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Report 62

Coroners

August 2000
Wellington, New Zealand

The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

The Commissioners are:

The Honourable Justice Baragwanath – President
Judge Margaret Lee
DF Dugdale
Denese Henare ONZM (retired 30 June 2000)
Timothy Brewer ED
Paul Heath QC

The Executive Manager of the Law Commission is Bala Benjamin
The office of the Law Commission is at 89 The Terrace, Wellington
Postal address: PO Box 2590, Wellington 6001, New Zealand
Document Exchange Number: SP 23534
Telephone: (04) 473-3453, Facsimile: (04) 471-0959
Email: com@lawcom.govt.nz
Internet: www.lawcom.govt.nz

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25 July 2000

Dear Minister

I am pleased to submit to you Report 62 of the Law Commission *Coroners*.

It draws together major themes: reconciling the public interest in effective determination of the cause of death with the particular cultural, religious and personal beliefs of many New Zealanders; and enabling systematic comparison of coronial experience nationwide by the establishment of the office of Chief Coroner.

The Law Commission commends the proposed reforms as a firm foundation for improved investigation of deaths, understanding patterns of sudden death, and demonstrating greater sensitivity to the values of our different cultures. Our recommendations work as a package to improve the systems for protecting New Zealanders from unnecessary illness, injury and death. The role of a Chief Coroner is particularly critical in this regard.

We invite you to respond to our suggestions for reform within six months from the publication date of this report.

Yours sincerely

The Hon Justice Baragwanath
President

The Hon Phil Goff
Minister of Justice
Parliament Buildings
Wellington

Preface

PROTECTING THE LIVES OF ITS CITIZENS is a primary function of the State. Its processes for investigating sudden death ideally should be geared to finding the causes and eliminating them for the future, while respecting the sensibilities of the family in its grief.

The Law Commission's preliminary paper *Coroners: A Review* brought an overwhelming response from those involved in the operation of the coronial system and from the public alike. All submitters considered that, despite the high ability and sensitivity of many involved in the coronial process, the system is patchy, unsystematic and inadequate.

Indeed, many coroners told us that the coronial system seems to be the poor relation in the justice system. Coroners stated that they are performing important functions under the Coroners Act 1988 with inadequate support systems. The consequences place heavy burdens on coroners, cause frustration to all those who currently administer or who provide services in the coronial system, and draw criticism from the community. Ultimately the effectiveness of the coronial system is diminished.

In recent years, the role of the coroner has increasingly been recognised as one in which the thorough investigation of a death can lead to a reduction in future injury and preventable deaths.

However, the ability of coroners to fulfil their many functions, and in particular to assist in death and injury prevention and thus influence the development of public health policy, has been limited by the systemic problems identified in our preliminary paper and confirmed in the submissions.

Under the present haphazard regime there is no centralised recording system which would allow patterns to be discerned and responded to, nor any Chief Coroner, suitably resourced, to devise and maintain the necessary systems, to oversee coroners, and to monitor the implementation of coronial recommendations.

Other problems include:

- inadequate procedures for the appointment of coroners;
- the lack of uniformity of coronial practices throughout New Zealand;
- a need for training programmes for coroners; and
- the perception that in the coronial system there is little or no regard taken of the cultural values and beliefs of communities, particularly Māori cultural values and beliefs.

There has been a changing view of death in our society. This view is perhaps best summed up in a submission that:

Just as we changed our birth practices in the second part of the 20th century, we need to change our death practices in the first half of the 21st century.

The community is the ever-present client of the coronial system for two reasons: first, because of the expectations of the public and the ensuing scrutiny that attach to the coroner's role; and secondly, the families of the deceased are the coroner's clients and their needs for sensitive support as well as receiving clear information about post-mortems and inquests should influence in concrete ways the methods and practices adopted by the coronial system. It is difficult to imagine a context requiring clearer and more sympathetic communication skills than that of notification of death. Over and above coming to grips with their loss, the bereaved need immediate information about the coronial system. What will be the impact of the coroner's involvement on their funeral arrangements and, indeed, on the process of grief? With whom are they dealing? Why is the coroner involved anyway? What is a post-mortem? Apart from these questions, the structure of the system itself can be a source of confusion.

Responding to the challenges of serving the public interest successfully requires coherent and systematic approaches that address:

- the role and performance of coroners;
- the procedures for the efficient conduct of post-mortems and inquests;
- the resolution of conflicts in the law and cultural values;
- the development of effective coronial support systems, including information systems; and
- the co-ordination of coronial services.

The Ontario Coroners' motto is "to speak for the dead in order to protect the living". If this is to be a key objective of the coronial system in New Zealand then an urgent overhaul of the current system and practices is required.

ORGANISATION OF THIS REPORT

This report has been divided into three parts with a number of appendices.

Part I makes a number of recommendations that work as a package to address:

- the role and status of coroners; and
- the practices, systems and services required to improve the operation of the coronial system; and
- amendments to the Coroners Act 1988.

Part II sets out recommendations to address the concerns of Māori and other cultural and religious groups, as well as many individual families, that current coronial practices are insensitive, both in their treatment of the deceased and with regard to the removal and retention of body parts.

Part III discusses various points of a legal nature concerning suggested amendments or additions to the Coroners Act. While these aspects were not focused on in our preliminary paper we consider that we are in a position to make recommendations concerning many of them with guidance from overseas legislation.

Appendices A and B set out summaries of our recommendations.

Appendix C sets out a summary of the role and responsibilities of a Chief Coroner.

Appendix D lists the submissions of individuals and/or agencies that we received in response to our preliminary paper.

Appendix E details the individuals and agencies that we consulted.

We are indebted to all of the contributors to this report. In particular, we are grateful to the members of the Coroners' Council who gave of their time so willingly. We acknowledge the assistance of Mr Graeme Johnstone, Victoria State Coroner who provided us with information about the Australian coronial system. We also greatly appreciate the support and guidance of the members of the Māori Committee to the Law Commission:

- Rt Rev Bishop Manuhua Bennett ONZ CMG
- His Honour Justice ETJ Durie
- Professor Mason Durie
- Judge Michael JA Brown CNZM
- Whetumarama Wereta
- Te Atawhai Taiaroa

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

Part I
Systems and Services

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 identify practices that have cost human lives and then to modify or eliminate them.
- 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 certificate as to cause is issued by a registered medical practitioner. 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, including 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 prisons or psychiatric hospitals.¹ These cases necessitate an inquiry by the coroner to establish the cause and manner of death. In the great majority of cases, 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 complete 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

¹ Coroners Act 1988, s 4.

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.² In deciding whether to authorise the conduct of a post-mortem examination, the coroner must therefore 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 ancillary powers of a District Court judge. It is a fact-finding exercise rather than a method of apportioning guilt. Consequently, it is an inquisitorial process; a process of investigation quite unlike a trial.
- 7 The purpose of an inquest is to establish that a person has in fact died, their identity, when and where they died, and the causes and circumstances of their death.³ In addition, if in the coroner's opinion the death appears to have been unnatural or violent, the coroner must consider whether this appears to have been due to the actions or inaction of any person.
- 8 A further important objective of an inquest is to enable the coroner to make recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or to comment on how other people should act in such circumstances, so as to reduce the chances of other similar deaths occurring. For this purpose to be achieved, the inquiries of the coroner should not be limited to matters of mere formality, but should be of social and statistical significance in a modern community.⁴
- 9 Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context, it has progressively become evident that the fundamental

² *The Laws of New Zealand* (Butterworths, Wellington, 1992–) vol 8, Coroners, para 17.

³ Coroners Act 1988, s 15(1)(a)(i)–(v).

⁴ *Re Hendrie* (12 January 1988) unreported, High Court, Christchurch, CP 445/87, Hardie Boys J.

causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by coroners.

- 10 With certain notable exceptions, such as the exemplary report of the Invercargill coroner concerning the Foveaux Strait Air Accident,⁵ deaths tend to be considered in isolation. There is no system for appraisal of the background factors contributing to the death to determine whether it is an isolated episode or an example of a deep-seated problem. The Commission considers it imperative that an investigation into the possibility of fundamental causes be a regular exercise of the coroner's function. A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster. This is made difficult at present, however, because there is no system for the collation and appraisal of one coroner's finding in relation to others.⁶

The Status of Coroners

- 11 The Law Commission's recommendations in this report aim to enhance the role of coroners and improve the operation of the coronial system. For these recommendations to be effective, it is also necessary to consider the status of coroners and to bring them in line with other judicial officers in New Zealand and coroners in other jurisdictions, particularly Australia.
- 12 At present, with rare exceptions, coroners are appointed on a part-time basis. Many of them fit their coronial work around busy legal practices. Coroners commented time and again that:
- coroners' workloads are increasing;
 - coroners' legal practices are effectively subsidising the coronial system;
 - access to court time is uneven which creates huge backlogs of cases;
 - the terms and conditions of work are inadequate;

⁵ Invercargill coroner, Trevor Savage, delivered on 16 July 1999. See also: the report investigating the deaths resulting from the Raurimu shootings (Taumarunui coroner Tim Scott, 16 April 1999); and the inquests into the deaths (by carbon monoxide poisoning from accidental inhalation of fumes from an LPG lamp being used in an unventilated tent) of the Taiko seabird observers on the Chatham Islands (Wellington coroner Garry Evans).

⁶ The absence of such a system also has the consequence that inquiries carried out by coroners at a more advanced level of investigation, and findings and recommendations pitched at a higher level than the norm, may easily go unacknowledged.

- there is a lack of adequate support, facilities and administrative services; and
- the responsibilities of coroners are unappreciated.

13 It was extremely troubling to learn of these concerns. The Law Commission had not anticipated the extent to which coroners currently feel undervalued in the justice system. As a result of our correspondence and consultation with coroners, it became clear that coroners are attempting to fulfil a critical role in preventing future unnecessary deaths, meet the individual needs of families, obtain the confidence of the public, and manage an increasing workload, without the necessary systems and facilities in place to support their role. The fact that the coronial system is able to function at all is a testament to the dedication of coroners and other individuals who work diligently in the coronial system. In the words of Warwick Holmes, former Chairperson of the Coroners' Council:⁷

Ours is a call for help which we know is unselfish given the role coroners are endeavouring to fulfil in the business of making our country safer and incidentally saving lives.⁸

14 The lack of adequate systems and services to support the role of coroner has far-reaching consequences for society. In particular, it impacts on the ability of coroners to meet the objectives of the Coroners Act 1988 and develop a consistent approach when making findings. It has led to unacceptable backlogs of cases in many areas. These factors in turn affect the ability of other agencies to collect, record and comment on information from coroners' reports.

CORONERS' CONCERNS

15 In his presentation to the 1999 National Coroners' Conference,⁹ Garry Evans stated that:

It would be true to say that the public is largely unaware of the fact that the work of coroners encompasses . . . a wide variety of functions.

⁷ The Coroners' Council is not a statutory body and is composed of unpaid volunteers most of whom are principals in independent legal practices. The Chairperson, who operates by consensus of the members of the Council, has no other authority. The Council has no funding and carries its own overheads at the expense of its several members.

⁸ Warwick Holmes, letter to Hon Georgina Te Heuheu, Minister for Courts, 9 August 1999.

⁹ Garry Evans "Coronership in New Zealand in the New Millennium" (paper presented at the 1999 National Coroners' Conference, Wellington, 4–5 September, 1999).

The fact that coroners preside over inquests into deaths is well appreciated, but the nature of their administrative functions is largely unknown and the nature and extent of a coroner's investigatory functions goes largely unappreciated.

- 16 All the coroners we spoke to considered they were inadequately remunerated for their work. They were also concerned about various issues related to the recovery of basic costs.¹⁰ In his presentation to the 1999 National Coroners' Conference, Garry Evans stated that:

Coroners are poorly remunerated for the work they carry out; the legal firms in which most coroners are senior partners effectively subsidise the State, coronial remuneration being considerably less than a coroner law partner's professional income and inadequate to meet heavy legal practice overheads.

- 17 He explained that coroners are effectively paid on a piece-work basis for their professional services in terms of the Coroners (Fees) Regulations 1992:

Payment in this manner is anachronistic. All coronial work should be paid for at an hourly or daily rate that is commensurate with the heavy responsibilities borne by coroners as judicial officers and should be fixed, independently of Government, by the Higher Salaries Commission.

- 18 In his submission, the Rotorua coroner, David Dowthwaite, expressed his concern thus:

I did not appreciate when I expressed interest in this position the extensive voluntary nature [as a result of] the unreasonable remuneration. I naively anticipated that the remuneration would be upon a par with District Court judges and made this naive conclusion from the Act which grants the coroner the same powers in his court as a District Court judge. In the present political and litigious climate of our community and heightened expectations and interest in the courts including the Coroner's Court the risk of appeal, the limited indemnity and the inability to insure sit uncomfortably with the voluntary aspect of a large part of the administrative and actual work done.

- 19 The submission from the Department for Courts acknowledged the concerns of coroners regarding remuneration and the recovery of administrative costs. It stated that:

The fees to be paid to coroners are specified in the Coroners Regulations. It is the single most difficult area for both the Department and for coroners. Many coroners consider they are under paid for the

¹⁰ Issues concerning remuneration and recovery of costs are discussed in paras 53–62.

work they are required to carry out and claim that the office of coroner is often subsidised by their law firms. The Crown is in the difficult position of choosing to increase fees or choosing to allow coroners to leave.

- 20 The adequacy of administrative support for coroners has been the subject of ongoing debate between coroners and the Department for Courts. Coroners repeatedly expressed frustration at being unable to recover disbursements. They often cite the recent experience of Invercargill coroner, Trevor Savage, to illustrate that the administrative support provided by the Department is inadequate. During the course of two major aviation accident inquiries, Trevor Savage was obliged to write off in excess of \$1500 of disbursements. This cost was ultimately borne by his legal practice. Another example was provided by Hokianga coroner Heather Ayrton. Recently, she received a fee of \$50 for a case that had involved disbursements of \$42. She told us that when she approached the Department for Courts to recover her costs, she was advised that her only avenue was to claim them on her taxes.
- 21 The process for recovering administrative costs is unclear. Coroners have attempted to recover costs under section 45 of the Coroners Act 1988, which provides for regulations prescribing salaries, fees and travelling expenses. The Crown Law Office's advice to the Department for Courts is that section 45 of the Act does not, and was never intended to, authorise regulations permitting recovery of disbursements.¹¹ Disbursements are not seen as being salaries, fees, allowances, or travelling allowances and expenses, in terms of section 45(a), nor as being necessary for the due administration of the Act in terms of section 45(b).
- 22 There is an immediate need to re-evaluate the administrative support provided to coroners. The Department for Courts submitted that it would support an independent review of coroner's fees and expenses.
- 23 Coroners also expressed concern about their working conditions, including the lack of training, support services, and provision for annual leave. In commenting on the terms and conditions of appointment, Trevor Savage stated that:

There are none in the generally accepted sense. You are appointed, the Act sets out your statutory functions, you are given a handbook and

¹¹ Margaret Soper, Crown Counsel, Crown Law Office, letter to the Department for Courts, 21 October 1999.

that's it. You are expected to be on call 24 hours a day, 365 days a year. Remuneration is on the basis of piecemeal work and there are no entitlements such as leave or other benefits. There is no training and so far as I am aware, no performance review.¹²

24 In its submission to us, the Department for Courts confirmed that:

Apart from the Fees Regulations there are no terms and conditions of appointment specified for coroners. However, for 3 of the 74 coroners appointed (Auckland, Wellington and Christchurch) different conditions of appointment have been put in place.

