body for the Tangihanga . . . To the Māori people the body symbolises a spiritual

cord which links the living with those who have passed along the pathway to the ancestral world. It is important in Māori tradition that mourners should spend as much time as possible with the body after death occurs. The body should not be left alone before burial. (p 5)

- 21 Because of the importance attached to death and the deceased, the tangihanga is a central aspect of Māori culture (Dansey 1992; Oppenheim 1973). It takes precedence over all other hui, and indeed over all other activity. Māori consider it critically important that the deceased's body be taken to a marae as quickly as possible so that the tangihanga may begin. Delay in the release of the body causes great anguish to whānau, hapū and iwi as it hinders the timely commencement of the tangihanga. As an example, Māori practise distinct protocols in deciding where a deceased is to be buried. In the most general sense, this decision is made by the deceased's "people" (Salmond 1987; *Awa v Independent News (Auckland) Ltd*). Anxiety will understandably increase if the coronial process is delayed, for instance due to the unavailability of a coroner or pathologist in the weekend. This could prevent the body being taken to an appointed burial place some distance from where the post-mortem was conducted. Or it may hinder the common practice of allowing the funeral procession to spend some time en route at certain marae so that particular hapū or whānau may grieve and farewell the deceased.
- 22 Tikanga requires that the deceased be kept warm. The deceased must not lie alone between death and burial. Many Māori find the:
 - physical coldness and isolation of the hospital mortuary contrary to the Māori view that the body and soul of the deceased must be kept continually warm and comfortable by the presence of kinfolk. (Ngata 1986, 8)
- 23 It is for this reason that Māori often ask to be allowed to remain with the deceased while the coroner has possession of the body. During the consultation process, many whānau were upset that they were not allowed to remain with the deceased while the body was under the coroner's control.
- 24 Māori suggested that there should be provision in the Coroners Act 1988 to permit a whānau representative to act as kaitiaki of the deceased while proceeding through the coronial system. A kaitiaki would be able to:
 - represent the wishes of the whānau in any discussions with coroners and agencies;
 - give assurance to the whānau that the deceased is being cared for and treated with respect; and
 - remind those involved in the coronial process that there is a whānau waiting for the return of their deceased for the continuation of the funeral process.
- 25 Because of the importance of the deceased to the whānau, many Māori consider that state intervention in the death process should be kept to an absolute minimum. Indeed, in our view, such limited intervention is implicit in the legislation.

CORONERS ACT 1988

- 26 A number of provisions were included in the Coroners Act 1988 with the intention of ensuring that coronial practices would have regard to cultural values.

- 27 Section 8 provides that when a coroner is deciding whether or not to authorise a post-mortem examination, the coroner must consider:
- (e) The desirability of minimising the causing of distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as is possible after death; and
 - (f) The desirability of minimising the causing of offence to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find the post-mortem examination of bodies offensive.
- 28 Section 9 provides that when a coroner has authorised a post-mortem, the coroner must consider whether the deceased or a member of the deceased's immediate family has:
- ethnic origins, social attitudes or customs, or spiritual beliefs [which] customarily require bodies to be available to family members as soon as is possible after death.
- 29 If the deceased or the deceased's family do have such beliefs, the coroner:
- shall direct the doctor to perform [the post-mortem] forthwith; and in that case the doctor shall do so. (s 9(1))
- 30 Section 14 provides that the coroner must authorise the disposal of a body as soon as he or she is satisfied that it is no longer necessary to withhold the body from family members.
- 31 If a coroner authorises a doctor to perform a post-mortem examination, the coroner must take all reasonable steps to ensure that a member of the deceased's immediate family is given notice, as soon as is practicable, that a post-mortem is to take place (s 11(1)). The coroner must state the coroner's reasons for authorising the post-mortem (s 11(1)(b)). If a coroner holds an inquest, the coroner must direct the Police to notify every person with a sufficient interest in the inquest that an inquest is to be held (s 23(1)). The immediate relatives of the deceased must be notified under this section (s 23(2)).
- 32 The provisions listed above seek to ensure that coronial practices under the Coroners Act 1988 are culturally sensitive in a number of ways. First, consideration must be given to cultural values at several stages of the coronial process. Secondly, the Act emphasises the importance of releasing the body of the deceased to the family as quickly as possible. Thirdly, the Act requires coroners to keep families informed of what is happening to the deceased.
- 33 These provisions were intended to address Māori and other communities' concerns that coronial practices were culturally insensitive. However, it appears from the consultation process undertaken by the Law Commission that, in some instances, these provisions are not having their intended effect and cultural values and beliefs are still being ignored. A recent incident involving a coroner which received widespread media attention is one example.
- 34 The deceased, a Māori, died in 1992 as a result of head injuries sustained in an altercation. The day after the death, the deceased's spouse was advised that the body was being held for a post-mortem. A post-mortem examination concluded that the deceased died from acute subdural haematoma. The next day (two days after the deceased's death), the funeral directors were advised that the body could be collected. On arrival at the mortuary, however, they were told by a Police Officer involved in the investigation into the cause of death that the

brain of the deceased was being retained for between 1–14 days. No reason for this was given. The funeral directors passed this information on to the family.

- 35 Over the next few days, the family attempted to convene a meeting with the coroner to discuss their concerns and to request the return of the brain so that a tangi might proceed. The coroner would not meet with them. The coroner said that the brain had been retained to give the defence an opportunity to examine it prior to trial. Ultimately, it was established that there was no need to retain the brain. However, the family had to instigate legal proceedings before it was returned.
- 36 This example is not an isolated incident. During the consultation process, the Law Commission became aware of many cases where concern had been expressed about the cultural insensitivity of coronial practices. In particular, since the 1988 Act came into force, many families have written to the Minister of Justice concerned that they had not been allowed to remain with the deceased during the coronial process. Many families were also concerned they had not been notified a post-mortem was to be conducted.

OVERSEAS LEGISLATION

- 37 It is useful to contrast the position in New Zealand with that in Australia. In many Australian territories, unless the coroner believes that a post-mortem examination needs to be performed immediately, a coroner must not perform a post-mortem on the body of the deceased if the “senior next-of-kin of the deceased person”⁷ objects.⁸ If the coroner decides that a post-mortem is necessary despite the senior next-of-kin’s objection, the coroner must notify the senior next-of-kin of this and must not perform a post-mortem until 48 hours after such notification is given. This allows the senior next-of-kin time to apply to the courts for an order in its discretion preventing the performance of the post-mortem.
- 38 In deciding whether or not to perform a post-mortem examination, the coroner must balance the interests of the family of the deceased on the one hand (that they be permitted to follow and maintain their Aboriginal culture and law) against the interests of the community on the other (that the cause of an otherwise unexplained death be ascertained if possible). Two recent cases give some indication of how this should be done.

⁷ “Senior next-of-kin” is generally defined in the legislation as meaning:

- Where the deceased was married – the person’s spouse;
- Where the deceased was not married or, if married, the spouse is not available – the deceased’s son or daughter of or over 18 years;
- Where a spouse, son or daughter is not available – the deceased’s parent.
- Where a spouse, son, daughter or parent is not available – the deceased’s brother or sister of or over 18 years;
- Where no one else is available then the executor named in the deceased’s will or a person who was the deceased’s personal representative;
- Where a deceased was an aborigine – a person who, according to the customs and tradition of the community or group to which the deceased belonged, is an appropriate person.

⁸ Section 23 of the Coroners Act 1993 (NT); s 38 of the Coroners Act 1995 (Tas); s 29 of the Coroners Act 1985 (Vic); s 37 of the Coroners Act 1996 (WA).