25 In relation to training, Garry Evans stated that:

No training is, or has ever been, provided to coroners upon appointment. This stands in marked contrast to the training received by District Court judges and, now, Community Magistrates. No ongoing training, seminars or courses of instruction are provided by the Department for Courts and it has to be said that the judicial support resources of that Department, directed towards coroners, are woefully inadequate. Coroners are treated as the poor relations of District Court judges.¹³

26 Similarly, Rotorua coroner David Douthwaite commented that:

The result of the lack of initial training or guidance was that I deliberately delayed starting the job after my appointment which followed on a period of some two months between the resignation of my predecessor and my appointment. I also conducted my first hearings at some risk and in hindsight would do them differently now.

27 The huge pressures placed on coroners in the current system necessarily impact on their legal practices and other work. The Christchurch coroner, Richard McElrea, comments that:

The fact that it can be undertaken in conjunction with other (legal) work, is because much of the coroner's work (because of remuneration restraints) is done in "spare time" (evenings, weekends and public holidays)... Although there are annual variations, the trend is one of increased time input.¹⁴

28 Despite all of these concerns, the Law Commission found coroners to be extremely dedicated to their work and sensitive to the needs of families. Setting in place the systems and services to support them

¹² Trevor Savage, letter to the Law Commission enclosing other coroners' submissions, 15 November 1999.

¹³ Garry Evans, above n 9.

¹⁴ Richard McElrea, letter to the Law Commission, 24 January 2000.

in their role can only be of benefit to society. The recommendations in this part of the report therefore work as a package to address:

- amendments to the Coroners Act 1988;
 - the role and status of coroners; and
 - the practices, systems and services required to improve the operation of the coronial system.
-

2

Appointment and removal of coroners

29 **I**N OUR PRELIMINARY PAPER we sought submissions in relation to the appointment of coroners. We noted in the preliminary paper that coroners are judicial officers, are authorised to exercise many powers under the Coroners Act 1988 and have all of the powers, privileges, authorities and immunities of a District Court judge exercising jurisdiction under the Summary Proceedings Act 1957. We also noted that “any person” may be appointed coroner and that coroners are not required to be legally or medically qualified or to have any particular skills, characteristics, experience or training.¹⁵ The Coroners Act 1988 does not set out a procedure for the appointment of coroners and, in contrast to other judicial officers, there is currently no publicly accessible document which sets out the process involved in appointing coroners.

30 We made a number of proposals in the preliminary paper on which we sought submissions. We proposed that:

- the Coroners Act 1988 be amended to provide that coroners be legally qualified;
- the Coroners Act 1988, or regulations made under the Act, set out the experience or training which coroners must have, including an awareness of tikanga Māori;
- 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;
- more Māori coroners be appointed; and
- the Coroners Act 1988, or regulations made under the Act, provide for the appointment of an assistant to the coroner who could advise the coroner in relation to tikanga Māori.

¹⁵ New Zealand Law Commission *Coroners: A Review: NZLC PP36* (Wellington, 1999) 17–20.

- 31 These proposals are discussed below before recommendations 1–6.¹⁶ This chapter then discusses three related matters that were raised in submissions but not comprehensively dealt with in our preliminary paper, namely:
- the number, location and workloads of coroners (paragraphs 49–52);
 - the remuneration of coroners and the recovery of disbursements (paragraphs 53–62); and
 - the role of Justices of the Peace (paragraphs 63–65).
- 32 Finally, in paragraphs 66–69, we consider the procedure for removal of coroners and, in particular, whether section 34 of the Coroners Act should be amended.

LEGAL QUALIFICATIONS

- 33 There was general support for the proposal that the Coroners Act be amended to provide that coroners be legally qualified. Several submitters stated that coroners should be legally qualified because an understanding of legal principles and processes is necessary for conducting an inquest. A number of people who made submissions were of the view that simply requiring an individual to have legal training did not go far enough. In the submission received from the Chief District Court Judge’s Chambers (which incorporated the views of a number of District Court judges) it was stated that actual practice as a legal practitioner should also be a requirement.
- 34 Some submitters disagreed with our proposal. Several coroners from smaller communities stated that there would often be a conflict of interest if a coroner had to be legally qualified. It was noted that in many areas there may only be one legal practitioner and he or she may well have acted for the deceased or the deceased’s family. It was thought that it would be inappropriate if that person was also the local coroner. Others pointed out that coroners are readily able to get access to legal advice if and when they need it and there is therefore no need to require legal training. Several submitters were of the view that coroners should come from diverse backgrounds as this would ensure that a wide range of experience is brought to the

¹⁶ The proposal concerning the qualifications and on-the-job training of coroners has been split into two parts, with on-the-job training being dealt with separately at paras 40–42.

job. There was also a concern that there would be less representation of Māori and minority groups if coroners had to be legally qualified. The view was expressed that the appointment process should focus on all of the individual's characteristics and not just formal legal training and that people of good standing should be appointed.

35 As we noted in the preliminary paper coroners are judicial officers and exercise many judicial functions.¹⁷ The coroner must preside over an inquiry that will often involve cross-examination of witnesses and arguments from a number of counsel representing interested parties. Coroners must make decisions in relation to the admission of evidence and make findings based on the evidence presented to them. In the majority of submissions received from coroners it was noted that inquests are becoming increasingly complex and legalistic, with parties often represented by counsel.

36 In a submission received from the Ministry of Justice, it was stated that it has been the Ministry's practice in the past few years to appoint only persons who are legally qualified as it is generally conceded that an understanding of legal principles is helpful in conducting inquests. The Ministry notes that other criteria and characteristics are considered after legal experience. We consider that this practice is appropriate. However, we are of the view that the need for coroners to be legally trained should be set out explicitly in the Coroners Act. We have considered the argument that in small communities there may only be one legal practitioner and conflicts of interest could result if that person is also the local coroner. However, we recommend later in this paper that consideration be given to centralising the coronial districts and appointing fewer coroners but on a full-time basis (see paragraphs 49–52). If this were done there would be no difficulties in relation to conflicts of interest. We are also concerned that Māori and individuals from minority groups are appointed as coroners.¹⁸ We have considered whether the Act should require coroners to have practised as legal practitioners as some submitters suggested. However, in our view whether or not a person has practical experience should be considered along with an individual's other characteristics and should not be a requirement which is specified in the Act.

¹⁷ New Zealand Law Commission, above n 15.

¹⁸ See paras 44–45 where we recommend that more Māori as well as persons of other cultures and background be appointed as coroners and paras 37–39 where we recommend that one of the criteria for appointment as a coroner should be an awareness of tikanga Māori.

Recommendation 1

We recommend that the Coroners Act 1988 be amended to provide that coroners be legally qualified.

APPOINTMENT PROCESS

- 37 There was overwhelming support for the proposal that the Coroners Act, or regulations made under the Act, set out the experience which coroners must have, including an awareness of tikanga Māori. Many submitters were of the view that the appointment of coroners is currently shrouded in mystery and should be more transparent. In his submission, Rotorua coroner David Dowthwaite stated that he had applied for the position of coroner and was later advised that he had gained the position. No interview took place and he stated “whatever checking occurred is unknown to me”.
- 38 The Ministry of Justice submitted that coroners should be appointed under a similar process and criteria as other judicial officers. The Ministry noted that the appointment process undertaken by the Attorney-General’s Judicial Appointments Unit for other judicial officers involves: seeking applicants through advertising and by nomination; a consultation process with key persons; a shortlisting process; and an interview before making the final appointment decision. The criteria according to which judicial officers are selected includes: relevant qualifications and experience, personal integrity, impartiality and good judgment, communication skills, connections to the community and an awareness of its diversity, and an awareness of tikanga Māori.
- 39 In our view, the appointment of coroners needs to be more transparent. One way to achieve this is to set out appointment provisions in the Act. In New Zealand, legislation which authorises an individual to exercise judicial functions often sets out the procedure to be followed before an individual can be appointed to a particular office and the skills, characteristics and experience that appointees must have.¹⁹ The Law Commission agrees with the Ministry of Justice submission that coroners should be appointed in the same way as other judicial officers and according to similar criteria.

¹⁹ See for example: District Courts Act 1947, ss 5, 11A; Family Courts Act 1980, s 5; Judicature Act 1908, ss 6, 26C; Employment Contracts Act 1991, s 113; Te Ture Whenua Maori Act 1993, s 7; Resource Management Act 1991, s 249; Residential Tenancies Act 1986, s 67; Children, Young Persons and their Families Act 1989, s 435; and Disputes Tribunals Act 1988, s 7.

Recommendation 2

We recommend that the Coroners Act, or regulations made under it, set out the appointment process for coroners and the criteria according to which coroners will be selected. Such criteria will include an awareness of tikanga Māori.

TRAINING

40 Once coroners are appointed, there is a need to ensure that they receive appropriate training. Coroners repeatedly expressed concern about the lack of training upon appointment and the absence of ongoing training. In his submission David Dowthwaite noted that:

upon appointment I was advised that there was a manual. I in fact borrowed one from the local judiciary until subsequently upon further enquiry I received one from the Department of Courts. When I was told there was no training . . . I had a meeting with my predecessor to uplift his files and then arranged to . . . observe the Hamilton coroner . . . conduct a morning's hearing of three inquests and talked with him before and after. I am self taught from there aided by phone calls I have made from time to time to other coroners for assistance . . . a little bit of training would go a long way.

41 Another coroner noted that the absence of training for coroners stands in marked contrast to the training received by District Court judges and, now, Community Magistrates.

42 The work of coroners encompasses a wide variety of functions, including judicial, administrative and investigatory roles. Coroners work in a stressful and highly sensitive environment. They must address the needs of individual families, obtain the confidence of the public, and manage an increasing workload. Coroners have a critical role in the prevention of future unnecessary deaths. It is imperative that they receive training to equip them in fulfilling their many responsibilities.

Recommendation 3

We recommend that the Department for Courts establish suitable post-appointment and ongoing training programmes for coroners. There is a future role for a Chief Coroner to monitor and further develop training programmes.²⁰

²⁰ The need for a Chief Coroner is discussed at paras 71–79 of this report.

APPLICATION FORM AND PAMPHLET

- 43 There was no disagreement with the proposal that the Attorney-General'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. Submitters emphasised that the appointment process would be more transparent if information pamphlets about the position were published. It is already the Judicial Appointments Unit's practice to publish information pamphlets and application forms in respect of some judicial offices.²¹

Recommendation 4

We recommend that the Attorney-General's Judicial Appointments Unit publish an application form for those interested in applying for the position of coroner as well as a pamphlet setting 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 for District Court judges by the Unit.

MÄORI CORONERS

- 44 Wide support was received for our proposal that more Mäori coroners be appointed. It was felt that this would make the coronial system more representative of the population it serves. It was also felt that the appointment of more Mäori coroners would be a positive step as other coroners could seek assistance from them on matters of tikanga. In our view, it is important that offices that exercise judicial functions are representative of the population. One of the most common concerns raised about the coronial system was that it is not culturally sensitive to Mäori. In our view, the appointment of more Mäori coroners should help to ease concerns about the lack of cultural sensitivity as well as making the coronial system more representative.

²¹ In relation to District Court judges, the Judicial Appointments Unit produces an application form (entitled "Expression of Interest to be Appointed a District Court Judge"), which candidates must fill out if they are interested in becoming a District Court judge. The Unit also produces pamphlets that 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).

- 45 A few submissions commented that the Law Commission should also consider the need for persons of other cultures to be appointed to reflect the ethnic diversity that now characterises New Zealand society. While we feel that it is appropriate to focus on Māori in the first instance,²² we accept that the need to reflect the ethnic diversity of New Zealand society is an important factor to be taken into account when applications are being considered, along with the other qualities and skills possessed by an individual.

Recommendation 5

We recommend that more Māori and persons of other cultures and backgrounds be appointed as coroners.

CORONER'S ASSISTANT

- 46 Little support was received for the proposal that the Act, or regulations made under the Act, provide for the appointment of an assistant to the coroner who could advise the coroner in relation to tikanga Māori. Several coroners noted that an assistant would have a limited role in many areas. In its submission, Te Puni Kokiri questioned whether the appointment of an assistant to the coroner to advise on matters of tikanga would be the most effective way of encouraging responsiveness to Māori issues. The Department for Courts submitted that coroners should seek advice and assistance on tikanga Māori as and when required rather than an assistant being appointed. It was concerned that the appointment of one particular person to advise the coroner on all aspects of tikanga or culture may prove problematic.
- 47 Given the lack of support for this proposal, we do not recommend that the Act provide for the appointment of an assistant to each coroner to advise on matters of tikanga. We agree with the Department for Courts that coroners can seek assistance in this area as and when required and suggest that this be done through the office of Chief Coroner.²³
- 48 During consultation, we met with Moe Milne, the Kaiwhakahaere to the Health and Disability Commissioner. In a document comment-

²² See the discussion at paras 212–215.

²³ See paras 71–79 for discussion of our recommendation that a Chief Coroner be appointed in New Zealand.

ing on the Code of Rights and Māori concepts of health,²⁴ the Health and Disability Commissioner discussed the position of Kaiwhakahaere. She stated that this appointment demonstrates the commitment of the Commissioner's office to the principles of the Treaty of Waitangi and ensures that the rights of Māori consumers are promoted and protected. She explained that the role of the Kaiwhakahaere focuses on the special needs of Māori, including the need to promote awareness and education among Māori consumers about rights under the code. In our view, a similar position attached to the Office of the Chief Coroner has merit. A person in this role could: contribute to the development of protocols and ensure these are consistent with analogous protocols developed under other legislation (such as the Human Tissue Act 1964); assist the Chief Coroner's Office in meeting its obligations under the Treaty of Waitangi; look at ways to address any lack of understanding and the need for education as regards cultural issues both within the coronial system and amongst the public; and advise the Chief Coroner of appropriate steps to take where a coroner asks for assistance in matters of tikanga.²⁵

Recommendation 6

We recommend that the Chief Coroner's Office establish a kaiwhakahaere (co-ordinator) position.

NUMBER, LOCATION AND WORKLOADS OF CORONERS

- 49 In the preliminary paper we noted that 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.²⁶ We also noted that the Working Party highlighted the

²⁴ Robyn Stent and Moe Milne, *Oranga Tangata, Oranga Whanau: The Code of Rights and Māori Concepts of Health – Co-operating to Achieve Individual and Whanau Wellbeing*, 27–28 May 1999, <http://www.hdc.org.nz/media/speeches.html>.

²⁵ It was suggested to us that one of the options available to a Chief Coroner is to investigate a potential role for the Māori Land Court to assist in matters of tikanga.

²⁶ New Zealand Law Commission, above n 15, 24. Note that this issue was the subject of a report of the Justice and Law Reform Committee in 1988, which did not see the need at that time for the regionalisation of Coroners (Report of the Justice and Law Reform Committee on the inquiry into the Regionalisation of Coroners (Ministry of Justice, Wellington, 1988)).

lack of uniformity of coronial practices within New Zealand and that coroners in smaller centres gained little experience and adopted different procedures to coroners in larger centres.²⁷

- 50 We received many submissions discussing the status, disposition, workload and remuneration of coroners. The majority of submitters recommended that the number of coroners and coronial districts should be reduced and that coroners should be appointed on a full-time basis. Many were of the view that the workload in some rural districts is so light that the incumbent coroner does not have an opportunity to gain or maintain an adequate level of expertise. There are currently 74 coroners. In many areas coroners will rarely be involved in conducting inquests and will gain little experience. The Department for Courts submitted that 20 per cent of coroners do 80 per cent of the work. It was submitted that a smaller number of coroners, working full-time and serving a wider area, would mean that issues surrounding lack of uniformity of coronial decisions and inexperienced coroners would be reduced. These submitters also made the point that if districts were to be centralised and a small number of full-time coroners appointed, the coroners would need to be resourced and remunerated adequately.
- 51 On the other hand, some submitters were of the view that coronial districts should not be centralised. It was argued that having fewer coroners would mean that there would be greater delays in the release of the deceased. Also, it was felt that an important part of a coroner's function is to develop a rapport with the community that he or she serves, including the public, the police and pathologists. This helps the coronial process to flow smoothly and means that the families involved often know and respect the coroner. It was submitted that a coroner from another city might not understand the family's situation as well as a local coroner.
- 52 We are of the view that the number of coronial districts and coroners should be reduced and coroners appointed on a full-time basis. We do not see a reduction in the number of coroners and coronial districts as necessarily leading to delays in the release of the deceased, or to the isolation of coroners from the communities they serve. Coroners will be full-time and better resourced and will not have to balance their commitments as coroner with other work. We envisage the centralisation of coronial districts occurring by attrition as coroners who are not re-appointed under the new system finish their term. The Chief Coroner, after liaising with other

²⁷ New Zealand Law Commission, above n 15, 21.

coroners, would be involved in assisting the Department for Courts and the Ministry of Justice in determining how many coronial districts and full-time coroners are required. We agree with submitters who noted that coroners would need to be adequately resourced and remunerated.

Recommendation 7

We recommend that the Ministry of Justice and the Department for Courts, in consultation with the Chief Coroner, review the number of coroners and coronial districts currently in existence with a view to regionalising the coronial districts, reducing the number of coroners, and moving to a system of full-time coroners.

REMUNERATION AND THE RECOVERY OF DISBURSEMENTS

53 As we noted previously, all of the coroners we spoke to were concerned about issues of remuneration and recovery of basic costs. This concern was highlighted in Garry Evans' presentation to the Coroners' Conference. He stated that:

Coroners are poorly remunerated for the work they carry out; the legal firms in which most coroners are senior partners effectively subsidise the State, coronial remuneration being considerably less than a coroner law partner's professional income and inadequate to meet heavy legal practice overheads.²⁸

54 He explained that coroners are effectively paid on a piece-work basis for their professional services in terms of the Coroners (Fees) Regulations 1992 and that payment in this manner is anachronistic.

55 The Department for Courts acknowledged coroners' concerns about remuneration and recovery of costs in its submission to the Law Commission. The Department explained that currently in each case coroners are paid a single sum which covers both the coroner's fee and expenses. It made the following statement:

The fees to be paid to coroners are specified in the Coroners Regulations. It is the single most difficult area for both the Department and for coroners. Many coroners consider they are under paid for the work they are required to carry out and claim that the office of coroner is often subsidised by their law firms. The Crown is in the difficult position of choosing to increase fees or choosing to allow coroners to

²⁸ Garry Evans, above n 9.

leave. The Department would support an independent review of coroners fees and expenses. It would be appropriate for the appointing authority, Ministry of Justice, to undertake this review.

- 56 The Coroners' Council had an opportunity to comment on the Department for Courts submission. The Council stated that:

The Council supports the Department's call for an independent review of coroners' fees and expenses but it believes the review should be by a disinterested body rather than the Ministry of Justice.

The Council believes that remuneration of coroners should be fixed by the Higher Salaries Commission, with a consequential amendment to the Higher Salaries Commission Act 1977.

- 57 The Law Commission acknowledges the enormous social commitment shown by coroners in New Zealand. We consider that the current formula for remuneration (incorporating fees and expenses) needs to be reviewed. We emphasise again that our recommendations are intended to work as a package to improve the coronial system and give coroners a more professional status. Appropriate and fair remuneration and cost-recovery mechanisms for coroners are necessary to support these objectives. In addition, a more professional system should ensure that such mechanisms are able to be easily implemented.

- 58 Section 35 of the Act invests coroners with the powers, privileges, authorities and immunities of District Court judges exercising jurisdiction under the Summary Proceedings Act 1957. We therefore consider it is appropriate for the Act to provide for coroners' remuneration to be fixed by the Higher Salaries Commission as occurs with other judicial officers.

- 59 Further, the Law Commission further considers that the Coroners Act should be amended to expressly provide for regulations to be made concerning the provision of administrative services to support coroners and the recovery of actual and reasonable disbursements by coroners. At present, section 45 of the Act provides as follows:

45. Regulations—

The Governor-General may from time to time, by order in Council, make regulations for any of the following purposes:

- (a) Prescribing salaries, fees, allowances, and travelling allowances and expenses, for coroners, deputy coroners, assessors, witnesses, doctors, analysts, and pathologists, who perform any function under this Act or give evidence at an inquest held under this Act;
- (b) Providing for other matters contemplated by or necessary for giving full effect to this Act and for its due administration.

60 The Crown Law Office's advice to the Department for Courts is that section 45 of the Coroners Act 1988 does not and was never intended to authorise regulations permitting recovery of disbursements.²⁹ They are not seen as being salaries, fees, allowances or travelling allowances and expenses in terms of section 45(a), nor necessary for the due administration of the Act in terms of section 45(b). Crown Counsel commented that:

I appreciate that you would like to be able to reimburse the coroners if you can, because the Coroners (Fees) Regulations 1992 have slipped behind actual costs, to the great dissatisfaction of the coroners. Nevertheless, you do need some authority for the disbursement of public money . . .³⁰

61 The Coroners' Council stated that regulations under section 45 should allow for the reimbursement of out-of-pocket expenses to coroners.

62 The Law Commission considers that all actual and reasonable administrative expenses arising from the conduct of the coronial office and coronial enquiries should be borne by the Department for Courts as the State agency responsible for the administration of the coronial system.

Recommendation 8

We recommend that the Act be amended to provide for coroners' remuneration to be fixed by the Higher Salaries Commission as occurs with other judicial officers.

We also recommend that section 45 should authorise the Governor-General to make regulations providing for administrative services to support coroners in carrying out their functions under the Coroners Act and for the recovery of actual and reasonable disbursements by coroners and that such regulations should be made.

JUSTICES OF THE PEACE

63 In the submission received from the Chief District Court Judge's Chambers it was noted that all District Court judges and Justices of the Peace are authorised to carry out coronial functions. It was felt that this factor may have created numerous problems, such as: making

²⁹ Margaret Soper, above n 11.

³⁰ Margaret Soper, Crown Counsel, Crown Law Office, letter to the Department for Courts, 17 December 1999.

it possible for the police to bypass the normal coroner in certain circumstances; creating difficulties in ascertaining who the correct coroner is in a given instance; and creating an unequal spread of work amongst coroners. It was submitted that this has meant some coroners are getting less work and therefore may not be able to acquire or maintain the necessary expertise in the field. It was felt that this factor may be contributing to the lack of uniformity of coronial practice and inconsistencies in the quality of coronial work. The Department for Courts submitted that the power of Justices of the Peace to act in the place of coroners should be re-examined with a view to its removal. In another submission, Owhata general practitioner John Armstrong recommended that Justices of the Peace should not act as coroners, rather that in the absence of a local coroner, either a neighbouring coroner, the proposed Chief Coroner, or a local deputy coroner should act as coroner.

- 64 The Coroners' Council disagreed with the suggestion that Justices of the Peace should no longer be involved in coronial work. The Council submitted that they support the work undertaken by Justices of the Peace and recommended that the function should continue. The powers of Justices are limited under section 6(2) to those matters dealt with in Part III of the Act, to the opening and immediate adjournment of an inquest, and to the hearing, admission and recording of identification evidence concerning the deceased. The Council noted that only a small number of Justices of the Peace are called upon to do coronial work and that the experience which these Justices gained enabled them to exercise the limited powers conferred on them.
- 65 We do not consider that any change to the current arrangement between coroners and Justices of the Peace is appropriate at this time. We reiterate that our recommendations work as a package to enhance the role of coroner and to implement appropriate systems and services to assist coroners in carrying out their functions. Until such time as these support systems are in place, particularly those relating to the Office of Chief Coroner, any revision of the role of Justices of the Peace would be premature. This is an area that should be reviewed by a Chief Coroner in consultation with the Ministry of Justice and the Department for Courts.

Recommendation 9

We do not recommend any change to the current arrangement between coroners and Justices of the Peace at this time.

REMOVAL OF CORONERS

- 66 In the preliminary paper we noted that section 34 of the Coroners Act 1988 provides that the Governor-General may remove coroners for “inability” or “misbehaviour”. This wording mirrors section 7(1) of the District Courts Act 1947 relating to removal of District Court judges. We noted that in England a coroner may be removed on similar grounds and that the terms had been interpreted widely. We were of the opinion that no change to section 34 of the Coroners Act 1988 was required. This opinion was supported by the Coroners’ Council in their submission.
- 67 Margaret Soper, Crown Counsel, Crown Law Office, submitted that coroners should be treated in a similar way to Community Magistrates in terms of the process of removal. Section 11F(2) of the District Courts Act 1947 provides that:
- The Governor-General may remove a Community Magistrate from office for neglect of duty, inability, disability affecting performance of duty, bankruptcy, or misconduct, proved to the satisfaction of the Governor-General.
- 68 In another submission, Christchurch coroner Richard McElrea stated that a Chief Coroner should have input into a decision whether to remove a coroner. He submitted that the Act should stipulate the circumstances in which a coroner’s warrant is withdrawn. This would include bankruptcy, disqualification as a director in terms of the Companies Act 1993, criminal convictions, and convictions with respect to certain other offences of a serious nature.
- 69 In our view, it is not necessary to amend section 34 of the Coroners Act. Our recommendations are intended to enhance the status of coroners and properly integrate the Coroner’s Court into the courts system. Section 35 of the Act provides that, for the purpose of exercising or performing any power, function, or duty under the Coroners Act, coroners have the same powers, privileges, authorities and immunities of a District Court judge. We therefore consider that it is appropriate for coroners to be subject to the same removal process as District Court judges.

Recommendation 10

We do not recommend any change to section 34 of the Coroners Act.

3

National co-ordination and the Office of Chief Coroner

70 **I**N THIS CHAPTER, we begin by examining the need for a Chief Coroner to be appointed in New Zealand (recommendation 11).³¹ We then discuss the argument that a national coronial information database is necessary to support a Chief Coroner in carrying out his or her functions. Thirdly, we discuss the role of a Chief Coroner in co-ordinating the relationships between the coronial system and the many administrative agencies that are interested in determining the cause and circumstances of particular deaths. Fourthly, we canvass a number of areas that would benefit from the development of guidelines or protocols from the Office of Chief Coroner. These matters concern:

- major disasters;
- the role of pathologists;
- the role of the Police;
- unnecessary post-mortems and the role of partial post-mortems; and
- a broader approach (with particular reference to SUDI³² deaths).

Finally, we discuss funding issues.

³¹ Many of the issues discussed in this chapter were matters that were not canvassed in our preliminary paper, but rather were subsequently raised in submissions and during consultation. We have included our preliminary view concerning these further matters in this report in recognition of their importance and because we consider it appropriate that a Chief Coroner investigate them further.

³² Sudden and Unexpected Death of an Infant. SIDS (also known as cot death) is the highest cause of SUDI deaths.

THE NEED FOR A CHIEF CORONER

71 In the preliminary paper we noted that during consultation, many people expressed concerns in relation to the supervision of coroners. It was noted that in New Zealand there is currently no person or office responsible for the administration of the Act and for overseeing how coroners exercise their powers or carry out their duties. We observed that this causes a number of problems in practice:

- 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. Individuals and groups have also expressed concern that there is no one person they can approach in relation to coronial matters.
- There is a perceived lack of uniformity in practice between coroners. It was noted that many coroners will investigate very few deaths during their time as coroner. Other coroners will investigate many deaths. This often means that coroners have different amounts of experience and often adopt different procedures.
- There is no guidance as to how coroners should exercise their discretionary powers under the Act.

72 We noted that a Chief Coroner is appointed in most territories in both Australia and Canada. We proposed that a Chief Coroner be appointed in New Zealand. The Chief Coroner's functions would include:

- engaging in research and planning to ensure coroners are equipped to perform their functions systematically and properly;
- ensuring that coroners are properly trained;
- liaising with the government in relation to the appointment and disposition of coroners throughout New Zealand;
- liaising with the public and other coroners;
- ensuring that reports from coroners are properly appraised and that they are publicly available;
- 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 needed for their prevention or reduction.³³

73 The Chief Coroner would also be responsible for issuing guidelines or protocols to coroners in relation to the performance of the coroner's functions. The guidelines could relate to, for instance:

- exercise of the coroner's discretionary powers;
- the judicial ethics of coroners;³⁴
- how coroners should liaise with family members and organisations;
- the needs of interested cultural and religious groups and families in general;
- procedures for the release of the deceased;
- standardisation of procedures for the creation and maintenance of coronial records; and
- the availability of coroners during weekends and holidays.

74 Our proposal that a Chief Coroner be appointed received overwhelming support. It was submitted that a Chief Coroner could ensure the efficient administration of the Coroners Act and could help to identify and prevent potential harm and unsafe practices. In a presentation at the 1999 National Coroners' Conference, the Wellington coroner stated that:

The establishment of an office of Chief Coroner for New Zealand is urgently needed if the dignity, usefulness and effectiveness of the office of coroner is to be preserved, developed and enhanced . . . Until such

³³ In the State of Victoria a coroner may report to the Attorney-General:

- ♦ on a death which the coroner investigated; and
- ♦ on any matters connected with a death, including public health or safety or the administration of justice.