- 39 In *Green v Johnstone* [1995] 2 VR 176, a deceased child's aboriginal parents sought an order from the Supreme Court of Victoria preventing the coroner from performing a post-mortem. The coroner intended to carry out a post-mortem to discover whether the child had died of sudden infant death syndrome. The parents objected to the post-mortem as it conflicted with a traditional Aboriginal law which prohibited mutilation of the body. The parents also objected because the post-mortem threatened the preservation of the deceased's spirit.
- 40 In *Green v Johnstone*, Beach J held that in the absence of suspicious circumstances surrounding the death, the rights of the parents to be spared further grief overrode the community's interest in discovering the actual cause of death. In granting the order preventing the post-mortem, Beach J stated:
- In a multi-cultural society such as we have in this country, it is my opinion that great weight should be given to the cultural and spiritual laws and practices of the various cultural groups forming our society, and that great care should be taken to ensure that their laws and practices, assuming they are otherwise lawful, are not disregarded or abused. (p 179)
- 41 In *Re Death of Simon Unchango (Jnr), ex parte Simon Unchango (Snr)* (1997) 95 A Crim R 65 an aboriginal child aged only 12 days died suddenly. The coroner gave notice to the relatives of the child that it was likely that a post-mortem examination would be ordered. The father of the child applied to the Supreme Court of Western Australia for an order prohibiting the performance of the post-mortem. The father objected to its performance on both cultural and religious grounds. Evidence was given that Aboriginal people believe that:
- if the body of the child is cut up then that will mean that his spirit will not rest . . . the spirit will be roaming around and will not enter the Dream Time. (p 68)
- 42 In *Re Death of Simon Unchango*, Walsh J stated:
- I would have thought that it is beyond doubt that the cultural beliefs of the applicant are of course always essentially relevant and in the case of Aboriginal people such as this, who fervently believe of the spirit leaving the body and the difficulties that occur if a body is interfered with, then proper regard should be had to that factor when balancing the relevant considerations. (p 70)
- 43 Walsh J held that there was no doubt on the available evidence that the death was due to natural causes. Walsh J granted the order preventing the post-mortem and stated:
- One should take into account the very strong cultural beliefs held by the relatives and by the community at Kulumburu and the effect that the post-mortem would have on them by way of emotional trauma, particularly in view of the fact that it would prohibit, in their view, the spirit of the deceased remaining in the body and returning to the body and would leave the spirit roaming at large. (p 71)
- 44 It is important to note, however, that in both decisions the Court emphasised that each case must be decided on its individual facts. Nonetheless, these cases emphasise to decision-makers the importance to be given to cultural beliefs when making decisions concerning the coronial process. They therefore provide a useful reference point for coroners in New Zealand when having regard to cultural values and spiritual beliefs as required by the Coroners Act 1988.

REMOVAL/RETENTION OF BODY PARTS

- 45 Another area of coronial practice that particularly troubles Māori relates to the removal and retention of body parts. It was often expressed during our consultation process that the removal or retention of a body part conflicts with cultural or spiritual beliefs and values. A number of other concerns were also frequently noted. These were:
- the failure of coroners and pathologists to inform whānau that a body part would be removed from the deceased and the lack of discussion about why removal was necessary;
 - difficulties in getting the body part returned quickly; and
 - the absence of a specific provision requiring the return of body parts removed during a post-mortem examination and the consequent failure in some cases to return a body part with the body.

Māori custom law

- 46 Māori law does not tolerate the removal or retention of body parts. Māori consider that all parts of the body are imbued with a life spirit handed down from the ancestors, contributed to by each successive generation, and passed on to future generations. (Mead 1996, 46–47). Since Māori view their most sacred role as being the preservation of the dignity of their ancestors, the removal or retention of body parts is sacrilegious to them. It undermines their cultural values and prevents them from carrying out their responsibilities in relation to the deceased.
- 47 The removal and retention of any body part therefore needs to be resolved with the whānau. The coroner needs to inform the whānau and/or kaitiaki why, where, and how long, the body part will be required for examination (see para 67).

The common law

- 48 The definition of “body” in the Act, which includes body parts, is more limited than the Māori understanding of those terms. Section 2 of the Coroners Act 1988 defines “body” as meaning:
- a dead person, and includes –
 - (a) any part of a person without which no person can live; and
 - (b) any part of a person discovered in such circumstances or such a state that it is probable that the person is dead – whether or not the identity of the person concerned is known when the part is discovered or is later determined; but does not include a foetus or a stillborn child.
- 49 Coroners do not have a statutory right to the possession of a body or its parts. However, at common law, the coroner has the right to the possession and control of the body from the time “the report reaches the coroner that a person has been killed or died violently” until the conclusion of the inquest (*R v Bristol Coroner, ex parte Kerr* [1974] 1 QB 652, 658–659). It appears that coroners have the right to the possession of the body so that they can hold an inquest and thereby carry out their function of determining the deceased’s cause of death.

Once the inquest has been completed, the executors or administrators have the right to the possession of the body for the purposes of burial.⁹

- 50 Section 14 of the Coroners Act 1988 reflects the idea that the coroner is not entitled to possession of the body after the inquest has been completed. Section 14 provides that the coroner must authorise the disposal of the “body” as soon as the coroner is “satisfied that it is no longer necessary to withhold [the] body from family members”.
- 51 The coroner has the right to the possession of the body for the purpose of conducting an inquest. Section 15 of the Coroners Act provides that a coroner holds an inquest for a number of specific purposes. These include determining:
- that a person has died;
 - the person’s identity;
 - when and where the person died;
 - the causes of the death; and
 - the circumstances of the death.

It could be argued that it will only be “necessary” for a coroner to withhold a body (as defined in s 2) from the deceased’s family in order that the coroner may establish the matters listed in s 15. If this is correct, then s 14 requires the coroner to authorise the disposal of the body as soon as it is no longer required for one of the purposes set out in s 15. The coroner could not, for example, retain the body after the post-mortem had been completed solely because the defence in a homicide case wanted to conduct further tests. Due to the limited definition of “body” in s 2, it is unclear if this would apply to all body parts.

- 52 Neither coroners nor pathologists have a statutory right to remove body parts from the deceased during a post-mortem examination. Often, however, a coroner or a pathologist may wish to remove or retain a body part from a body. If body parts are removed during a post-mortem examination, it is unclear what should happen to those body parts and who has the right to the possession of them.
- 53 The Coroners Act does not require a pathologist to notify a coroner if the pathologist has removed a body part from the deceased. Coroners are not required to notify or obtain the consent of the deceased’s family if body parts are to be removed and retained from a body. In 1992, the Department of Justice developed a number of new forms which were to be used by coroners. One of the forms notified families that a body part had been retained and indicated for how long the body part would be retained. Although the forms were sent to coroners, there is nothing in the Act, or in regulations made under the Act, which requires coroners to use the forms. Since the forms were sent out, complaints have continued to be made about the retention of body parts.
- 54 There is no provision in the Coroners Act for body parts removed during a post-mortem to be placed back with the body before the body is released.

⁹ *Tapora v Tapora* (28 August 1996, CA206/96) 3; *Halsbury’s Laws of England*, paras 1017–1019; *Murdoch v Rhind & Murdoch* [1945] NZLR 425, 426–427; *Re Clarke (Deceased)* [1965] NZLR 182, 183; *Williams v Williams* (1882) 20 Ch D 659, 665; *Awa v Independent News (Auckland) Limited* [1995] 3 NZLR 701.

DISCUSSION CONCERNING THE RETENTION OF BODY PARTS

- 55 There are a number of reasons why it may be necessary in the course of a post-mortem examination to remove and retain body parts. The most predominant of these is the need to ascertain the cause of death.
- 56 As the law currently stands in New Zealand, neither coroners nor pathologists have a statutory right to the possession of the body or to remove or possess body parts. Also, there is nothing in the Act which requires coroners or pathologists to notify family members if a body part has been removed or retained. If body parts are removed, it is unclear whether the coroner, pathologist, or administrator has the right to the possession of those body parts. One of the difficulties which arose in the case example discussed at para 34, was that the coroner believed that he could not give the pathologist who had retained the body part any directions as to what should be done with the body part. It was unclear who was responsible for the body part and therefore to whom the family should address their concerns. In the end, the family were forced to begin court proceedings.
- 57 The Law Commission consulted with a forensic pathologist about the retention of body parts and tissue. We were informed that pathologists should, as a matter of practice, take and retain microscopic samples from many of the deceased's organs. In most cases, the causes and circumstances of death will be ascertained from a post-mortem examination and testing of these small samples. Generally, there will be no need to retain major body organs. Where body parts are retained, however, the body part should only be needed for between four and five days for all the required testing to be carried out. It would be rare for a body part to be retained for longer than this.
- 58 Where there has been a homicide or a suspected homicide (a small proportion of all cases where a pathologist performs a post-mortem examination), issues arise in relation to the defence having access to the body for the purposes of conducting their own post-mortem.
- 59 The Law Commission has been advised that if a post-mortem is held in a homicide case after a suspect has been arrested, the defence will generally be invited to have their own pathologist attend the post-mortem. Where a suspect has not been arrested at the time of the post-mortem, the report from the post-mortem, photographs taken during the examination, the results of any testing done on samples from the deceased's organs, and the ability to do tests on retained microscopic samples, will provide an adequate basis for a second opinion by a defence pathologist. Where the cause and circumstances of death are not entirely clear, samples sufficient for such future testing should be retained. Again, in most circumstances, there will be no need to retain an entire organ.
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3 Resolving the conflicts

INTRODUCTION

- 60 **I**N THIS CHAPTER we outline our proposals for change to the Coroners Act 1988. These proposals recognise that determining the cause of death is an important public function. They clarify the legislation so as to:
- reflect the common law position that coroners have the right to possess the body until the conclusion of the post-mortem examination; and
 - make it clear that a pathologist may lawfully take tissue samples and may remove and retain a body part in specific circumstances.

We also recommend including in the Act two options intended to address Māori concerns that current coronial practices are culturally insensitive in the treatment of the deceased and in the removal and retention of body parts.