³⁴ Our recommendations are intended to enhance the status of coroners. It is therefore appropriate that a Chief Coroner develop some form of "rules of coronial conduct". One issue that was raised with us, and which could appropriately be included, is the ethical propriety of a coroner, as a judicial officer, also practising as legal counsel before a fellow coroner in the Coroner's Court. It is important to ensure that there is no perception of bias associated with the functioning of the Coroner's Court.

time as statutory provision is made for the appointment of a Chief Coroner, coroners will continue to act in a fragmented and uncoordinated way.³⁵

- 75 The majority of submitters agreed that a Chief Coroner should have the functions listed above. It was suggested that a Chief Coroner should also be responsible for:
- receiving complaints about coroners;
 - ensuring that coroners and the Coroner's Court operate effectively and efficiently;
 - liaising with the public, media, government departments, health professionals, other judicial officers and other relevant agencies;
 - ensuring consistency in terms of coronial findings, recommendations and processes;
 - monitoring investigatory standards for coronial inquiries;
 - ensuring that all deaths which should be referred to a coroner are in fact referred;
 - creating and maintaining a coronial database; and
 - ensuring that coroners' reports are published in a readily available form.
- 76 It was also suggested that in line with other jurisdictions it would be desirable for a Chief Coroner to practice as a coroner on a regular basis.
- 77 We are of the view that 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 are more uniform by issuing forms, guidelines and protocols 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, the Department for Courts and other agencies.
- 78 Finally, we acknowledge the offer of the Chief District Court Judge to provide leadership in establishing the Office of Chief Coroner. During consultation, he advised us that he would be prepared to liaise between coroners and government departments to ensure the proper development of the Office of Chief Coroner. He performed a similar role during the development of the Office of Principal

³⁵ Garry Evans, above n 9.

Disputes Referee. The Coroners' Council stated that it would welcome the leadership role that the Chief District Court Judge could play. The Council envisages that the Chief District Court Judge and the designated Chief Coroner could work alongside each other in initiating and developing the Office of Chief Coroner.³⁶

- 79 We consider that the Chief Judge's assistance in this area would be invaluable in ensuring that the Coroner's Court is properly integrated into the courts system. The establishment of a centralised system is a critical base for moving forward on all other issues.

Recommendation 11

We recommend that a section be added to the Coroners Act 1988 providing for the appointment of a Chief Coroner. The section should set out a Chief Coroner's functions, which would include the functions listed in paragraphs 72, 73 and 75.

A NATIONAL CORONIAL INFORMATION DATABASE

- 80 A number of submitters emphasised that a Chief Coroner would have difficulty in fulfilling his or her functions in the absence of a National Coronial Information Database. The 1999 Coroners' Conference passed a resolution to the effect that:

the Conference agrees with the Law Commission's view that there is a need for a national collation and appraisal of Coroners' finding[s] and is of the view that the establishment of a National Coronial/Surveillance System is critical to addressing this and for facilitating the work of individual coroners and further recommends that the National Coronial/Surveillance System be modelled on the Australian one. In particular the system would have a minimum data set; (data elements to be recorded for all events) and that there be modules for specific events such as suicides, firearms, drownings, work related deaths, road deaths, drug related deaths and fire.

- 81 A submission from Safekids, the child injury prevention service of Starship Children's Health, states that strategies for injury prevention cannot develop without the proper information systems:

³⁶ Richard McElrea, Chairman, Coroners' Council, letter to the Law Commission, 12 May 2000. In initiating and developing the Office of Chief Coroner, useful prototypes can be found in Victoria, Australia and British Columbia, each of which appear to have a well-resourced, effective and integrated coroners service.

Safekids believes coroners have a very important role to play in preventing injuries to the New Zealand public, including our children. The injury fatality data provided through coroners and medical examiners is an important source of information to uncover a multitude of injury causes and to plan injury prevention strategies. One of the major limitations to the current scheme is that it fails to provide sufficient, useable information for injury prevention. There is also a lack of uniformity between coroners and coronial practices and therefore there is inconsistent injury fatality data available across New Zealand.

82 Advice from the President of the Law Commission who currently chairs the Aviation Safety Group is that the aviation experience shows that apparently unrelated events assume a different character when looked at collectively. The systematic collection of accurate coronial data and information is crucial in developing strategies for injury and death prevention.

83 At the 1999 Coroners' Conference in Wellington, the State Coroner for Victoria, Graeme Johnstone, described the advantages of the National Coronial Information System (NCIS) for preventable injury and death that is currently being developed in Australia in conjunction with Monash University in Victoria. Mr Johnstone stated that:

There will be many benefits of a National Coronial Information System ranging from the early identification of new and emerging hazards to improved indicators of the health of our society. Some additional benefits include standardised practice, access to other coronial comment and recommendations, coronial legislation, precedents, design standards and the like. Information will become available on injury prevention issues and medical related problems through articles, books and libraries. Coroners will eventually obtain overseas information from other coroners and medical examiners offices. A sophisticated system may be able to automatically "flag" some problem areas. Coroners will become aware of "experts" on particular areas and greater links will be made with other areas interested in injury prevention and research.

84 Mr Johnstone also referred to the fact that in Australia there is recognition that coronial files are a source of information on causation and provide new ways of looking at old problems. He stated:

With developed national . . . information systems sound research on similar cases will no doubt become a regular part of the coroner's investigatory brief. Early hazard identification from the linking of coronial files will mean that governments, industry and the community will be able to better plan short and long-term countermeasures . . . The

future will hopefully see responsible agencies having either addressed the problem before the inquest or joining to assist in developing well-targeted recommendations . . .

To adequately perform this important social and community function there is a need for minimum standards of coronial investigation, clear direction and appropriate governmental resourcing of the coroner's role. Information technology can be used in this regard to assist in providing both the tools and help with the solutions.

85 The NCIS in Australia was developed with the support of a number of organisations that have an interest in coronial data, including Road Safety, Worksafe Australia, Consumer Affairs, Australian Bureau of Statistics, Australian Institute of Criminology, Department of Health, National Injury Surveillance Unit, and Monash University (Monash Department of Forensic Medicine/Accident Research Centre). All organisations that have an interest in coronial data have access to the NCIS to assist in early hazard identification and research. The NCIS gives public health agencies the ability to assist the coronial service in improving the quality of investigation and knowledge of incidents.

86 Submissions suggested that an information database for New Zealand could well be modelled on the Australian NCIS. In the words of the New Zealand Health Information Service (NZHIS):

We also believe that in order to function effectively the Chief Coroner would require the establishment of an effective information system possibly modelled on the Australian electronic database system . . . Core users of coroners' files (e.g. NZHIS) should be consulted in the development phase of the information system . . . The Australian system is expected to have many benefits not only in helping coroners to standardise their investigations but also to play a major role in hazard identification and injury prevention as well as aiding the production of more accurate and timely statistics of cause of death.

87 Similarly, the Christchurch coroner, Richard McElrea, submitted that:

There is overwhelming evidence for the establishment of a coroners' database, based on or linked to the National Coroners' Information System in Australia. Without such a process, systemic issues will not be properly detected and the coroner's process wasted.

88 Submissions raised a number of factors to be considered in the development and maintenance of an information database. Professor Anthony Taylor noted that, in addition to those with expertise in the traditional medico-legal areas connected with sudden death, the development of a national database should include input from people with expertise in cultural matters, the social sciences, and

aircraft and shipping fatalities.³⁷ Many submitters emphasised the need for collaboration between the ultimate users of the data. The relationship between the proposed system and existing databases will need to be examined. Ethical and privacy issues will also need to be addressed.

- 89 The Law Commission has consulted with and had the benefit of a comprehensive submission and additional materials from Professor John Langley of the Injury Prevention Research Unit (IPRU) in Dunedin. Professor Langley has been actively involved in promoting the need for a National Coronial *Surveillance* System in New Zealand. He expressed concern that there is a lack of understanding about what is required for an effective surveillance system:

Contrary to some perspectives it involves more than the loading of existing information onto a database. While this would be an advance we wish to emphasise that this information is variable in quality.

He explains that:

Epidemiologic surveillance is the ongoing systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event . . . This information is used in planning, implementing, and evaluating interventions and programs which impact on the health of the public. Surveillance data are used both to determine the need for public health action and to assess the effectiveness of the programs.

- 90 Professor Langley advises that much more thought is needed with regards to the future analysis, interpretation, and dissemination of the data generated by a national database. He states that resources need to be allocated for these purposes as there exists already much health-related data that is “untouched by human thought”.
- 91 A number of submissions addressed the need to set up specialist modules of data to complement the core dataset of the coronial database. The areas considered include: suicide; SIDS; child mortalities generally; work-related fatal injuries; alcohol and drug related deaths; road deaths; drowning; and medical misadventure. Methods of standardising terminology and practice between agencies will need to be examined. It was also stressed that there is a need to ensure mortality statistics reflect the true level of Māori and Pacific deaths. The collection of ethnicity data at present is inadequate.

³⁷ Professor Anthony Taylor, letter to the Law Commission, 18 February 2000.

92 The Occupational Safety and Health Service (OSH) of the Department of Labour supports the vision statement of the business statement for the Australian NCIS which is:

To develop and maintain a high quality information service for coroners, which will also be of assistance to policy makers and researchers in the field of public health and safety, to benefit the . . . community by contributing to a reduction in preventable death and injury.

OSH believes that a mortality dataset is required that will provide comprehensive and up-to-date data information to a range of users: coroners, public policy makers and researchers. OSH supports the establishment of a working party to discuss the development of such a system. They state that agencies who should be included in the working party as a minimum include: coroners; Accident Compensation Corporation; Civil Aviation Authority; Department of Labour; Ministry of Health; Land Transport Safety Authority; Maritime Safety Authority; Ministry of Pacific Island Affairs; Te Puni Kokiri; Statistics New Zealand; and the Department of Preventative and Social Medicine, Dunedin School of Medicine. To this list we would add: the Department for Courts and the Institute of Environmental Science and Research. A working group would also no doubt benefit from consulting with Police and pathologists given their integral roles in the coronial process and the collection of data. Finally, the Privacy Commissioner has requested that he be specifically consulted concerning the development of such a database.

93 The Law Commission supports any move towards establishing a national coronial database. We consider that a Chief Coroner could be responsible for overseeing the implementation of such a database. We accept that the development of such a system requires the collaboration of many agencies, including those listed above. While we are not in a position to make any formal recommendations as regards the best approach to establishing a database, we support the establishment of a working party or a steering committee led by a Chief Coroner to discuss the many issues in this area and suggest that an independent agency take on the role of lead agency in instigating this process. Alternatively, it may be possible to contract the NZHIS to take on this role since they already calculate a minimum dataset and there is an important link between the public health functions of the coronial system and the Ministry of Health.

CO-ORDINATION BY THE CHIEF CORONER

94 There is a need to clarify and co-ordinate relations between coroners and administrative or government agencies with an interest in

coronial work. This co-ordination role would be the responsibility of a Chief Coroner.

- 95 At the 1999 National Coroners' Conference, Richard McElrea presented an update of a paper given at the 1997 Coroners' Conference on the topic of "The Coroner and Outside Agencies". He noted that:

The statutory role to examine the cause and circumstances of death was shared in varying degrees with outside agencies and that as this process has evolved over the years, there has been an erosion of the role and responsibilities of coroners. The work of some of these agencies duplicates the work of coroners.

- 96 The agencies discussed in Mr McElrea's presentation were: the Police; the Police Complaints Authority; hospital health services; the Health and Disability Commissioner; the Transport Accident Investigation Commission; the Maritime Safety Authority; the Occupational Safety and Health Service; the Commissioner for Children; the New Zealand Armed Forces; the Department of Corrections and the Office of the Ombudsmen (regarding deaths in custody); the Department for Courts; Transit New Zealand; the Mountain Safety Council/Federation of Mountain Clubs; New Zealand Mountain Guides Association; the Ministry of Commerce (now the Ministry of Economic Development); mental health services; and the New Zealand Fire Service.
- 97 The constitutional status of the Coroner's Court is fundamentally different to that of administrative or government agencies. Coroners are required to determine whether or not to hold an inquest and their decision is reviewable by the High Court. However, confusion as to jurisdiction may exist where the investigatory, fact-finding, and recommendatory powers of administrative or government agencies seem to be similar to, or even to run parallel with, the jurisdiction of coroners. Such confusion was sometimes evident in the submissions that commented on the relationship between coroners and particular agencies.
- 98 The Department for Courts commented that:
- There has been some concern raised about the authority of coronial inquiries where other organisations such as TAIC and the Maritime Safety Authority also investigate. The question concurrent investigations raise is essentially which investigating agent or authority is the ultimate one. The issue is particularly important where conflicting decisions or recommendations are released.
- 99 The Health and Disability Commissioner noted that sometimes coroners make findings on the standard of health or disability

services and recommendations on policy and practice for the purpose of avoiding similar deaths in the future. This is a matter that she considers impacts on her jurisdiction as Commissioner. She stated that:

There is a need for consistency between coroners' recommendations about policy and practice on matters to do with the quality of health and disability services. While I recognise the difficulties due to the number of different coroners, I would recommend that matters impinging on the Commissioner's jurisdiction be referred to the Commissioner to investigate. Perhaps the Coroners Act should be amended to give effect to this, i.e. rather than individual coroners making different recommendations on what they consider to be an applicable standard, it would be preferable for coroners to recommend that the Health and Disability Commissioner investigate those matters under the Commissioner's jurisdiction.

- 100 In response to the Health and Disability Commissioner's submission, the Coroners' Council reiterated the important difference between administrative and government agencies and the Coroner's Court and submitted that:

Section 28 [of the] Coroners' Act makes provision for the postponement of the opening or the adjournment of an inquest where an inquiry into the death or the circumstances in which it occurred is being or is likely to be held under some other enactment.

It is not surprising that after a public and judicial hearing at which evidence is tested, coroners may make findings of fact which are different from those of administrative agencies whose enquiries are more limited in function and extent.

Coroners inquiries may well be less expensive than other forms of inquiries. [The] Council notes that in Australia inquests are routinely conducted into circumstances which, if they had arisen in New Zealand, and judging by past history, would have been referred to some ad hoc body at considerable expense (eg the Cave Creek inquiry). The enhanced professionalism that would follow from the appointment of a Chief Coroner, judicial training, and rationalisation may reduce the need for overlapping costs.

- 101 In a separate submission, the Wellington coroner emphasised that the Health and Disability Commissioner's statutory functions are restricted in their nature and are quite different to the work of a coroner. He stated that:

Those functions revolve about a statutory Code (the Code of Health and Disability Services Consumers Rights) and, as recorded, the Commissioner works at a lower level than a Court. The making of determinations as to the cause of a person's death and the making of

findings as to the circumstances surrounding such death, is the preserve of coroners, whose jurisdiction is at once judicial and wholly untrammelled.³⁸

102 In the Law Commission's view, there is clearly a need to co-ordinate relations between coroners and the many agencies that have an interest in the causes and circumstances of death.

103 In his presentation concerning coroners and outside agencies, McElrea concluded that:

The interaction of the coroner with the many agencies . . . that have an interest in, and in some instances have a statutory role to enquire into, the causes and circumstances of death is complex. Coroners must capitalise on the goodwill and expertise of such agencies and work to improve the legislative interface between the coroner and other agencies.