PROPOSALS

- 61 The Law Commission proposes that the Coroners Act 1988 be amended to provide that:
- coroners have the right to possess the body and its parts from the time a death which is reportable under s 4 of the Coroners Act 1988 occurs until the post-mortem examination is completed or the coroner sooner authorises the disposal of the body under s 13 of the Coroners Act 1988. (Section 4 sets out when a death must be reported to a coroner. Section 13 provides that a coroner may, at any time, authorise the disposal of the body);
 - a pathologist authorised by the coroner may remove and retain any body part or tissue which the pathologist considers necessary in order to determine any of the matters set out in s 15 of the Coroners Act 1988. As noted above, in most cases the pathologist will not need to retain a body part to determine the causes and circumstances of death. However, the Law Commission is of the view that the Coroners Act should be clear about what is to happen in the rare case when it is necessary to retain a body part. The pathologist should be required to notify the coroner which body part the pathologist has removed, the reason for its retention, and the length of time for which the pathologist proposes to retain the part;¹⁰
 - it is explained to the family at the outset that a post-mortem examination has been authorised and that the family is asked whether, and in how much detail, they would like to be kept informed of this process. We are aware that information requirements will be specific to each family. We envisage that,

¹⁰ The whānau is also entitled to receive this information. We acknowledge that some Māori advocate the position that body parts should not be removed under any circumstances unless consent from the whānau is first obtained. However, in recognising the importance in appropriate cases of ascertaining the cause of death and in order to ensure the timely release of the body, we do not feel that this position is practicable.

in some cases, families may not wish to receive information concerning the specifics of the coronial process, but in others, families will wish to be alerted to issues concerning the removal and retention of body parts;

- the body, including body parts, should be returned to the family as soon as is reasonably practicable;
- the terms “body parts” or “tissue” should exclude microscopic samples which pathologists retain as a matter of practice. In the Law Commission’s view, families would not, in general, want the slides on which the microscopic samples are contained returned to them. Further, on the advice which the Law Commission has received, such a requirement would unduly hamper pathologists in their work;
- persons who have an interest in the matters set out in s 15 of the Coroners Act 1988, such as defence counsel, may apply to the coroner to conduct independent tests on the body or specific body parts. Ensuring that such tests are subject to a process of application and approval allows the coroner to further protect the rights of families to be informed and have their cultural values taken into account.

62 In the Law Commission’s view, these proposals would clarify the law in relation to who has the right to the possession of body parts and body tissue. Determining the cause of death is an important public function. It should be clear that the coroner has the right to the possession of the body and the deceased’s body parts so that the coroner can effectively carry out this function. With these proposals, the coroner would only have the right to the possession of the body until the conclusion of the post-mortem or until the coroner sooner releases the body under s 13. After the post-mortem is completed, the coroner would have no right under the Act to possess the body or any body part and would be required by s 14 to authorise the disposal of the body to the family.

63 In the Law Commission’s view, the above proposals would prevent the reoccurrence of the situation discussed at para 34 above. The coroner would be responsible for liaising with the whānau and keeping them informed of what was happening and could give the pathologist directions about the retention of the body part or tissue as required. We are aware, however, that there are a number of issues arising from our recommendation concerning the requirement to inform the family that may need to be further addressed. For example, it is possible that some families will not want to know even that a post-mortem examination has been authorised. Another issue is whether in some cases, such as those where there are no suspicious circumstances surrounding the death, families should have the right to object to the decision to undertake a post-mortem examination. **We are interested to receive submissions on these points.**

OPTIONS

64 There are two major areas of cultural conflict which require resolution. The first is insensitive treatment of the deceased and hence the whānau. Several provisions were included in the Coroners Act 1988 which were intended to address concerns that practices under the Coroners Act 1951 were culturally insensitive. However, it appears from the consultation process undertaken by the Law Commission that there are still concerns about the cultural insensitivity of coronial practices.

65 Such practices may be occurring because the Act:

- does not expressly provide that a member of the whānau can touch, view,

- remain with, or be in close proximity to, the deceased prior to a post-mortem examination; and
- does not allow a member of the whānau to remain with, or be in close proximity to, the deceased during a post-mortem.
- 66 Secondly, there is the issue of retention and/or removal of body parts. As discussed at para 38, Māori are particularly concerned about: the failure of coroners and pathologists to consult with whānau before removing a body part from the deceased; the lack of discussion about the reasons for the removal; and the difficulties in getting the body part returned quickly.
- 67 In attempting to address these areas of conflict, the Law Commission proposes that the Coroners Act 1988 be amended to provide that the deceased's whānau be given the following options of:
- with the consent of the pathologist, viewing and touching the body prior to the post-mortem examination.¹¹ We envisage that this option would allow karakia to be performed;
 - having a family representative or kaitiaki remain with, or be in close proximity to, the body while it is under the coroner's control and/or possession. Currently, s 10(3) of the Act provides that any "doctor may, with the authority of a coroner granted on the application of any person, be present as the person's representative at a post-mortem examination authorised by the coroner" under the Act. In our view, the scope of this section should be widened to include any registered health professional or funeral director of the family's choice. We would envisage that in the exercise of this option, the chosen kaitiaki would have an opportunity to meet with a co-ordinator acting on the coroner's behalf and located in the coroner's office so as to fully understand the processes involved. The role of the co-ordinator would be to liaise with the whānau, kaitiaki, pathologist and coroner. (The position of co-ordinator would probably be best filled by a trained health professional, although in more isolated areas it may be adequately served by another respected member of the community, such as a local police officer).
- 68 As regards the second option, we are aware that many Māori would prefer that s 10(3) allow for any person of the family's choice to be appointed as kaitiaki. It has been suggested, however, that this would be problematic if the kaitiaki chooses or feels obliged in the interests of keeping the body warm to remain with the body during a post-mortem examination, as distinct from simply remaining in close proximity to the body. To watch a post-mortem is a traumatic and extremely unpleasant experience. In many cases, for instance where there has been a homicide, the deceased will be in the same state in which he or she died. It is difficult even for those who have elected to undertake anatomical pathology as a full-time occupation to deal with a body in a state of decomposition. In addition, we have been advised that many pathologists would feel extremely uncomfortable about performing a post-mortem examination in front of family members and may be reluctant to do so. **We are particularly interested to receive submissions on these points and on alternative ways that these issues might be resolved.**
- 69 We envisage that having a liaison process similar to the one recommended will serve a number of purposes. First, both the coronial process and the family have

¹¹ In Western Australia, the coroner must ensure that the deceased person's next-of-kin may view or touch the body (unless the coroner determines that it is undesirable or dangerous to do) (s 30(2) Coroners Act 1996 (WA)).

a mutual interest in ascertaining the cause of death. We envisage that liaison with a kaitiaki as one means of communication with the family will enhance this, ensure a timely post-mortem examination, and thereby facilitate the timely release of the body.¹²

- 70 Further, if in the coroner's opinion it would be dangerous or undesirable for the kaitiaki to remain with the deceased, these concerns could be explained and discussed during the liaison process. Examples of such concerns include where the deceased would pose a health risk to the kaitiaki, or if the deceased had been involved in a homicide, and there was a risk of contamination of evidence if the kaitiaki was allowed to remain with the body. In these instances, the kaitiaki could wait in an adjoining room while the post-mortem examination was carried out. We envisage that the availability of this option will prompt the need to consider the development in mortuaries of appropriate facilities and amenities to cater for this situation. In addition, improving the current physical condition of mortuaries would serve to reassure whānau that appropriate respect is being accorded to the deceased.
- 71 The liaison process will also ensure that any plans to remove and retain body parts or tissue are explained to, and discussed with, the whānau. We have been advised that in most cases, the taking of tissue samples will be all that is required to further the investigation. In our view, once the whānau understands the practicalities of the tissue sampling process and its importance in ascertaining the cause of death, they are unlikely to take issue with the procedure. In those rare cases where, in determining the cause of death, it is necessary to remove a body part, the liaison process will serve to keep the whānau informed and reassure them that all steps are being taken to return the body part as quickly as possible.
- 72 Finally, liaison will provide the first opportunity for other issues be resolved in a timely manner. As an example, the potential exists for the coroner to be faced with competing claims when it comes time for the body to be released. Debate and conflict over the deceased is common and accepted in Māori custom. The Billy T James case provides a useful analogy. Shortly after Billy T James's death, members of Tainui arrived at his family home and, against the wishes of his widow, took his body to another town to lie on a marae before being taken to Taupiri Mountain for burial. This was in accordance with tikanga that it is the tribe which determines funeral arrangements rather than the grieving family.
- 73 At common law, those persons responsible for the estate of a deceased person have a duty to see to a proper burial according to law (*R v Sharpe* (1857) D & B 160; 169 ER 959). An executor has the right to a body for burial purposes, even against the wishes of the widow (*Hunter v Hunter* (1930) 65 OLR 586). In the Billy T James case, there was no will and so no one had a common law right to Billy T James's body at the relevant time. But the body was in the lawful possession of the widow and those in the Muriwai house (*Awa v Independent News (Auckland) Ltd* (HC Hamilton, 16 October 1995, CP152/92, Hammond J).
- 74 Kennedy and Grubb summarise the common law position thus:
- The person who has actual physical custody of the body has lawful possession (and the duty of disposal) of it until someone with a higher right (eg, an executor or parent) claims the body . . . In the absence of the executors there is a common law