104 We consider that the relations between coroners and administrative and government agencies can be co-ordinated by the Office of Chief Coroner. The Chief Coroner can lead or take part in discussions aimed at clarifying the roles of the many agencies with an interest in the coronial system and their interaction with coroners, and the development of corresponding guidelines.

GUIDELINES AND PROTOCOLS TO BE DEVELOPED BY THE CHIEF CORONER

105 In this section we discuss a number of further issues raised in submissions that impact on the Office of Chief Coroner, many of which are appropriate subject matter for guidelines or protocols to be developed by the Chief Coroner.³⁹ These matters concern:

- major disasters;
- the role of pathologists;
- the role of the Police;
- unnecessary post-mortems and the role of partial post-mortems; and
- a multi-disciplinary approach (with particular reference to SUDI deaths).

³⁸ Garry Evans, letter to the Law Commission, 11 May 2000.

³⁹ These topics were not specifically canvassed in our preliminary paper but raise important issues that warrant discussion.

Major disasters

- 106 The Transport Accident Investigation Commission (TAIC) submitted that there is a need for specific protocols to be developed in the event of a major disaster. It submitted that:
- the Law Commission should ensure that any review of the role of coroners should include specific arrangements for a major disaster involving multiple trauma victims in large numbers. It is important not to erode the ability of the State to improve the safety of all its citizens through the comprehensive investigation of major accidents.
- 107 During consultation, the TAIC's medical consultant, Dr Robin Griffiths, commented that in major disasters it is particularly important to note patterns of injuries. Further, care must be taken before deceased person are released to ensure that body parts have been placed with the correct bodies in order that the possibility of stowaways or terrorists can be ruled out.
- 108 Professor Anthony Taylor commented on the need for mortuaries in major centres to be expandable to accommodate the demands of a major disaster.
- 109 At the 1999 National Coroners' Conference, David Crerar commented that one of the Chief Coroner's functions should be to prepare a plan for coroners in anticipation of a major disaster.
- 110 The Law Commission agrees that one of the Chief Coroner's functions should be to prepare a plan for coroners in anticipation of a major disaster.

Role of pathologists

- 111 A number of submissions considered that our report should review the role of pathologists in the coronial system. The submissions raised issues concerning the availability of pathologists; delays; the role, function and requirements of pathologists; and the need for standardised procedures in post-mortems.
- 112 The Funeral Directors Association of New Zealand stated that:
- Any review that has as its goal the intention to reform must address all aspects of the issue requiring reform and it therefore would be to no avail to encourage the changes being recommended if they were going to be hampered in their implementation by the bottleneck which is found in the pathology services in many of the coronial areas of New Zealand.
- 113 The Ministry of Justice stated that we should consider including the role of the pathologist in the legislation. They noted that:

The Act is largely silent as to the undertaking and requirements of post-mortems, even though this aspect of the coronial system appears to be of concern to many stakeholders. Aspects of the pathologist's role, function and requirements could perhaps be expressed in statute, as a means of bringing more transparency to the post-mortem procedure.

- 114 This is the approach taken in some Australian states. Part 3 of the Coroners Act 1995 (Tasmania) establishes the position of State Forensic Pathologist and sets out the State Forensic Pathologist's functions and powers. Part 9 of the Coroners Act 1985 (Victoria) establishes the Victorian Institute of Forensic Medicine and sets out its objectives and functions. Further, pathology services in Victoria are located with the Office of Chief Coroner in order to enhance the working relationship between law and medicine at a high level of policy development.
- 115 The Law Commission acknowledges the critical role that pathologists play in the coronial system. The coronial process can only benefit from any undertaking to review the functions and requirements of pathologists and the relationship between pathology services and the Office of Chief Coroner. However, such a review would necessarily require a large amount of input from pathologists and is outside the terms of reference for this report.

Role of Police

- 116 Section 37 of the Coroners Act 1988 provides that the Commissioner of Police must cause members of the Police to assist at all inquests, inquiries, and investigations under the Coroners Act.
- 117 Several submitters recommended that the role and functions of the Police under the Coroners Act be reviewed. It was submitted that the training and support which police officers receive should also be considered.
- 118 Professor John Langley of the IPRU commented that there is increasing pressure being put on Police support given to coroners due to Police restructuring. He states that the IPRU has been advised that there is minimal national support for police officers who perform the role of inquest officer on a regular basis, and no formal training is provided. A dedicated and trained inquest officer is important in ensuring the efficient running of the coronial office.
- 119 During consultation, Gordon Matenga the Hamilton coroner commented that police officers sometimes confuse their role as the investigating officer to the coroner under the Act with their criminal investigation role.

120 Again, the Law Commission recognises the crucial role that the Police play in the coronial system. While we agree that there is need for a review of the training and support which police officers who work within the coronial system receive, we consider that any such review should be led by, and co-ordinated from within, the Police.

Unnecessary post-mortems

121 A number of submitters, including coroners, hospitals, Māori groups, pathologists and funeral directors believe that in some instances unnecessary post-mortem examinations are being performed. The reasons given in explanation fall into two main categories: the first category relates to section 37 of the Births, Deaths and Marriages Registration Act 1995 and the second category relates to the coroner's decision to authorise a post-mortem.

Section 37(1) of the Births, Deaths and Marriages Registration Act 1995

122 Section 37(1) of the Births, Deaths and Marriages Registration Act 1995 provides that:

- (1) Subject to subsection (3) of this section, a doctor who attends any person while that person was ill and later learns of the person's death,—
 - (a) If satisfied that the death was a natural consequence of the illness concerned, shall forthwith on learning of the death complete, sign, and give to the person having charge of the dead person's body a medical certificate; but
 - (b) If not so satisfied, shall not complete or sign any such certificate.

123 Section 37(4) of the Births, Deaths and Marriages Registration Act 1995 provides that:

- (4) Notwithstanding subsection (1) of this section, where any person has died, and the doctor who last attended the person while ill is unavailable, any other doctor may complete, sign, and give a doctor's certificate if,—
 - (a) Having had regard to the medical records of the unavailable doctor relating to the person; and
 - (b) Having examined the person's body, and having had regard to the circumstances of the death,—the other doctor is satisfied that the death is not a death required to be reported under section 4 of the Coroners Act 1988.

124 The Christchurch coroner, Richard McElrea, submitted that in his view there are too many cases of death by "natural causes" where a doctor for one reason or another will not issue a certificate, despite

the terminology of section 37(1) of the Births, Deaths and Marriages Registration Act. Good Health Wanganui expressed the issue thus:

Without jeopardising coronial practice it is our opinion that a significant proportion (perhaps up to 20%) of deaths initially warranting an investigation could be dealt with without post-mortem examination if coroners would more readily accept, and in particular medical practitioners more readily offer a probable cause of death following careful assessment of the deceased patients' medical records.

125 Mr A Hall, the Gisborne coroner, informed us that where a doctor can give a probable cause of death, he will generally accept a certificate as to the probable cause and would not require a post-mortem (except in SIDS cases, motor crashes, in sudden deaths of young people or the like).

126 On the other hand, the Wanganui coroner, Colin Riddet, alluded to a reference in *Coronial Law and Practice in New South Wales* where the following comment was made:

If coroners are satisfied with accepting evidence of visible medical causes of death, without fully investigating the manner of death and the real causes behind such medical causes, there seems no real reason why the office of coroner should survive at all. My view is that one's duty is to ensure that all available information about a death is placed before the coroner to ensure that a proper finding is made.⁴⁰

127 Having said that, however, Mr Riddet stated that:

I do recognise the problem and indeed from time to time (with respect to elderly people who were clearly seriously ill before death) rely on reports as to "probable cause of death" . . .

128 We have considered these arguments. In addition to increasing the trauma suffered by families, unnecessary post-mortems are costly and time-consuming. We consider that the Chief Coroner, after consultation with coroners, pathologists, general practitioners and the Police, could issue guidelines as to the circumstances in which it would be appropriate for medical practitioners to give, and coroners to accept, a certificate as to probable cause of death.

129 Another reason given to explain why unnecessary post-mortems are being conducted relates to section 37(4) the Births, Deaths and Marriages Registration Act 1995 and the narrow definition of "unavailable". In the Births, Deaths and Marriages Registration Act, "unavailable" means when the deceased's usual doctor is either "dead,

⁴⁰ KM Waller *Coronial Law and Practice in New South Wales* (2 ed, Law Book Co, Sydney, 1982) 108.

unknown, missing, of unsound mind, or unable to act by virtue of medical condition". A number of submitters, including one doctor and a number of coroners, suggested that the definition of "unavailable" as it relates to doctors in section 37(4) of the Births, Deaths and Marriages Registration Act should have its ordinary meaning. Dr Armstrong, a general medical practitioner based at Owata, explained that:

Under present law, if an "owner" general practitioner is not able to be contacted (may be overseas, away for the weekend for example) when their patient dies, then that person will become a coroner's case because no other doctor can sign a medical certificate.

If the coroner is unable to obtain other medical evidence as to the probable cause of death, then a post mortem will be ordered.

This is clearly a major area of concern. In this situation people are being subjected to post mortem examination in spite of the fact that were the "owner GP" able to be contacted, a medical certificate could be issued.

By expanding the definition of unavailability to include such examples as given above, a "relieving GP" could issue a medical certificate and avoid the risk of unnecessary post mortem.

- 130 These concerns have been addressed by a proposed amendment to the Births, Deaths and Marriages Registration Act 1995 in the Statutes Amendment (No 7) Bill:

Clauses 20 and 21 amend the principal Act to extend the situations in which, if a person dies after an illness, a doctor other than a doctor who attended the person during the illness may give a doctor's certificate for the death ("a death certificate"). Current requirements of the principal Act can create delays in the giving of death certificates that can distress the family of a dead person.

Clause 20 inserts in section 2 of the principal Act a definition of "give a doctor's certificate".

Clause 21 repeals section 37 of the principal Act, and substitutes a new section. Under *new subsection (1)(b)*, a doctor other than a doctor who attended the person during the illness may give a death certificate not only (as the current subsection (4) permits) if the doctor who last attended the person during the illness is "unavailable"... but also if more than 24 hours has passed since the death and the doctor who last attended the person during the illness has not given a death certificate.⁴¹

- 131 The Law Commission supports the proposed amendment.

⁴¹ Explanatory Note to the Statutes Amendment (No 7) 1999 Bill, No 334-1, iii.

The coroner's decision to authorise a post-mortem

- 132 A group of submitters stated that in some instances post-mortems are being authorised where this is inappropriate, with SIDS deaths being the common example. Other submitters suggested that in some instances the authorisation of a limited or partial post-mortem is appropriate. One submitter suggested that the Law Commission should consider whether medical examiners should be appointed to assist coroners in deciding whether it is necessary to have a post-mortem. These issues are discussed in turn.
- 133 In our preliminary paper, we alluded in a footnote to the recent controversial debate about whether post-mortem examinations should be conducted on infants believed to have died of SIDS.⁴²
- 134 Some submitters questioned whether there is a need to carry out post-mortems on infants who have died of SIDS. Te Mana Hauora o Te Arawa proposed that in-depth discussions need to take place around the issue of SIDS and whether post-mortems following infant death are required in every case. Practices currently differ on this issue. An informal survey conducted by coroners before the 1997 Coroners' Conference suggested that some coroners do not require a post-mortem in every SIDS case.
- 135 One paediatrician considered it right that coroners can decide not to order a post-mortem in SIDS cases. Conversely, Dr Jane Zucollo, a paediatric pathologist submitted that coroners should not have a discretion in this area. She considered that a post-mortem should definitely be conducted in all SIDS cases, and ideally within 12 hours of death in order to get good tissue preservation. The Police submission pointed out that sometimes the only way that foul play can be ruled out is by conducting a post-mortem. For example, an infant may appear to have died from a cot death, when in actual fact someone has suffocated the child. A number of coroners and a paediatrician submitted that a diagnosis of SIDS cannot accurately be made without a post-mortem. The Wellington coroner, Garry Evans, emphasised that sudden infant death syndrome is a diagnosis by way of exclusion. He stated that SIDS:

is simply a diagnostic label that attaches to a death for which no discrete patho-physiological cause may be found. It has been termed a "diagnosis in search of a disease." . . . [SIDS] is a term covering a variety of patho-physiological mechanisms which may result in a fatal outcome. How then can it be suggested that a post-mortem may not be

⁴² New Zealand Law Commission, above n 15, 24, n 30.

required “in every SIDS case”? In the absence of a post-mortem no death may logically or properly be classified as being due to “SIDS”.⁴³

- 136 Under section 8 of the Coroners Act 1988, a coroner may authorise a doctor to conduct a post-mortem examination after the coroner has had regard to a number of matters, including:
- (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.
- 137 As we discussed in our preliminary paper and noted previously in this report, 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” objects.⁴⁴
- 138 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 SIDS. The parents objected to the post-mortem as it conflicted with a traditional Aboriginal law that prohibited mutilation of the body. The parents also objected because the post-mortem threatened the preservation of the deceased’s spirit.
- 139 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.
- 140 The Law Commission considers that the balancing exercise contemplated by Beach J should be at the heart of any decision concerning whether a post-mortem is necessary. In other words, the question to be asked is whether the community’s interest in discovering the actual cause of death, and any contributing features of a systemic nature, clearly outweighs the rights of the relatives to be spared further grief and to have their cultural, religious or

⁴³ Garry Evans, above n 38.

⁴⁴ See Coroners Act 1993 (NT), s 23; Coroners Act 1995 (Tas), s 38; Coroners Act 1985 (Vic), s 29; Coroners Act 1996 (WA), s 37.

personal values respected. The Chief Coroner will be responsible for the development of guidelines to assist coroners in exercising their statutory discretion in deciding whether or not there is need for a post-mortem, with a view to achieving consistency in decision-making. However, we acknowledge that in the development of such guidelines, further discussion will be needed concerning a variety of issues including SIDS in particular.

141 A related issue concerns the conduct of partial post-mortems. The submission from the Police stated that it appears that in some cases only a partial post-mortem may be required.

142 The submission from a general practitioner, Dr Armstrong, also favoured the availability of partial post-mortems. He submitted that:

A coroner is only required by law to determine the cause of death. A case can be made for a limited post mortem in some circumstances whereby a coroner can determine the cause of death without the need to order a full post mortem. Examples where limited post mortem (that is, where not all organs are examined) could be: in some instances of cot death; where someone is killed for example by crushing in an earthquake; where passengers are killed in a car crash. In some of these instances, the cause of death can be established without the need to perform a full post mortem. Coroners should be given the discretion to order a limited post mortem in such circumstances, requiring only enough medical evidence sufficient to order the disposal of the body.