¹² These matters could form part of the guidelines to be developed by the Chief Coroner (see para 106).

duty to see that the body is buried and the person lawfully in possession is normally the occupier of the premises where the body lies, or the person who has the body. (Kennedy and Grubb 1989, 10)

- 75 In the normal course of events, in the absence of a will, anyone may apply for the grant of Letters of Administration to obtain the right of possession to a body for burial purposes. This is usually granted without objection to a spouse. However, the issues concerning possession may be complicated where the deceased is Māori. The case of *Re Tupuna Māori* (HC Wellington, 19 May 1988, P580/88, Greig J) seems to suggest that on an application for the grant of Letters of Administration, a member of the deceased's iwi may be granted possession of the body for the limited purpose of according the deceased a proper burial according to Māori custom. The proposition that collective tribal rights to the body of a Māori should take precedence over other rights, such as those of a spouse, has not been tested in law.¹³
- 76 Clearly where time is of the essence and the deceased is Māori, the liaison process could be used to assist the coroner to release the body to the right people. The co-ordinator could be given the responsibility of ensuring that each coroner's office establishes a relationship with local communities so that coroners can call on kaumātua to assist in resolving these kinds of issues. Then if, for example, a debate arose regarding the person to whom the body should be released, the co-ordinator would be able to liaise with the coroner, the executor, the kaitiaki, local kaumātua and other interested parties in determining the appropriate course of action.
- 77 In our view, these proposals would ensure that Māori and other communities' cultural beliefs are more adequately taken into account. The Māori belief that the body should be kept warm prior to burial is given recognition. The proposals would also ensure that the coroner and the pathologist are not unduly restricted from performing their functions under the Act.

¹³ The extent to which Māori and Pakeha values conflict in this area will be canvassed in the Law Commission's proposed preliminary paper on Māori custom law. It may be that changes are required to be made to the Administration Act.

4

Appointment of coroners

- 78 **T**HERE HAVE BEEN numerous calls for the overhaul of the appointment provisions of the Coroners Act 1988.¹⁴ It appears that these calls have been made as a result of a number of incidents where coroners have exercised, or have failed to exercise, their powers in such a way as to cause public criticism of the coroner. In some cases, the incidents have received widespread media coverage.¹⁵
- 79 In New Zealand, the Governor-General may appoint “any person” to be a coroner (s 32 Coroners Act 1988). Coroners are not required to be legally or medically qualified (*Re Sutherland* [1994] 2 NZLR 242, per Barker ACJ). Indeed, coroners are not required to have any particular skills, characteristics, experience or training whatsoever.¹⁶ In New Zealand, legislation which authorises an individual to exercise judicial functions often sets out the skills, characteristics, experience or training which appointees must have.¹⁷
- 80 The Coroners Act does not require appointees to have undergone any particular training prior to their appointment.¹⁸ This can be compared with other judicial officers such as Community Magistrates (see rr 5–7 Community Magistrates Regulations 1998). Also, the Coroners Act 1988 does not require coroners to have any particular knowledge of Māori or other communities’ cultural values.
- 81 In New Zealand, legislation often sets out the procedure to be followed before an individual can be appointed to a particular office (eg, see ss 7–8 of the Disputes Tribunals Act 1988 and the Disputes Tribunal Rules 1989 in relation to the

¹⁴ See for example, The Evening Post, “*High time Coroners Act was overhauled*”, 5 July 1997. The Ministry of Justice holds many letters from members of the public calling for review of the appointment procedures of coroners.

¹⁵ See the cases referred to in The Evening Post, “*High time Coroners Act was overhauled*”, 5 July 1997.

¹⁶ The Department for Courts has informed us that the majority of coroners are lawyers and, that the current policy is to appoint coroners from within the legal community.

¹⁷ See for example: s 5 of the District Courts Act 1947; s 5 of the Family Courts Act 1980; ss 6, 26C of the Judicature Act 1908; s 113 of the Employment Contracts Act 1991; s 7 of the Te Ture Whenua Māori Act 1993; Māori Land Act 1993; s 249 of the Resource Management Act 1991; s 67 of the Residential Tenancies Act; s 11A of the District Courts Act 1947, s 435 of the Children, Young Persons and their Families Act 1989, s 7 of the Disputes Tribunal Act 1988.

¹⁸ Coroners are not given any training in relation to the performance of their duties after they are appointed. Coroners are, however, provided with a handbook concerning the exercise of their powers. *The Coroners’ Handbook* discusses the legislation which relates to the coroners office but does not provide answers to the issues raised in this paper.

appointment of Referees). The Coroners Act 1988 does not set out a procedure for the appointment of coroners.¹⁹

- 82 There is currently no publicly accessible document available which sets out the process involved in appointing coroners. There is also no "application form" which interested individuals must fill out to be considered for appointment as a coroner. This can be compared with the situation in relation to both District Court Judges and Community Magistrates.
- 83 In relation to District Court Judges, the Minister of Justice's Judicial Appointments Unit produces an application form which candidates must fill out if they are interested in becoming a District Court Judge. (The form is called: "Expression of Interest to be appointed a District Court Judge".) The Judicial Appointments Unit also produces pamphlets which set out the process involved in appointing a District Court Judge (*District Court Judge Appointments*, June 1997) and a Community Magistrate (*Community Magistrates*, July 1998).

OVERSEAS LEGISLATION

Australia

- 84 In Australia, each territory has legislation which governs the functions, powers and appointment of coroners. In Queensland (s 6(2) of the Coroners Act 1958 (Qld)), Tasmania (s 10(1) of the Coroners Act 1995 (Tas)), South Australia (s 11 of the Coroners Act 1975 (SA)), and New South Wales (s 5 of the Coroners Act 1980 (NSW)), the Governor may appoint any person to be coroner. No particular training or expertise is required. In Victoria, the Governor in Council may appoint magistrates, acting magistrates, barristers, and solicitors as coroners (s 8 of the Coroners Act 1985 (Vic)).

Canada

- 85 In British Columbia (s 1(1) of the Coroners Act, RSBC 1996, c 72) and New Brunswick (s 2(2) of the Coroners Act, RSNB 1997, c 23), coroners are not required to have any particular training or expertise and are appointed by the Lieutenant Governor in Council. In Quebec, coroners must either be medically or legally qualified, but only the legally trained coroners are authorised to conduct inquests (s 108 of *An Act respecting the determination of the causes and circumstances of death* SQ 1983, c 41). In Ontario, the Lieutenant-Governor in Council may appoint one or more legally qualified medical practitioners to be coroners (s 3(1) of the Coroners Act, RSO 1990, c 37).
- 86 In its 1995 report, the Ontario Law Reform Commission recommended that there should be two types of coroner, namely "investigating coroners" and "presiding coroners" (p 191). It was recommended that "investigating coroners" should be responsible for all initial investigations and pre-inquest case preparation, and that "presiding coroners" should be responsible for conducting inquests. The Commission recommended that "investigating coroners" should be medically qualified and that "presiding coroners" should be legally qualified.

¹⁹ An article in *The Dominion* entitled "Coroners turn up volume on comeback" (22 May 1998, 9) notes that the Coroners Council chairman will be consulted about the suitability of proposed replacements for coroners positions from law societies. However, there is no requirement in the legislation that this must occur.

- 87 The Ontario Law Reform Commission recommended that “presiding coroners” should be legally qualified as:

the presiding officer must be able to conduct the inquiry, resolve conflicts, maintain the integrity of the process, and instil public confidence in the process . . . The presiding officer will be required to deal impartially with issues of evidence and procedure in order to ensure that the inquiry proceeds fairly and effectively to completion . . . The demands of coroners’ inquests require the ability to make timely decisions about complex legal issues, including the relevance and admissibility of evidence, disclosure, and the appropriate limits of participation by parties with standing . . . (pp 188–189)

England

- 88 In England, the Committee on Death Certification and Coroners also recommended that presiding coroners should be legally trained (Report of the Committee on Death Certification and Coroners (1971) Cmnd 4810). The Committee stated:

A coroner takes his decisions judicially even when he is making enquiries outside the formal context of an inquest. He has to decide between the competing claims of society for information and of relatives for privacy. He must be able to assess the value of diverse and sometimes conflicting evidence . . . A coroner who is a lawyer is more likely to command the confidence of the public by virtue of his independence from the medical profession, on whose evidence he will so often have to rely . . . (paras 20.37–20.41)

- 89 The Coroners Act 1988 (UK) provides that no person is qualified to be appointed a coroner unless he or she has a five year “general qualification” (s 2(1)(a))²⁰ or is a legally qualified medical practitioner of not less than five years standing (s 2(1)(b)).
- 90 *R v HM Coroner for Inner North London District, ex parte Linnane (2)* (1990), 155 JP 343 demonstrates that, in some instances, coroners who are not legally trained may have difficulty understanding the scope of their role. In this case, a medically trained coroner was found by the divisional court to have erred by refusing to call a medical witness after ruling that his own expertise made the witness’s testimony irrelevant.