143 During consultation, mixed views were expressed about this approach. For example, one inquest officer in Auckland was not in favour of partial post-mortems. He commented that post-mortems need to be thorough to meet evidential requirements and that partial post-mortems may have implications for ACC and insurance claims. On the other hand, Gordon Matenga the Hamilton coroner already directs pathologists to perform limited post-mortems in some circumstances. For instance, they may be instructed to avoid the head if at all possible where this is of particular importance to the family.

144 Partial post-mortems may be directed in some Australian States. Section 48A of the Coroners Act 1980 (New South Wales) provides that where an objection to a post-mortem examination is made, the Supreme Court may make an order that a partial post-mortem examination be performed if it is desirable in the circumstances. Section 18(9) of the Coroners Act 1958 (Queensland) provides that where a coroner is empowered to order a post-mortem examination to be made and in the opinion of the coroner an external examination of the body is sufficient, the coroner may order accordingly.

- 145 The Law Commission is of the view that partial post-mortems are appropriate in some circumstances and can help to minimise the distress caused to families by the coronial process. They may assist the coroner in balancing the desire of the family to have minimum State intervention and the deceased treated with respect, with the interests of the State in determining the cause of death. In our view, a Chief Coroner should investigate further the circumstances in which partial post-mortems may be acceptable.

Medical examiner

- 146 The Department for Courts submitted that we should consider whether medical examiners should be appointed to assist coroners in deciding whether it is necessary to have a post-mortem. They explain that:

Under the Act, coroners are required to make two judicial decisions, first whether it is necessary to perform a post-mortem and second to determine the cause of death. In some jurisdictions, the first decision is made by an independent medical examiner. This means that it is an administrative decision and subject to judicial review, rather than a judicial determination. The coroner may be given the discretion to overrule any decision of the medical examiner and order a post-mortem if this is thought to be necessary. . . .

requiring that the first decision about whether a post-mortem is necessary in a particular case be made by an independent medical examiner would have the following advantages:

1. The technical issues around the decision would be addressed by appropriate professionals;
2. These professionals would be required to keep up with developments in this specialist and fast changing field;
3. Medical examiners would be in a position to manage the funding stream and delivery of post-mortem services directly, which judges cannot do;
4. There may be considerable cost savings, both in terms of appropriate decisions being made and in establishing efficient management of the process;
5. The position of medical examiner could be established in such a way as to preserve the requirement for independence when making the decision;
6. The coroner could call on the expertise of the medical examiner as an input to the determination about cause of death; and

7. Responsibility for administration of medical examiners and coroners could be aligned with the appropriate health and justice sector agencies.

147 The Coroners' Council has had an opportunity to comment on the Department for Courts suggestion. The Council does not agree that there is a need for the appointment of medical examiners and made the following points in response:

- Authorising a post mortem examination is a very important matter. It should be a judicial and not merely an administrative decision. It has been held already that such decisions are subject to judicial review and no change is needed to achieve this. Medical examiners would not be legally trained or qualified and their decisions as to whether a post mortem examination should be carried out would be made against their training and background in medicine rather than in law. The present system works satisfactorily;
- The coroner and his/her pathologists are the appropriate professionals. The coroner should remain independent of forensic pathologists who presumably would be the candidates for the positions of medical examiners;
- Forensic Pathologists who advise coroners do keep up with developments in their specialist field;
- Funding issues and delivery of post mortem services are administrative matters. Medical examiners would no more be in a position to manage them than coroners;
- The Coroners' Council supports a more appropriate alignment between Health and Justice responsibilities than currently exists (with Department for Courts having responsibility for the country's mortuaries) but this does not need the introduction of medical examiners.

148 The Law Commission considers that the appointment of medical examiners would be premature. In our view, the development of guidelines from the Office of the Chief Coroner concerning the circumstances in which post-mortem examinations should be authorised will address any perceived problems with current practices. Other concerns may be addressed by the instigation of appropriate training programmes and support services for coroners.

A broader approach

149 A number of submissions commented on the desirability of the coronial system taking a broader, multidisciplinary approach to the

investigation of deaths. We also received a comprehensive submission from Caroline Everard detailing the development of a multi-disciplinary approach in the context of SUDI deaths which is already far advanced. These issues are discussed below.

- 150 Professor Anthony Taylor, a registered psychologist, pointed out that the brief history of the Coroner's Court in our preliminary paper shows that the functions of the Court have changed over the years. He submitted that:

They could change further to include a socio/cultural *post-mortem* with the legal. In my own experience as a clinician and researcher, as well as that of a supervisor of post-graduate students researching the topic of suicide, I thought that the best time to gather comprehensive data about sudden unexplained death was near the event – not months after when the evidence was blurred.

- 151 During consultation, Professor Taylor emphasised that while the coronial system was historically developed with medico-legal factors in mind, most people now accept holistic definitions of health, which include cultural, social, spiritual and other aspects in addition to physical health. Further, he stated that a systematic attempt to gather information concerning psychological, social and other factors places coroners in a better position to answer the questions with which they are faced.

- 152 Similarly, in the context of investigations into road fatalities, Drs John and Margaret Bailey submitted that the current coronial system includes little investigation of human factors:

The medical cause of the death is examined in great detail, but what led to that death is not covered adequately. Even when an inquest is held, some coroners' reports consist simply of witness reports plus a brief police report, with no or hardly any interpretation by the coroner. Recent police reports look in detail at factors such as estimation of speed, roading, weather and so on, but with little investigation of human factors. The latter are considered by international researchers and ourselves to be much more important in causing accidents than the former factors.

- 153 They stated that a consequence of such inadequate investigation is that many coroners' reports fail to identify the fundamental cause of road fatalities. In their opinion, multidisciplinary investigation teams similar to those used in Finland need to be established:

In that country, since the early 1970s, fatal road accidents have been investigated by multidisciplinary teams consisting of a police officer, road engineer, vehicle engineer, physician and psychologist. The

procedure begins just after the accident with on-the-spot investigations followed by interviews with survivors, eyewitnesses and relatives of the deceased. In contrast, in New Zealand, hardly any investigations of the actual accident are undertaken by other than police and vehicle inspectors. Consequently, coroners may be unable to make recommendations likely to prevent similar accidents in the future.

- 154 The State Coroner for Victoria, Graeme Johnstone, commented at the 1999 National Coroners' Conference that an inquest is a good time to investigate mental health matters. Coroners Bain and Douthwaite told us that one of the main advantages of the Coroner's Court is its ability to get to the core of many issues. However, they noted that in practical terms coroners do not have the time and resources in the present structure to capitalise on this potential. Yet it is crucial that coroners obtain all of the relevant facts if they are to make appropriate recommendations for future prevention of deaths.
- 155 The Ministry of Health suggested that we consider whether there is a need for some type of auxiliary investigative body attached to each coroner's office. They suggested that such a body may be called for since coroners currently rely on police to gather information. Police resources are constrained and often only a limited inquiry can be conducted.
- 156 A number of submitters were concerned that the mental health needs of families and others involved in the coronial process be met. Professor Anthony Taylor submitted that trained social workers should be available to assist the bereaved at mortuaries, especially those who are in difficulty when viewing the bodies of their loved ones and who have no family support. He stated that the need for such staff first came to his attention in the aftermath of the Mt Erebus disaster.
- 157 Finally, the submission of Dr Martin Sage, Chairperson of the Forensic Subcommittee of the Royal College of Pathologists of Australasia (NZ) and the New Zealand Society of Pathologists, sets out an alternative option to the present system. It comments that:

The report of the Commission assumes continuance of the current statutory position of having the coroner as central player in both decision making and interchange of information. However . . . the coroner is the one part of the system currently with the *least* direct contact with next of kin, isolated totally from direct involvement at the scene (the Police role) or the autopsy (the Pathologist role) and dependent entirely on hearsay from both these executive arms. The consequences of this are inefficiency in decision making and mis-communication.

158 The submission questions whether, as a logical and practical extension of the present system, some parts of the statutory authority of coroners could or should be deputed to those who are in direct contact with both the deceased and their relatives. It states that:

There is a direct analogy in the Singapore system in which there is a distinction made between a “Field Coroner” and the “Office Coroner”. In that multi-racial, multi-lingual nation of similar population size to our own, the traditional oversight and judicial aspects of the Coronial office are met by the “Office” coroner who is just as remote from the deceased and their family as are our own. The practicalities of everyday logistics are deputed to the “Field” coroner who attends with Police and pathologists at scenes and the mortuary. Such a system could be easily accommodated in New Zealand with little change to legislation . . .

It is conceivable that such a system could be trialled initially in a major urban centre.

159 The common underlying theme in these submissions is the desirability of a co-ordinated and thorough approach to the investigation of deaths. We consider that the implementation of our recommendations is a critical step in achieving just such an approach. In particular, a Chief Coroner would be equipped to oversee the system as a whole. In addition, the development of protocols from the Office of Chief Coroner has the potential to play an important part in achieving an expanded focus to the investigation of deaths. If further changes are needed, a Chief Coroner would be well placed to assess how the system should be further developed and the implications of such developments.

Sudden and Unexpected Death of an Infant – Death Scene Protocols

160 A particular example of the rationale for adopting a multidisciplinary approach to the investigation of deaths is provided in the context of SUDI deaths. A number of submitters expressed concern at the inadequate investigation procedures in place for collecting “at the scene” information in cases of infant deaths. In particular, we received a comprehensive submission from Caroline Everard, who is actively involved with the Māori SIDS Prevention Programme based in the Department of Māori and Pacific Health, School of Medicine, University of Auckland. She is currently facilitating the development of an Integrated National SUDI Death Scene Protocol. This submission was accompanied by a letter of support from Dr Tipene-Leach, Medical Director of the Māori SIDS

Prevention Programme. We also received a submission on behalf of the Paediatric Society of New Zealand from the President of the Society, Professor Barry Taylor, expressing similar concerns.

161 The essence of Caroline Everard's submission was that:

- the current coronial investigation into SUDI deaths needs to change its primary focus on forensic investigation to one that also meets the needs of the families, including the collection of data for public education and prevention of these deaths; and
- the forensic investigation itself needs to be complemented by an examination of the medical and social circumstances surrounding the deaths in order to more fully inform the coroner and the pathologist.

162 The submission stated that extensive consultation with all of the key agencies involved has led to the consensual development of a series of SUDI Death Scene Protocols. Caroline Everard has since informed the Law Commission that these protocols have advanced even further and are now quite sophisticated. They are now calling for legislative changes and support services.

163 In explaining the rationale for death scene protocols, the submission stated that:

When a previously healthy baby is found dead in a deprived family there are often other negative assumptions and associations around the death which give the investigation a more forensic or criminal focus, e.g., the condition of the house, and previous history with law enforcement and social agencies. Their deaths require a much greater medical analysis than, for example, the case of a baby who falls into a swimming pool and drowns. Families need to be assured of a balanced and professional process.

164 It continued on to say that:

In the case of apparent SIDS deaths,⁴⁵ it appears that the medical and social focus is being largely overlooked due to the forensic focus of the police and pathologists. Of the approximately 100 apparent SIDS deaths per year, approximately 5% will be difficult to diagnose and will require the full forensic approach. However, 95% of the SIDS deaths will be associated with a cocktail of known risk factors and other medical and social events. If the status of the medical and social investigation were enhanced it would potentially lead to a greater understanding of how to prevent the medical and social causes of these 95% of SIDS deaths.

⁴⁵ The submission explains elsewhere that SIDS is the highest cause of SUDI deaths.

165 The submission emphasised the effect of a SIDS death on the family:

The shock of losing a young child is often made worse by the current coronial investigation: the emphasis on Police collecting all the information at the scene of death; an obligatory post mortem; the threat of an inquest; the lack of any medical explanation; the apparent lack of interest in the possible medical and/or social causes of death; and the judgemental attitudes of neighbours, family members and others. All of this leaves the SIDS parents feeling blamed, guilty, misunderstood and cut off from society. This may lead to breakdowns in relationships, anti-social behaviour, physical and mental illness, addictions and attempted suicides, as well as over anxiety with raising other children, current and future ones.

166 The submission recommended that the recently developed Integrated National SUDI Death Scene Protocol needs to be established at a national level with formal arrangements forged with the national offices of each agency. At the same time, regional responses need to be developed that link into a national structure. Further, training needs to be developed for all agencies at a national level and made available to regions in order to establish a minimum standard of practice.

167 The SUDI Death Scene Protocol involves paediatricians as key participants in the process. At the 1999 National Coroners' Conference,⁴⁶ Caroline Everard explained that a paediatrician should attend the death scene to collect the medical history of the deceased and the social and family history and assess the environment in which the death occurred from a medical perspective:

she would also be able to answer the medical questions the family may have, explain the post mortem process in detail, and generally support the family through the ordeal, freeing police to do their specialist job. The paediatrician would then provide the pathologist with the essential information they require, be on hand to advise if necessary during the post mortem, and supply the coroner with a medical report and an opportunity to discuss the whole case where desirable. The paediatrician would also be available to explain the post mortem findings to the family and link the family with a multi-disciplinary team for appropriate ongoing long term support . . . To be effective and long lasting this additional medical position and process needs to be enshrined in legislation and adequately resourced through the Health Funding Authorities.

⁴⁶ Caroline Everard, Riripeti Haretuku, David Tipene-Leach "A New Approach to SIDS" (paper presented by Caroline Everard at the 1999 National Coroners' Conference, Wellington, 4-5 September 1999).

- 168 We discussed this approach with Dr Dawn Elder, a Wellington paediatrician. She agreed that the only way to obtain the information necessary to enable a coroner to conduct a thorough investigation in SIDS cases is to have a paediatrician take a medical history before a post-mortem. This approach would also allow professionals experienced in dealing with childhood deaths to question and reassure the families. Dr Elder stated that she is personally happy to attend the death scene as long as a system is in place to allow for this and there is adequate recompense.
- 169 Professor Barry Taylor of the Paediatric Society of New Zealand was another submitter concerned about the process for investigating childhood deaths. He stated that:
- It has been the experience of paediatricians that there is inadequate effort in the investigation of deaths in childhood in collecting “at the scene” information and little careful taking of a medical history and in particular the environmental issues that might illuminate the preventable aspects of any death. Such an analysis can only be done by a multi-disciplinary team.
- 170 During consultation, Professor Taylor suggested that any generically trained health professional with an interest in SIDS should be engaged to attend the death scene. He felt that it may not be practical to restrict this position to paediatricians. Further, Professor Taylor considered that a multidisciplinary approach should be employed for the investigation of all deaths with a group of appropriately trained people who consistently attended death scenes. He thought it would be difficult to obtain enough resources to establish separate groups to attend particular categories of death, such as suicide, SIDS or road deaths.
- 171 Both in her submission and during consultation, Caroline Everard expressed support for the Sudden Death Liaison Officer Program instituted in the Sunshine Coast Police District in Queensland, Australia. She indicated that the New Zealand Police are supportive of this approach but due to a lack of resources and funding are not in a position to investigate setting up a similar system in New Zealand. Superintendent Pieri Munro, the Police Cultural Affairs Adviser, informed us that in some areas Police are nonetheless attempting to implement a SIDS training process.
- 172 It is encouraging to see that the many individuals and organisations working with SIDS and SUDI deaths are collaborating to effect changes in the way such deaths are handled. We support the work that is underway concerning the development of a SUDI Death Scene Protocol. This work is particularly valuable in that it

recognises the family as the critical focus in procedures surrounding SUDI deaths. We consider that future developments in this area would benefit from the Chief Coroner's input and recommend that a Chief Coroner assist in co-ordinating and promoting a multidisciplinary approach to SUDI death investigations.

FUNDING

- 173 Several submitters recommended that the Commission should consider issues related to the funding of the proposals contained in our preliminary paper, with recommendations regarding how any extra costs will be met and by whom.
- 174 Our proposals have a number of funding and resource implications. These include:
- establishing the Office of Chief Coroner;
 - providing services to support a Chief Coroner and coroners generally (such as the appointment of a kaiwhakahaere and co-ordinators, and the provision of court facilities);
 - regionalising coroners;
 - appointing full-time coroners with appropriate remuneration;
 - establishing a national coronial database; and
 - upgrading mortuary facilities.
- 175 While we recognise that funding issues need to be examined, they are matters that need to be addressed by appropriate organisations at a policy level.⁴⁷ The Law Commission is not the appropriate body to determine matters of funding.

⁴⁷ We note that in British Columbia, the Chief Coroner runs an independent financial entity. All coroner-related expenditure is under the jurisdiction of the Chief Coroner, including the renting of mortuaries, payment of pathologists and other experts, transportation costs in recovery of bodies and the like. There seems to be merit in having all such expenditure through one budget. The British Columbian prototype is perhaps an indication of the New Zealand Coroners' service in years to come.

4

Implementing the recommendations of coroners

176 **I**N THE PRELIMINARY PAPER we proposed that the Coroners Act 1988 be amended to provide that:

- a Chief Coroner be responsible for bringing coronial recommendations to the attention of relevant agencies and individuals (recommendation 12);
- a Chief Coroner be responsible for producing an annual report, which would include details of coronial recommendations and be tabled in Parliament (recommendation 13); 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 and that report must be provided to the Chief Coroner who will be required to include particulars of the agency's response in the annual report⁴⁸ (recommendation 14).

CORONERS' RECOMMENDATIONS

177 In the preliminary paper we noted that section 15(1)(b) of the Coroners Act 1988 provides that 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.

⁴⁸ New Zealand Law Commission, above n 15, 31.

178 In “The Changing Role of the Coroner”, Dr Bennett, the Deputy Chief Coroner of Ontario, wrote that the purpose of a coroner’s inquest:

is not to name, blame or determine responsibility, but to allow the community to review the circumstances surrounding deaths that appear preventable. An effort is made to obtain recommendations which might prevent a similar death in the future . . . the ultimate objective of each investigation is to gain knowledge to prevent similar deaths. To be successful there must be co-operation and communication at every level of involvement.⁴⁹

179 And in commenting on coroners’ recommendations following deaths in custody, Boronia Halstead stated that:

Coroners’ recommendations represent the distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted. It should be noted that every single death represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy has the potential to avert not only deaths but alleviate risks to health and safety more generally.⁵⁰

180 However, in our preliminary paper we noted the problem that has arisen is that there is no process for ensuring recommendations are brought to the attention of relevant agencies or individuals. Further, where recommendations are brought to the attention of the appropriate agency, there is no requirement that the agency must consider the recommendations or act on them. The ability of recommendations to achieve their purpose is therefore limited.

181 All of the submissions that commented on this issue agreed that a Chief Coroner should be responsible for bringing coronial recommendations to the attention of relevant persons and agencies. However, the submission from the Chief District Court Judge’s Chambers considered that some form of statutory mechanism should be put in place to guide a Chief Coroner in carrying out this function. It stated that:

The process of identifying the appropriate agencies in these circumstances can be complicated and on-going and if there is no

⁴⁹ RC Bennett “The Changing Role of the Coroner” (1978) 118 CMA Journal 1133.

⁵⁰ Boronia Halstead “Coroners’ Recommendations Following Deaths in Custody” in Hugh Selby (ed) *The Inquest Handbook* (The Federation Press, Sydney, 1998) 186, para 187.

statutory guidance available, it is thought that there may be a risk of exposing the Chief Coroner to potential criticism.

182 Overseas experience suggests that stipulating in coronial legislation a formal process for bringing coronial recommendations to the attention of appropriate groups is unnecessary. Section 4(1)(d) of the Coroners Act, RSO 1990, c 37 (Ontario) simply requires the Chief Coroner to:

bring the findings and recommendations of coroners' juries⁵¹ to the attention of appropriate persons, agencies and Ministers of government.

183 In its 1995 report, the Ontario Law Commission noted that an informal process of bringing recommendations to the notice of relevant persons and agencies had been developed in Ontario:

When verdicts are received by the Chief Coroner's office, the recommendations, the coroner's report, and any explanations are examined with a view to developing a list of agencies and persons that should be advised of the [coronial] recommendations. The Chief Coroner's office then notifies these individuals and agencies, provides them with a copy of the verdict, and requests their comments, including their plans to implement any recommendations that are within their authority.⁵²

184 The Ontario Law Commission considers that section 4(1)(d) of the Ontario Coroners Act works in practice provided:

it receives a broad and liberal interpretation to ensure that the findings and recommendations are brought to the attention of all relevant parties, including relevant agencies and individuals, both public and private, and appropriate professional governing bodies.

185 In our view, the responsibility of a Chief Coroner to bring coronial recommendations to the attention of appropriate agencies and individuals should be expressed in the Act. The Chief Coroner can then develop a suitable process for notification that works in practice. In providing appropriate information to affected agencies

⁵¹ In many Canadian territories, coroners' juries are authorised by statute to make recommendations in relation to matters arising out of an inquest. In Ontario at least, a jury's findings and recommendations (often made after technical advice is first sought) are included with the presiding coroner's verdict explanation (which includes an explanation of why the jury's recommendations were made).

⁵² Ontario Law Reform Commission *Report on the Law of Coroners* (Toronto, 1995) 97–98.

and individuals, the Coroners' Council submitted that the notification process should reflect the distinction between the coroner's record and the coroner's findings.⁵³

186 We support the practice that has developed in Ontario where the Chief Coroner makes informal inquiries as to the implementation of coronial recommendations, or the reasons why implementation has been postponed or rejected. The Chief Coroner therefore plays an active role in pursuing compliance with significant recommendations. At the same time, the Chief Coroner can identify any practical problems with implementing particular recommendations, which may not have been apparent during the inquest.

187 A number of other comments were made concerning our proposal. The Department for Courts suggested that the reporting process ensure individuals and organisations are notified of any proposed recommendations that may affect them before they are finalised, with a right of reply. The Coroners' Council disagreed with this suggestion. In its submission, the Council noted that, while such a process may be appropriate for an administrative body, a coroner:

will only make recommendations after a public hearing and the notion of private communication with only some of those represented at the hearing is incompatible with the exercise of judicial functions and the concepts of natural justice.⁵⁴

188 The Coroners' Council stated that Section 15(2) of the Coroners Act is sufficient. Section 15 (2)(b) provides that the coroner shall not comment adversely on any living person without taking all reasonable steps to notify the person of the proposed comment, and giving the person a reasonable opportunity to be heard in relation to the proposed comment.⁵⁵

⁵³ One interpretation of the findings of a coroner is that they include all supporting evidence and documents. However, the Coroners' Council emphasised that "although the complete documents of evidence etc are an integral part of the coroner's record, there should be a differentiation with the findings of a coroner." It is sufficient for interested individuals and organisations to receive the findings of a coroner rather than the complete record, particularly since when making a finding there is an obligation on coroners to set out their reasons (as held by the High Court).

⁵⁴ In practice, the principles of natural justice mean that coroners cannot make findings or recommendations adverse to the interests of persons to whom right of representation is granted, without giving the opportunity to be heard in opposition to that finding, see *Mahon v Air New Zealand Ltd* [1984] AC 818, 820.

⁵⁵ See also our discussion of s 15(2) below at paras 366–371.

189 The Ministry of Justice, while not advocating a right of reply, considered that individuals and organisations should receive notice of recommendations that affect them before they are released. Other submitters also took this view. The Department of Corrections stated that:

Every interested party should be given a minimum of 5 working days notice of any written recommendations the coroner intends to make affecting that party, before they are publicly released. This is particularly relevant to government agencies to enable them:

- to consider the impact of any recommendations of the coroner that affect them and to take appropriate steps; and
- to brief all staff involved; and
- to proactively manage the media enquiries and publicity that will invariably follow the release of the coroner's findings.

190 Similarly, the Office of the Health and Disability Commissioner stated that it is:

essential that a copy of the coroner's findings immediately be sent to all parties subject to a recommendation or comment . . .

Once finalised coroners' findings and recommendations are generally a matter of public record and should therefore be reported at this time. The agency responsible for implementing the recommendations is more likely to commence the necessary steps . . . at the time when public interest in the matter is likely to be at its highest.

191 The Law Commission has considered these arguments. We agree with the Coroners' Council that the notion of private communication with only some of those represented at the hearing is incompatible with the exercise of judicial functions and the concepts of natural justice. We therefore do not advocate a reporting regime with a right of reply. However, we accept that individuals and organisations should receive notice of recommendations that affect them before they are publicly released where this is possible.

Recommendation 12

We recommend that a Chief Coroner's functions include:

- where a coronial recommendation affects an agency or individual, giving notice of that recommendation to the relevant agency or person and taking reasonable steps to ensure that such notification is given before the recommendation is publicly released; and

- inquiring as to the implementation of coronial recommendations, or the reasons why implementation has been postponed or rejected.
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ANNUAL REPORT

192 Several submitters were concerned that a Chief Coroner would be reporting to Parliament. It was submitted that it would be inappropriate for the Chief Coroner, as a judicial officer, to report to Parliament as this would constitute a breach of the separation of powers. The Ministry of Justice suggested that instead of a Chief Coroner producing an annual report which would be tabled in Parliament, a Chief Coroner could publish a report and, with the agreement of the judiciary, include a synopsis of the report in the annual Report of the New Zealand Judiciary. Similarly, in a submission from the Chief District Court Judge it was suggested that a Chief Coroner produce a Coroner's Annual Report, which would be made public. We agree with these submissions.

Recommendation 13

We recommend that a section be added to the Coroners Act 1988 that requires a Chief Coroner to produce an annual report from the Office of Chief Coroner. The section would provide that the report may:

- include details of coronial recommendations including the progress of recommendations, the responses received from agencies, and any practical problems with implementing particular recommendations;
- identify the agencies that have chosen not to comply or that, in the opinion of the Chief Coroner, have obstructed the process of compliance; and
- 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.

We also recommend that a synopsis of the annual report from the Office of Chief Coroner be included in the annual Report of the New Zealand Judiciary.

A GOVERNMENT AGENCY'S RESPONSE TO CORONIAL RECOMMENDATIONS

- 193 We received a number of submissions on the proposal that where a recommendation concerns a government agency, that agency must report to its Minister the steps it intends to take in relation to the coronial recommendation and a copy of that report must be provided to a Chief Coroner who will be required to include particulars of the agency's response in the annual report from the Office of the Chief Coroner. There was general agreement that where a coronial recommendation affects a government agency, it is appropriate for a Chief Coroner to include particulars of that agency's response in the annual report from the Office of Chief Coroner.
- 194 Canterbury Health disagreed that a government agency must report to its Minister the steps it intends to take in relation to a recommendation. It submitted that it would be inappropriate for the Coroners Act and a Chief Coroner to interfere with the normal reporting lines between government agencies and their ministers.
- 195 However, no government agencies disagreed with the requirement in our proposal that they report to their Minister. Given that action taken in response to coronial recommendations has the potential to save lives, the Law Commission favours a proactive strategy towards achieving implementation of recommendations, as occurs in other jurisdictions. For example, as we noted in our preliminary paper, in the Australian Capital Territory where coronial recommendations relate to deaths in custody the coroner who presided at the inquest must give a written report to the custodial agency in whose custody the death occurred. That agency 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.
- 196 The Department for Courts stated that where recommendations relate to government agencies, the Office of the Attorney-General is the body best suited to monitor the implementation of such recommendations.

197 The Law Commission accepts that the Attorney-General should be notified of any recommendations that affect government agencies. However as we explained above, we consider that a Chief Coroner should be responsible for inquiring as to the implementation of coronial recommendations or the reasons why implementation has been postponed or rejected, and for including this information in an annual report. This process is similar to that adopted in some Australian States. For example, the Chief Coroner of the Australian Capital Territory is required to provide an annual report to the Attorney-General. The annual report must include particulars of the reports prepared by coroners into deaths in custody, any recommendations made by coroners to the Attorney-General and responses of agencies to coronial recommendations. (section 102 Coroners Act 1997 (ACT)).

Recommendation 14

We recommend that where a coronial recommendation concerns a government agency, a Chief Coroner must give notice of that recommendation to the agency concerned, the Minister responsible for that agency, the Attorney-General, and any other agency or individual affected by the recommendation. The government agency must, within three months, report to its Minister the steps it intends to take in relation to the coronial recommendation and a copy of that report must be provided to the Chief Coroner. The Chief Coroner must include particulars of the government agency's response in the annual report from the Office of the Chief Coroner.

Part II
Cultural Concerns

5

Introduction

198 **I**N CHAPTER 2 OF THE PRELIMINARY PAPER, the Law Commission noted that people have differing views and practices regarding death. For example, both Jewish and Islamic beliefs entail the need for a speedy burial of the deceased.⁵⁶ Under Islamic precepts, the body of the deceased must be handled with the utmost respect, and should only be handled by a person of the same sex.⁵⁷ Jewish customary law requires a specially appointed guardian to attend the deceased until burial. The guardian is required to spend the night with the deceased reciting prayers.⁵⁸ Cook Islanders believe the deceased should not be interfered with.⁵⁹ Traditionally, Fijians view post-mortems as unthinkable and believe that the dead should not be tampered with.⁶⁰ Niueans generally consider post-mortems to be a strange practice.⁶¹ Samoans⁶² and Tongans⁶³ regard post-mortems as an indignity to the deceased. In Buddhist practice, next-of-kin will wish to pray in front of the deceased, kneeling in front of the coffin and touching the deceased's hands. Buddhists believe in reincarnation, and many will want the body to be kept "whole" so that it will be reborn complete.⁶⁴

⁵⁶ Brennan "Accommodating Law to Culture", in Selby (ed) *The Aftermath of Death* (Federation Press, 1992).

⁵⁷ Brennan, above n 56, 212.

⁵⁸ A Hirsh "The Jewish way in Death and Dying" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 49.

⁵⁹ Reverend Kiriau "Cook Island Custom Relating to Dying and Death" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 16.

⁶⁰ Reverend Malakai Curulala, "Fijian Custom Relating to Death and Dying" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 21.

⁶¹ Sipeli "Death and Dying in terms of Niue Culture" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 24-25.