DISCUSSION

- 91 Coroners are judicial officers (*Re Sutherland* [1994] 2 NZLR 246, per Barker AC J). As such, coroners are authorised to exercise many powers under the Coroners Act 1988. Coroners have all the powers, privileges, authorities and immunities of a District Court Judge exercising jurisdiction under the Summary Proceedings Act 1957 (s 35 of the Coroners Act 1988).²¹ A coroner may issue summonses for the attendance of witnesses, issue warrants to enforce summonses, maintain

²⁰ A person has a “general qualification” if he or she “has a right of audience in relation to any class of proceedings in any part of the Supreme Court, or all proceedings in county courts or magistrates’ courts” (s 71 of the Courts and Legal Services Act 1990 (UK)). The rules in relation to rights of audience are set out in s 27 of the Courts and Legal Services Act 1990 (UK).

²¹ See *Crown Liability and Judicial Immunity: A response to Baigent’s case and Harvey v Derrick* (NZLC R37, Wellington, 1997) for a discussion of the immunity of District Court Judges and especially paras 167–171 for a consideration of the immunity and indemnity of coroners.

order, administer oaths, and punish for contempt (s 35 of the Coroners Act 1988). The coroner must preside over an inquiry which will often involve cross-examination of witnesses (ss 26(3) and (4)) and arguments from a number of counsel representing interested parties. Coroners must make decisions in relation to the admission of evidence (ss 26(6) and (7)) and must make a finding based on the evidence presented to them (s 31). The Coroners Act 1988 also requires coroners to make a number of decisions after weighing a list of factors. Such decisions include whether to hold an inquest (s 20) and whether to order a post-mortem (s 8). Coroners may make recommendations on the avoidance of the circumstances in which a death occurred and may also make recommendations in relation to the manner in which individuals should act in such circumstances. Coroners may also comment on the conduct of any person (s 15) and coroners are authorised to suppress details in relation to self-inflicted deaths (s 29).

PROPOSAL

- 92 For the reasons stated by the Ontario Law Reform Commission (1995) and by the Committee on Death Certification and Coroners (1971) quoted above, the Law Commission proposes that the Coroners Act be amended to provide that coroners must be legally qualified. The Law Commission is of the view that the coroner's functions would be best carried out by a person with legal training.
- 93 The Law Commission also proposes that the Coroners Act, or regulations made under the Act, set out the experience or training which coroners must have. This would include an awareness of tikanga Māori. In addition, the Act or regulations made under the Act could provide for the appointment, especially in the larger centres, of an assistant to the Coroner who could advise the coroner in relation to tikanga Māori. We have already proposed in chapter three that a co-ordinator be appointed to assist the Coroner. The appointment of Māori kaiawhina or co-ordinators is common in hospitals and other health providers.
- 94 There is only one Māori coroner. The Law Commission considers that more Māori coroners should be appointed. The Law Commission also believes that it is important to have coroners and/or co-ordinators appointed in areas where there are high Māori populations.
- 95 The Law Commission proposes that the Minister of Justice's Judicial Appointments Unit publish an application form for those interested in applying for the position of coroner as well as a pamphlet which sets out the procedure for the appointment of coroners. The pamphlet and the application form would be along similar lines to the pamphlet and the application form currently produced by the Unit for District Court Judges.
- 96 One of the concerns raised during the consultation process was that the appointment of coroners appeared to be shrouded in mystery. The public were not aware of how or why people were appointed to the office of coroner and the public were unable to scrutinise the appointment procedure. People were also concerned that coroners are not required to have any particular training or experience in order to exercise their functions under the Coroners Act. In the Law Commission's view, the proposals listed above would meet these concerns.

5

Supervision of coroners

A CHIEF CORONER

- 97 **I**N NEW ZEALAND, there is currently no person or body whose function is to supervise and direct coroners. There is no central direction as to how coroners should exercise their powers or carry out their duties and there is no particular person responsible for the administration of the Act. This causes a number of problems in practice.
- 98 There is perceived to be a lack of uniformity in coronial practices between coroners.²² This may be caused by two factors. First, there are currently 74 coroners in New Zealand and only one of the positions is full-time. Many of the coroners in New Zealand will investigate very few deaths during their time as coroner. Consequently, the experience which coroners have differs markedly throughout the country. Secondly, under the Coroners Act 1988, coroners have the discretion to exercise many powers, but the Act gives them no guidance as to how they should exercise those powers. The coroner's discretionary powers include:
- a coroner may authorise a doctor to perform a post-mortem examination on the deceased (s 7);
 - a coroner may authorise a doctor to be present at a post-mortem examination, either as a person's representative (s 10(3)) or as the coroner's observer (s 10(4));
 - a coroner may decide to hold an inquest (or not to hold an inquest) into certain deaths (ss 19 and 20);
 - a coroner may decide not to preside at an inquest and authorise another coroner to hold the inquest (s 22);
 - a coroner may exclude any person from the whole or any part of an inquest and may prohibit the publication of any evidence given during the inquest (s 25);
 - a coroner may postpone opening an inquest, open an inquest and then adjourn it, or adjourn an inquest already opened (s 28); and
 - a coroner may prohibit the publication of particulars in relation to self-inflicted deaths (s 29).
- 99 In 1984, the Working Party on the Delays in the Release of Bodies for Burial highlighted the lack of uniformity of coronial practices within New Zealand. The Working Party noted that coroners in smaller centres gained little

²² Since the 1988 Act came into force, the Ministry of Justice has received a number of letters noting the concern that there is a lack of uniformity in coronial practices. This concern was also noted by the Law Commission during the consultation process.

experience and adopted different procedures to coroners in larger centres. The Working Party recommended that:

[T]here should be uniformity of practice by coroners in the procedures leading to the release of bodies. (p 14)

- 100 Parliament also noted that there was a problem in relation to the lack of uniformity of coronial practices. In April 1988, when the Coroners Bill was reported back to Parliament by the Justice and Law Reform Committee, Mr Munro stated:

It is clear to me . . . that a wide range of different provisions applies throughout New Zealand under the present Act . . . It is clear that in major centres such as Wellington, in which some 550 deaths a year are examined by the coroner, a different practice is carried out from the practice used in many rural and remote areas in which relatively few deaths are investigated by the same coroner or the same coroner's court. (19 April 1988) 488 NZPD 3413. See also Mr Munro's comments during the second reading of the Coroners Bill (14 June 1988) 489 NZPD 4365).

- 101 Another problem is that there is currently no point of contact for coroners or members of the public concerned about the operation of the Coroners Act 1988. Coroners have expressed concerns about their isolation from each other and the reluctance of the Department for Courts or the Ministry of Justice to arrange regional meetings for coroners. (This information was obtained from the Ministry of Justice files.) Individuals and groups have also expressed concern that there is no one person they can liaise with in relation to coronial matters.

OVERSEAS LEGISLATION

Australia

- 102 A Chief Coroner (or a "State Coroner") is appointed in a number of Australian territories.²³ The Chief Coroner is generally required to be either a Judge, a magistrate, or a legal practitioner.²⁴ The role of Chief Coroner varies between the territories. Generally, however, the role of the Chief Coroner is to oversee and co-ordinate coronial services. This includes functions such as:
- ensuring that all reportable deaths reported to a coroner are investigated;
 - ensuring that an inquest is held whenever it is desirable to do so;
 - issuing guidelines to coroners to help them carry out their duties;
 - establishing an advisory ethics committee;
 - publishing forms;
 - publishing annual reports;
 - making rules regulating the exercise of coronial powers and practices;
 - giving coroners directions regarding the investigation of a death and the manner of conducting it;
 - ordering a fresh inquest to be held;

²³ Section 6 of the Coroners Act 1996 (WA); s 6 of the Coroners Act 1985 (Vic); s 7 of the Coroners Act 1975 (SA); s 7 of the Coroners Act 1995 (Tas); s 6 of the Coroners Act 1997 (ACT); s 4(A) of the Coroners Act 1980 (NSW).

²⁴ Section 6 of the Coroners Act 1997 (ACT); s 6(2) of the Coroners Act 1996 (WA); s 6 of the Coroners Act 1985 (Vic); s 7(1) of the Coroners Act 1975 (SA); s 4A(3) of the Coroners Act 1980 (NSW).

- ensuring that a post-mortem examination is performed whenever it is desirable to do so; and
- ensuring that a counselling service is attached to the court.²⁵

Canada

- 103 A Chief Coroner is also appointed in Ontario (s 4 of the Coroners Act, RSO 1990, c 37); Northwest Territories (s 4 of the Coroners Act RSNWT 1988 c C-20); British Columbia (s 3(1) of the Coroners Act, RSBC 1996, c 72); Quebec (s 8 of *An Act respecting the determination of the causes and circumstances of death*, SQ 1983, c 41) and New Brunswick (s 2(1) of the Coroners Act, RSNB 1997, c 23). Generally, the functions of the Chief Coroner in Canada are similar to those of the Chief Coroner in Australia.²⁶

DISCUSSION

- 104 In New Zealand, there are a number of individuals who are currently responsible for ensuring the efficient administration of a particular Act or of a particular court.²⁷ For example, the Principal Tenancy Adjudicator is responsible for “ensuring the orderly and expeditious discharge of the business of the [Tenancy] Tribunal throughout New Zealand” (s 71 (1) of the Residential Tenancies Act 1986). The Principal Tenancy Adjudicator may, for the purpose of ensuring that the Residential Tenancies Act 1986 is applied and administered consistently throughout New Zealand, issue any directions, notes, guidelines or suggestions for the guidance of other Tenancy Adjudicators, officers of the Tribunal, and parties before the Tribunal. The guidelines are not to be inconsistent with the Act or rules made under it (s 115 of the Residential Tenancies Act 1986).
- 105 The Law Commission proposes that a Chief Coroner be appointed in New Zealand. The Chief Coroner would have duties similar to those of Chief Coroners in Australia and Canada discussed above. The Chief Coroner’s functions would be set out in the Coroners Act and would include:
- engaging in research and planning to ensure that coroners are equipped to perform their functions systematically and properly;
 - ensuring that coroners are properly trained (eg, in relation to Māori society and cultural values);

²⁵ See ss 7 and 16 of the Coroners Act 1985 (Vic); ss 7 and 22 of the Coroners Act 1995 (Tas); ss 8, 16, 21, and 58 of the Coroners Act 1996 (WA); ss 101 and 102 of the Coroners Act 1997 (ACT); s 35 of the Coroners Act 1975 (SA); ss 17B and 23A of the Coroners Act 1980 (NSW).

²⁶ See s 3(2) of the Coroners Act, RSBC 1979, c 68; s5 of the Coroners Act, RSNWT 1988, c C-20; s 4(1) of the Coroners Act, RSO 1990, c C-37; ss 23 and 32 of *An Act respecting the determination of the causes and circumstances of death*, SQ 1983, c 41.

²⁷ See for example ss 11D and 11E of the District Courts Act 1947 (The Chief Community Magistrate is responsible for “undertaking appropriate measures to ensure that the integrity of the office of Community Magistrate is maintained and that the Community Magistrates operate effectively and efficiently within the framework of the District Courts”); ss 5A(1) and 9(1) of the District Courts Act 1947 (The Chief District Court Judge is responsible for “ensuring the orderly and expeditious discharge of the business of District Courts throughout New Zealand”); s 6 of the Family Courts Act 1980; s 251 of the Resource Management Act 1991; s 434 of the Children, Young Persons and their Families Act 1989; and ss 6A and 6C of the Disputes Tribunals Act 1988.

- liaising with the government in relation to the appointment and disposition of coroners throughout New Zealand;²⁸
 - liaising with the public and with other coroners;
 - ensuring that reports from coroners are properly appraised and that they are publicly available;²⁹
 - maintaining an overview of patterns of sudden deaths and their fundamental causes and considering whether additional inquiries are required; and
 - reporting regularly to the Ministers of Justice and Health with particular emphasis on patterns of circumstances leading to death or risk of death and the steps available for their prevention or reduction.
- 106 The Chief Coroner would also be responsible for issuing guidelines to coroners in relation to the performance of the coroner's functions. The guidelines could relate to, for instance:
- the exercise of the coroner's discretionary powers;³⁰
 - how coroners should liaise with other organisations³¹ and family members;
 - procedures leading to the release of bodies;
 - the standardisation of the procedures governing how coroner's records are maintained; and
 - the availability of coroners during weekends and holidays.
- 107 In summary, the appointment of a Chief Coroner in New Zealand would ensure the more efficient operation of the Coroners Act 1988. The Chief Coroner would be able to ensure that coronial practices throughout New Zealand were more uniform by issuing forms and guidelines to coroners in relation to the exercise of their powers. The Chief Coroner would also be the liaison point between coroners, the public, the Ministry of Justice, and the Department for Courts.
- 108 The Law Commission is of the view that a Chief Coroner should exercise the function of supervising coroners. A Chief Coroner would not threaten the coroner's independence from the Executive in the way a government department supervising and directing coroners would.

²⁸ In the Appendix to the Final Report of the Working Party on Delays in the Release of Bodies for Burial, the Working Party recommended that there should be an examination of the location and workloads of coroners throughout the country. Numerous examples have been brought to the attention of the Law Commission that support the appropriateness of this recommendation. For instance, there is no longer a resident coroner in Gisborne. This district is served by the coroner in Napier.

²⁹ During the consultation process, concerns were expressed in relation to the availability of coroners' decisions. In our view, the Chief Coroner could be responsible for ensuring that coroners' decisions are published and are easily accessible (both in hard copy and electronically as part of a database maintained by the Chief Coroner) by members of the public.

³⁰ Including, for instance, the circumstances in which autopsies should be conducted. There has recently been much debate about whether autopsies should be conducted on infants where it is suspected that the infant has died of Sudden Infant Death Syndrome (SIDS) (*Journal of Law & Medicine* 1998, 8; *The Laws of Australia* 1997, 82–83).

³¹ For instance, in a submission received from the Health and Disability Commissioner (1 March 1999), the Commissioner calls for a system to be established whereby coroners inform the Commissioner whenever the coroner finds the quality of health and disability services, or the delivery of those services, to be an issue.

REMOVAL OF CORONERS

- 109 Section 34 of the Coroners Act 1988 provides that the Governor-General may remove a Coroner or Deputy Coroner from office for "inability" or "misbehaviour".

OVERSEAS LEGISLATION

England

- 110 The Lord Chancellor may, if he or she thinks fit, remove any coroner from office for "inability" (s 3(4) of the Coroners Act 1988 (UK)). A recent House of Lords case considered the definition to be given to the word "inability" in s 12 of the Sheriff Courts (Scotland) Act 1971. In *Stewart v Secretary of State for Scotland* the appellant had been removed from his position as Sheriff Substitute at Wick. Section 12(2) provided that the appellant could be removed from office "by reason of inability, neglect of duty or misbehaviour". The appellant had been found to be unfit for office by reason of inability as he had a "character flaw which produced unwarranted outbursts from the bench". The appellant argued that the word "inability" in s 12 meant physical or mental infirmity. The respondent submitted that the word embraced any form of incapability of performing the functions of judge as appropriate. The House of Lords noted that the section was:

concerned with the removal of a Sheriff Principal or Sheriff who is unfit for office. This is a provision which is directed to the proper administration of justice, not to the benefit of individual holders of the office. It is in the public interest that members of the Shrievalty should be fit for the office which they perform and this objective must be borne in mind when the section is being construed.

- 111 The House of Lords dismissed the appeal. The House accepted the statement made in the Inner House that "what has to be shown is that he is not really capable of performing the proper function of a judge at all". In dismissing the appeal, Lord Hutton stated: "I consider that it is right to read the word 'inability' . . . as having its normal meaning of 'being unable' or 'lack of capacity' ".
- 112 In England, a coroner may also be removed because of "misbehaviour" in the discharge of their duties (s 3(4) of the Coroners Act 1988 (UK)). Examples of misbehaviour have included: improper refusal to hold an inquest, wrongfully refusing to hear evidence in favour of the person accused or suspected, drunkenness, corruption, and indefinite absence (*Halsbury's Laws of England*, vol. 9(2) para 828).
- 113 The Lord Chancellor's power to remove a coroner is exercised judicially. The Lord Chancellor acts on a complaint substantiated by evidence and after giving the coroner an opportunity of being heard (*Halsbury's Laws of England*, vol. 9(2), paras 824–828). An order for the removal of a coroner will be made if the Lord Chancellor considers that the case for removing the coroner has been established.

DISCUSSION

- 114 In New Zealand, as in England, a coroner may be removed by the Governor-General for "inability" or "misbehaviour". It appears that in England these terms encompass a wide range of behaviour.

PROPOSAL

- 115 The Law Commission is of the opinion that no change to s 34 of the Coroners Act 1988 is necessary.
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6 Coroners' recommendations

116 **T**HE CORONERS ACT 1951 did not contain a provision which authorised coroners to make recommendations. The clause which became s 15 in the Coroners Act 1988 was referred to during the various readings of the Coroners Bill:

[A]s a result of [a post-mortem examination] it may be responsibly worthy for the coroner to indicate that, if such and such had not been the position, the individual might still have been with us today. That is an important public responsibility. ((19 July 1988) 490 NZPD 5163)

I am particularly concerned that coroners should speak out fearlessly and frankly and should focus on the issues. Often, matters such as faulty traffic lights may be involved, or perhaps medical malfeasance to which the public's attention should be drawn, in relation to a state of affairs involving a surgeon or an anaesthetist; or a dangerous road, or a driver who has caused many accidents . . . I do not want to see any fettering of a coroner's power. ((14 June 1988) 489 NZPD 4367)

The coroners clearly have a job to do. That job can be put very simply. It is to prevent unnecessary and early death, if possible. There are many circumstances in which those words from a coroner are the only means by which grave dangers can be brought to public attention. ((14 June 1988) 489 NZPD 4370)³²

117 Section 15 of the Coroners Act 1988 provides that a coroner holds an inquest for a number of purposes. One of the purposes of an inquest is for the coroner to make:

any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances. (s 15(1)(b))

118 However, there is nothing in the Coroners Act 1988 which requires agencies or individuals to act on, or to consider, coronial recommendations. There is also no procedure set out in the Coroners Act for ensuring that coronial recommendations are brought to the notice of relevant agencies or individuals.

119 Every year there are close to 1400 inquests, resulting in around 130 coronial recommendations. Coroners have recently voiced their concerns that agencies are failing to take coronial recommendations into account (*The New Zealand Herald*, "Clear and present danger ignored", 17–18 October 1998; *The New Zealand Herald*, "Give coroners a break", 15 September 1998).

³² See also: (14 July 1987) 482 NZPD 10430; (14 June 1988) 489 NZPD 4367 and 4371; (19 July 1988) 490 NZPD 5156 and 5159.

OVERSEAS LEGISLATION

Canada

- 120 In Canada, the importance of coronial recommendations has been recognised by the Ontario Divisional Court. In *People First of Ontario v Porter* (1991) 85 DLR (4th) 174, it was stated:

A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of the conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventative function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths. (p 619)

- 121 In its 1995 report, the Ontario Law Reform Commission also noted the significance of coronial recommendations, stating:

the prevention of similar deaths in the future is one of the central objectives of public inquiries into death. Thus, the recommendation phase of the inquest will often be its most significant aspect. (p 148)

- 122 In many Canadian territories, coroners or coroners' juries are authorised by statute to make recommendations in relation to matters arising out of an inquest.³³ Generally, in these territories, the Chief Coroner is responsible for bringing coronial recommendations to the attention of appropriate persons, agencies and Ministers of government.³⁴

- 123 The Ontario Law Reform Commission (1995) considered the process surrounding the making of coronial recommendations in Ontario. In Ontario, there is no statutory process for following up or ensuring the implementation of coronial recommendations. However, s 4(1)(d) of the Coroners Act, RSO 1990, c 37 does require the Chief Coroner to:

bring the findings and recommendations of coroners' juries to the attention of appropriate persons, agencies and Ministers of government.

- 124 In its report, the Ontario Law Reform Commission noted that an informal process of bringing recommendations to the notice of relevant individuals and agencies had been developed in Ontario (1995, pp 97–98). The Chief Coroner's Office notifies relevant individuals and agencies of any coronial recommendations and requests their comments, including any plans to implement the recommendations. When recommendations are specific, and the person or agency that appears to be responsible does not respond, or the responses are not satisfactory, the Chief Coroner's Office pursues the matter informally with

³³ Section 3 of *An Act respecting the determination of the causes and circumstances of death*, SQ 1983, c 41; s 27(3) of the Coroners Act, RSBC 1996, c 72; s 31(3) of the Coroners Act, RSO 1990, c 37; s 55(2) of the Coroners Act, RSNWT 1988, c C-20.

³⁴ Section 3(2)(d) of the Coroners Act, RSBC 1996, c 72; s 4(1)(d) of the Coroners Act, RSO 1990, c 37; s 5(2)(c) of the Coroners Act, RSNWT 1988, c C-20; s 98 of *An Act respecting the determination of the causes and circumstances of death*, SQ 1983, c 41.

government agencies whether provincial, federal or municipal. The Ontario Law Reform Commission noted that:

approximately 75% [of coronial recommendations] result in changes in implementation by the affected agencies, Ministers and persons. (p 98)

125 The Ontario Law Reform Commission went on to state:

we do not recommend that implementation or compliance with such recommendations be made compulsory . . . The Commission recommends . . . that section 4(1) of the Coroners Act should be amended to provide that the Chief Coroner shall inquire as to the implementation of the jury's recommendations, or the reasons why implementation has been postponed or rejected . . . The Commission recommends . . . that the Coroners Act should be amended to provide that the Chief Coroner shall deliver to the Minister an annual report on the operations of the office during the preceding year. The annual report should include . . . an analysis of the implementation of jury findings, including the specific responses of individuals or agencies affected by the recommendations. The Commission further recommends that the Minister should be required to table the annual report in the Legislature. (pp 249–250)

126 In Quebec, the Chief Coroner is required to send an annual report to the Minister of Justice. The report may include coronial recommendations or a summary of coronial recommendations. The Minister of Justice is required to table the report in the National Assembly (s 29 of *An Act respecting the determination of the causes and circumstances of death*, SQ 1983, c 41).

Australia

127 *The Laws of Australia* (1997, p101) states:

The role of the coroner in making recommendations to prevent injury and death or their recurrence is becoming more prominent.

128 In most Australian territories, coroners or coroners' juries are authorised by statute to make recommendations in relation to matters arising out of an inquest.³⁵

129 Several Australian territories have special provisions regarding coronial recommendations relating to deaths which occur in custody. In the Northern Territory, where a coroner holds an inquest into the death of a person who had been held in custody, the coroner must make "such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant" (s 26(2) of the Coroners Act 1993 (NT)). The coroner must send a copy of the report or recommendation to the Attorney-General "without delay". The Attorney-General is required to give a copy of the report to the relevant Northern Territory or Commonwealth Minister. The Attorney-General must also present a copy of the report or recommendation to the Legislative assembly (s 27 of the Coroners Act 1993 (NT)).³⁶

³⁵ Section 57(3) of the Coroners Act 1997 (ACT); s 22A of the Coroners Act 1980 (NSW); s 21(2) of the Coroners Act 1985 (Vic); s 35(2) of the Coroners Act 1993 (NT); s 43(5) of the Coroners Act 1958 (Qld); s 28 of the Coroners Act 1995 (Tas); s 25(2) of the Coroners Act 1975 (SA).

³⁶ The State Coroner in New South Wales, Western Australia and Tasmania must provide an annual report to the Attorney-General in relation to the deaths in custody which have been

- 130 In the Australian Capital Territory, a coroner who has completed an inquest into a death of a person in custody must give a written report to (among others): the Attorney-General; the custodial agency in whose custody the death occurred; the Minister responsible for that agency; and, if the deceased was an aboriginal person or Torres Strait Islander, an appropriate local aboriginal legal service (s 75 of the Coroners Act 1997 (ACT)). The custodial agency to which a report is given must, within three months, give the Minister responsible for the custodial agency a written response to the findings contained in the report, including a statement of the action (if any) which has been, or is being, taken with respect to any aspect of the findings contained in the report. The Minister must give a copy of the response to the coroner (s 76 of the Coroners Act 1997 (ACT)). Each year, the Chief Coroner must give the Attorney-General an annual report. The annual report must include particulars of the reports into deaths in custody prepared by coroners, any recommendations made by coroners to the Attorney-General, and responses of agencies to coronial recommendations (s 102 of the Coroners Act 1997 (ACT)). The Attorney-General must present a copy of the report to Parliament. (s 102 of the Coroners Act 1997 (ACT)).

DISCUSSION

- 131 The Law Commission agrees with the statements made in *People First of Ontario v Porter* and by the Ontario Law Reform Commission (1995) regarding the importance of coronial recommendations. Coroners' recommendations are a crucial aspect of the coronial system. This is recognised by the Coroners Act 1988 which provides that one of the purposes of holding an inquest is so that coronial recommendations may be made in order to "reduce the chances of the occurrence of other deaths in such circumstances" (s 15(1)(b)).
- 132 The purpose of allowing coroners to make recommendations is to try to ensure that similar deaths do not occur in the future. However, the problem which has arisen is that there is no process for ensuring that recommendations are brought to the attention of relevant agencies or individuals and that, even if recommendations are brought to the attention of the right agency or individual, there is no requirement that the agency must consider the recommendations and act on them. The ability of recommendations to achieve their purpose is therefore limited.

PROPOSAL

- 133 In the Law Commission's view, it is important for systems safety that agencies take account of coronial recommendations and take necessary steps to avoid future accidents and deaths. However, the Law Commission agrees with the Ontario Law Reform Commission (1995) that implementation or compliance with coroners' recommendations should not be made compulsory. Recommendations will be made in relation to a wide range of activities and will involve both public and private agencies. Often recommendations may have implications which the coroner has not been able to assess during an inquest. In the Law Commission's view, it would be dangerous to require both private and public agencies to comply with coroners' recommendations made after an

reported to the State Coroner. The Attorney-General must table the report in Parliament (s 12A of the Coroners Act 1980 (NSW); s 27 of the Coroners Act 1996 (WA); and s 69 of the Coroners Act 1995 (Tas)).

inquest in which the coroner may not have had all the available information and options in front of him or her.

- 134 The Law Commission proposes that the Coroners Act 1988 be amended to provide that:
- the Chief Coroner be responsible for bringing coronial recommendations to the attention of relevant agencies and individuals;
 - the Chief Coroner be responsible for producing an annual report which would include details of coronial recommendations and which would be tabled in Parliament. The report should trace the progress of recommendations, including the identification of agencies that have chosen not to comply or that, in the opinion of the Chief Coroner, have obstructed the process of compliance. It should also include particulars of the reports prepared by coroners into deaths in custody, any recommendations made in relation to those inquiries, and the responses to those recommendations; and
 - where a recommendation concerns a government agency, that agency must report to their Minister the steps they intend to take in relation to the coronial recommendation. That report must be provided to the Chief Coroner who would be required to include particulars of the agency's response in the annual report.
- 135 In the Law Commission's view, these proposals would ensure that coronial recommendations are taken seriously and be more likely to achieve their goal of preventing unnecessary deaths in the future. Requiring the Chief Coroner to be responsible for bringing coronial recommendations to the attention of relevant agencies and individuals would mean that coronial recommendations would not get "lost" in the system. The relevant agency would always be informed of recommendations which affect them. Requiring agencies to report to their Minister in relation to coronial recommendations would mean that agencies are required to consider the recommendations (and any alternative courses of action) and decide what should be done. The proposal requiring the Chief Coroner to provide annual reports to be laid before Parliament would ensure that there is some "follow-up" to coronial recommendations. Laying the annual report before Parliament would also mean there would be some public scrutiny and Parliamentary debate in relation to the recommendations and the resulting steps taken by the government agency.
- 136 The Law Commission believes that the cost of producing an annual report and the reports to Ministers is a worthwhile expense. It will ensure that coronial recommendations are publicised, considered and, most importantly, implemented.
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Appendix

HISTORICAL DEVELOPMENT OF THE OFFICE OF THE CORONER

*The English coroner*³⁷

- A1 **T**HE OFFICE OF CORONER is one of great antiquity. It is one of the oldest offices known to English law and precedes the signing of the Magna Carta in which it is mentioned. The first reference to coroners appears to be in the *Articles of Eyre* of 1194 (McKeough 1983, p 191; Thurston 1985, paras 1.02–1.03; Ontario Law Reform Commission 1995, p 7).
- A2 During the medieval period, the judicial system was motivated primarily by the prospect of securing revenue for the Crown. It appears that the office of coroner was created to ensure the Crown's pecuniary interest in the administration of law was protected (McKeough 1983, 191; Thurston 1995, para 1.04). The coroner was responsible for keeping a record of the matters regarding which the local community was answerable to the Crown.
- A3 By 1500, almost the sole remaining function performed by the coroner was that of holding inquests into deaths (Thurston 1995, para 1.19). Most coroners' inquests were held in relation to homicides and deaths by misadventure (Thurston 1995, paras 1.08–1.14; *The Laws of Australia* 1997, 43; McKeough 1983, pp 193 and 198–199). When a body was found, the coroner was notified and a jury assembled. The body was laid on a table and examined by the jury under the direction of the coroner.
- A4 Throughout the eighteenth and nineteenth centuries, statutory reform consolidated and clarified the powers of the English coroner, marking the beginning of a true medico-legal death inquiry system. In 1836, a system of death registration was instituted in England. The Coroners Act 1887 (UK) confirmed that the emphasis of the office of coroner was on the investigation of the cause and circumstances surrounding death rather than on protecting the financial interests of the realm. The coroner's interest in the medical causes of death grew as a result of the demand of the registration system which, as it developed, required more precise information (Thurston 1995, paras 1.31–1.32).
- A5 The scope of the coroner's practice in England is currently regulated by the Coroners Act 1988 (UK).³⁸

³⁷ The following account of the history of the English coroner is drawn from: McKeough 1983; Thurston 1985; Ontario Law Reform Commission 1995, pp 7–14; *The Laws of Australia*, Births and Deaths, 1997, 43.

³⁸ For a discussion of the Coroners Act 1988 (UK) see Halsbury's Laws of England 4th ed. Vol. 9(2).

History of the coroner in New Zealand

- A6 In New Zealand, it appears that the coroner's office existed prior to 1846. The Coroners Ordinance 1846 provided:
- All persons so to be appointed as [a Coroner], and all persons now so acting as Coroners shall hold their Offices during pleasure. (s 1)
- A7 The Coroners Ordinance provided that the Governor of New Zealand could appoint "fit persons" to be coroners (s 1). Coroners were required to take an oath to "well and faithfully" execute the duties of office (s 3). The Ordinance also provided that coroners had "all such powers and privileges" and were "liable to all such duties and responsibilities" as were coroners in England (s 4).
- A8 The Coroners Ordinance 1846 was repealed by the Coroners Act 1858. The Coroners Act 1858 was similar to the Coroners Ordinance, but the Coroners Act gave coroners authority to also inquire into the origin of a fire (s 7).
- A9 The Coroners Act 1858 was later replaced by the Coroners Act 1867. Section 8 of that Act provided that coroners had jurisdiction to inquire:
- concerning the manner of the death of any person who is slain or drowned or who dies suddenly or in prison or while detained in any lunatic asylum and whose body shall be lying dead and to inquire into the cause and origin of any fire whereby any building, ship or merchandise or any stack of corn-pulse or hay or any growing crop shall be destroyed or damaged.
- A10 Coroners were required to hold inquests before a jury (s 10) and were authorised to direct a medical practitioner to perform a post-mortem examination on the body of the deceased (s 22).
- A11 The next major piece of legislation in relation to coroners in New Zealand was the Coroners Act 1908. The Coroners Act 1908 largely re-enacted the Coroners Act 1867. However, the coroner's ability to accept bail where a jury had found a verdict of manslaughter³⁹ was removed. The jury's findings at an inquest also no longer had the force and effect of an indictment of the grand jury in England.⁴⁰ The Coroners Amendment Act 1908 provided that it was no longer necessary for a coroner, when holding an inquest, to have a jury (s 2).
- A12 In New Zealand, the law in relation to coroners continued to be governed by the Coroners Act 1908, its amendments, and the law which existed in relation to coroners in England, until the Coroners Act 1951 was enacted. It was intended that the Coroners Act 1951 would create a complete code by combining the law in relation to coroners in New Zealand and in England into one statute.⁴¹ The Coroners Act 1951 was more detailed than previous coroners legislation in New Zealand.
- A13 Coroners were required to hold inquests where a person had died a "violent and unnatural death" (s 5(1)(a)) and where the person had died in prison (s 5(1)(b)). The coroner also had a discretion to hold inquests in certain other cases (s 5(2))

³⁹ Under the 1867 Act, the coroner was authorised to accept bail where there was a manslaughter verdict (s 13).

⁴⁰ As did a jury's finding under the 1867 Act (s 16).

⁴¹ See the comments of the Hon. Mr Webb in (29 November 1951) 296 NZPD 1184.

and (3)). Coroners no longer had jurisdiction in regard to fires. Inquests were to be held before a coroner without a jury (s 13(1)).

- A14 The purpose of an inquest was to establish:
- (a) the fact that a person had died;
 - (b) the identity of the deceased person;
 - (c) when, where, and how the death occurred (s 12).
- A15 The Coroners Act 1951 continued the right of interested people to attend inquests and to examine and cross-examine witnesses (s 17(2))⁴² and also continued the authority of the Supreme Court to order that an inquest be held or re-held (s 26).⁴³ Coroners were given the same powers, privileges, authorities and immunities as were possessed by a justice (s 4(2)).
- A16 The 1951 Act was repealed in 1988. The current Act governing coroners in New Zealand is the Coroners Act 1988.⁴⁴
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⁴² See also s 7 Coroners Amendment Act 1908 which originally contained this provision.

⁴³ See also s 2 Coroners Amendment Act 1930 which originally contained this provision.

⁴⁴ For a detailed review of the law in relation to the Coroners Act 1988 see *Laws NZ*, Coroners (1992–).

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