⁶² Sister Pesio, "Samoan Customs Relating to Death and Dying" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 29.

⁶³ Father Falemaka "Tongan Customs Relating to Death and Dying" in *The Undiscover'd Country* (Department of Health, Wellington, 1986) 30.

⁶⁴ Brennan, above n 56, 213.

- 199 We described in some detail the manner in which death is perceived in Māori culture. We explained that tikanga requires that the deceased must not lie alone in the time between death and burial and that Māori consider it critically important that the deceased be taken to a marae as quickly as possible so that the tangihanga may begin. We referred to the results of a consultation process undertaken by the Law Commission in 1995 and 1996, which highlighted the concerns of Māori and other communities that coronial practices are culturally insensitive. This is despite the requirement in the Coroners Act 1988 that coroners have regard to spiritual beliefs and customary values in deciding whether to authorise a post-mortem examination.
- 200 We noted the position in many Australian territories where, unless the coroner believes that a post-mortem examination needs to be performed immediately, a coroner must not perform a post-mortem if the “senior next-of-kin of the deceased person” objects.
- 201 In the preliminary paper, we discussed a number of concerns relating to the removal and retention of body parts. They included:
- that the removal and retention of body parts conflicts with cultural or spiritual beliefs and values;
 - the failure of coroners and pathologists to inform whānau that a body part is to be retained and the lack of discussion about why retention is 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 specific body part with the body.
- 202 We explained that as the law currently stands in New Zealand, neither coroners nor pathologists have an express statutory right to the possession of the body or body parts of the deceased. Also, the Act does not require coroners or pathologists to notify family members that a body part has been retained. Neither does the Act address the question of who has the right to possession of retained body parts.
- 203 We explained that pathologists, as a matter of practice, take and retain microscopic samples from many of the deceased’s organs. Pathologists have confirmed that, generally, there will be no need to retain major body organs. In cases of suspected homicide, the Law Commission has been advised that if a post-mortem is held 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 conduct tests on retained microscopic samples, will provide an adequate basis for a second opinion by a defence pathologist.

- 204 In chapter 3 of the preliminary paper, we set out a number of proposals for change to the Coroners Act 1988 and recommended the inclusion in the Act of two options intended to address Māori concerns that current coronial practices are culturally insensitive, both in their treatment of the deceased and with regard to the removal and retention of body parts.
- 205 The Law Commission proposed that the Coroners Act 1988 be amended to provide that:
- coroners have the right to possess the body and body parts from the time a death which is reportable under section 4 Coroners Act 1988 occurs until the post-mortem examination is completed or the coroner sooner authorises the disposal of the body under section 14 Coroners Act;
 - a pathologist authorised by the coroner may retain any body part or tissue which the pathologist considers necessary in order to determine any of the matters set out in section 15 Coroners Act;
 - the pathologist must notify the coroner which body part the pathologist has retained, the reason for its retention and also the length of time for which the pathologist proposes to retain the part;
 - the family be advised at the outset by an agent of the coroner that a post-mortem examination has been authorised and that the family be asked whether and in how much detail they would like to be kept informed of this process;
 - the deceased's body, including body parts, be returned to the family as soon as is reasonably practicable;
 - the terms "body parts" or "tissue" exclude microscopic samples which pathologists retain as a matter of practice; and
 - persons who have an interest in the matters set out in section 15 of the Coroners Act, such as defence counsel, may apply to the coroner to conduct independent tests on the body or specific body part.

- 206 The Law Commission further proposed that the Coroners Act 1988 be amended to provide that the deceased's whānau be given the options:
- with the consent of the pathologist, of viewing and touching the deceased prior to the post-mortem examination; and
 - of having a family representative or kaitiaki remain with or be in close proximity to the deceased while it is under the coroner's control/possession.
- 207 In regard to the second option, we explained that section 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." We expressed the view that the scope of this section should be widened to include any registered health professional or funeral director of the family's choice.
- 208 We envisaged that in the exercise of this option, the chosen family representative or kaitiaki would have an opportunity to meet with a co-ordinator, acting on the coroner's behalf and located in the coroner's office, in order to fully understand the processes involved. The role of the co-ordinator would be to liaise with the whānau, kaitiaki, pathologist and coroner. We proposed that 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. We suggested that the co-ordinator could be given the responsibility of ensuring that each coroner's office establish a relationship with local iwi. Coroners would then be able to call on kaumatua to assist in appropriate circumstances, for example if a debate arose regarding the person to whom the deceased should be released.

DISCUSSION

- 209 A number of general comments were made in submissions about the cultural concerns expressed in our preliminary paper. In the submissions, there was obvious tension arising from the variety of ways in which individuals and groups view death and the coronial process. As an example, at one end of the spectrum some Māori and members of many other cultures and religions believe that a post-mortem is disrespectful to the deceased and should not be conducted in any circumstances. They consider their beliefs outweigh all other

considerations. On the other hand, some groups find this perspective incomprehensible and of less importance than other objectives, such as the prevention of future unnecessary deaths or the health gains to be achieved from post-mortem examinations. Depending on which viewpoint is held, individuals naturally have different opinions as to the weight the coroner should give to competing considerations when deciding whether to authorise a post-mortem.

210 The objective of this report is not to espouse an opinion on which perspective is more appropriate, since all views are to be respected. Rather it seeks to find a balance that meets the interests of the many groups involved, including the deceased, the family and the wider community, while ensuring that the State only intervenes to the minimum extent necessary. It is also important to recognise that diverse opinions exist within many groups in New Zealand.

211 Secondly, submissions frequently emphasised the need to recognise that many other cultures, religions and individual families also feel aggrieved by the coronial process for reasons similar to Māori. Therefore, our proposals should not focus solely on Māori values but rather should take into account the fact that contemporary New Zealand society is increasingly culturally, ethnically and religiously diverse.

212 The Law Commission accepts these arguments. Indeed, our proposals are intended to benefit and apply to all families.⁶⁵ However, our reasons for focusing on Māori values in the first instance arise from:

- the unique status of Māori in New Zealand;
- the Law Commission's acknowledgement of and commitment to the principles of the Treaty of Waitangi;
- the requirement of the Law Commission's founding statute that it take into account Te Ao Māori (the Māori dimension) in its work;⁶⁶ and
- the constancy and number of unmet concerns of Māori, as voiced by Māori to the Ministry of Justice and Department for Courts

⁶⁵ An important role of a Chief Coroner would be to develop protocols to take into account the needs of interested cultural and religious groups and families in general. See paras 275–286 for our discussion concerning a family representative or kaitiaki and paras 71–79 regarding the functions of a Chief Coroner.

⁶⁶ Law Commission Act 1985, s 5(2)(a).

since the enactment of the Coroners Act 1988 and to the Law Commission during its 1995 and 1996 consultation hui with Māori.

213 In the Law Commission's recent report, *Justice: The Experiences of Māori Women Te Tikanga o te Ture: Te Mātauranga o ngā Wāhine Māori e pa ana ki tēnei*, Māori women told the Commission that the essence of the principles of the Treaty require among other things that:

- the values of Māori are respected and protected; and
- Māori form part of the new society and feel as much at home in New Zealand and its institutions as other New Zealanders.⁶⁷

214 Neither of these points is met by the current coronial system. The problems are exacerbated by the current status of Māori health. Research indicates that:⁶⁸

- Māori may be more likely to die without having been seen by a doctor recently thus placing Māori quite frequently in the situation of requiring a post-mortem; and
- Māori have a higher risk of sudden death from conditions such as SIDS that also lead to post-mortems.

215 In conclusion, while our proposals are designed to accord respect to the deceased and the family in all cases, the values of Māori and the seamlessness of the life cycle in the Māori world view are given particular recognition. In discussing Māori views, our paper recognises that the primary obligations and expectations associated with death are similar for Māori throughout New Zealand. At the same time, we acknowledge the need for flexibility in approach to reflect the fact that Māori are a diverse group of people who have differing backgrounds and varying degrees of allegiance to cultural beliefs.

⁶⁷ New Zealand Law Commission *Justice: The Experiences of Māori Women Te Tikanga o te Ture: Te Mātauranga o ngā Wāhine Māori e pa ana ki tēnei*: NZLC R53 (Wellington, 1999) para 4.

⁶⁸ A paper prepared for Māori Health Group: Locality One, "Māori and Postmortem, Tissue Use and Body Parts: A Review of Information and Summary of Issues", March 1999, 3.

6

Resolving the conflicts

RIGHT TO POSSESSION

- 216 **WE** RECEIVED A NUMBER OF SUBMISSIONS on the proposal that coroners have the right to possess the body and body parts of the deceased from the time a death which is reportable under section 4 Coroners Act 1988 occurs until the post-mortem examination is completed or the coroner sooner authorises the disposal of the body under section 14 Coroners Act. The submitters accepted that the coroner should have control over the body of the deceased in fulfilling the objectives set out in the Act, although issues were raised as to when this control should come to an end. The point was often made that the question of when a post-mortem examination is complete needs to be addressed since it is arguable that the examination is not complete until any retained body parts have been returned to the body. The submission received from Ngatiwai Trust Board emphasised that the coroner should not have the right to possession of the deceased's body or body parts after the post-mortem is completed. Richard McElrea submitted that the proposal as it is currently worded is "unduly restrictive" because the coroner needs to be satisfied that proper formalities, such as formal identification of the deceased and completion of the certificate as to "life extinct", have been completed before the deceased's body is released.
- 217 A submission received from Te Mana Hauora o Te Arawa proposed that the words "right to possession" be changed to "guardianship". It stated that "Maori will not agree to anyone lawfully possessing their body". The submission raised the common Māori unease about notions of "ownership". We acknowledge that the concept of possession of the deceased is troubling to many Māori in light of the sacredness in which they view the life and death continuum.
- 218 The proposals in this part of the report are intended to give weight to Māori values as well as recognise that determining the cause of death is an important public function. Clearly, the coroner *in fact* requires legal possession to achieve the purposes set out in the Act. While we consider that the use of the word "guardianship" has the

potential to create confusion given its specific uses in law, in some Australian states the word “control” is used instead of “possession”.⁶⁹ It is our view that this is an appropriate compromise and we have amended our proposal accordingly. Although the effect is still to give the coroner authority over the deceased and the deceased’s body parts so that the coroner can effectively perform his or her functions under the Act, we recognise that a move away from a terminology of “possession” is preferable for some groups.

219 The need to determine the cause of death in each case must be balanced against the right of the family to have the deceased returned to them as soon as possible. We accept that the Act needs to be clear in determining exactly when the coroner’s authority over the body and body parts of the deceased comes to an end. In the rare cases where it is necessary to remove and retain a body part, the coroner will need to retain authority over the body part while the required tests are being carried out. In our view, therefore, the Act should make clear that a post-mortem examination is not complete until all necessary tests on body parts have been conducted.

220 We agree that the coroner will also need to retain authority over the body and body parts of the deceased while he or she ensures that the proper formalities have been completed, such as formal identification of the deceased and completion of the certificate as to “life extinct”.

Recommendation 15

We recommend that a section be inserted into the Coroners Act 1988 to provide that coroners have temporary control of the deceased’s body and body parts from the time a death reportable under section 4 of the Coroners Act 1988 occurs until:

- (a) the post-mortem examination is completed; and
- (b) all body parts have been placed back inside the body of the deceased or are otherwise being dealt with by direction of the family of the deceased;⁷⁰ and
- (c) the coroner is satisfied that all necessary formalities have been completed,

or, the coroner sooner authorises the release of the deceased under section 14 of the Coroners Act.

We also recommend that for the purposes of this Act the definition of a “post-mortem” include any necessary testing on body parts.

⁶⁹ See Coroners Act 1996 (WA), s 30; Coroners Act 1997 (ACT), s 15.

⁷⁰ Note that part (b) of this recommendation takes into account our recommendation concerning the return of the deceased to the family – see paras 241–245.

RETRIEVAL FOLLOWING RELEASE

- 221 In discussing when the coroner's right to possession should end, the Police submission raised the possibility that on rare occasions the body of the deceased may need to be retrieved after it has been released by the coroner. Indeed, we were told of an instance where Police had to interrupt a tangihanga on the marae to retrieve the deceased. The need for retrieval in that instance occurred as a result of an omission in procedure on the part of an official.⁷¹
- 222 We have not been able to find any legislation in other jurisdictions that addresses this issue. However, since the need for retrieval usually arises because of an omission in procedure, it is our view that the balance of objectives in the Coroners Act must favour the family in this instance. Obviously, the retrieval of the deceased would inflict further stress and trauma on a family already trying to come to terms with the death of a loved one. We consider, therefore, that the coroner would no longer be legally entitled to possession of the body of the deceased once the deceased is released and that retrieval of the deceased in these circumstances may only occur with the permission of the family.
- 223 In cases of suspected homicide, this conclusion is supported by the opinion of a number of pathologists that a second post-mortem is unlikely to be beneficial. Rather, 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.⁷²
- 224 Further, our recommendations as a whole are aimed at improving the operation of the coronial system and should ensure that there are unlikely to be instances where retrieval of the deceased is thought to be necessary. In particular, our recommendations relating to the training of coroners and the leadership role of a Chief Coroner should mean that the coroner will be in a better position to ensure that omissions in procedure by the coroner's agents are identified before the body of the deceased is released. In addition, effective lines of communication should have been established between the many sectors of the coronial system and the family, and

⁷¹ Retrieval after release is distinct from situations where, for example, the coroner directs that the deceased be removed from the family and placed under the authority of the coroner because the death was not reported and should have been.

⁷² See also the discussion concerning tissue samples at paras 246–250.

between the Coroner's Office and hapū and iwi in the region. In the event that an omission occurs requiring the retrieval of the deceased, it is appropriate that the coroner approach the family to explain the situation and obtain permission for the deceased to be retrieved. This underscores the fact that the coroner is the person accountable for the efficient functioning of the coronial process in his or her district.

Recommendation 16

We recommend that the Coroners Act be amended to stipulate that retrieval of the deceased's body following release by the coroner can only occur with the consent of the family.

THE RETENTION OF BODY PARTS

225 The wording of the proposal "that a pathologist authorised by the coroner may retain any body part or tissue which the pathologist considers necessary in order to determine any of the matters set out in section 15 Coroners Act" has been slightly changed since a number of submissions noted that our preliminary paper confuses the concept of "removal" of body parts with "retention". In his submission, Dr Martin Sage stated that:

The report . . . is somewhat careless in its use of the term "removal of organs" in the context of autopsy. No competent autopsy can be made without removal and careful dissection of all key internal organs.

226 We take the point that a professional post-mortem examination will always require organs to be removed for close examination. We refer to "retention" to describe the infrequent situation where a pathologist removes an organ and retains it for further testing before later placing it back in the body or returning it to the family of the deceased. This is distinct from the standard and necessary practice of removing an organ for the purposes of examination before immediately replacing it.

227 A large number of submissions commented on this proposal. The retention of body parts is a particularly contentious area given the inherent conflict between the view that the retention of body parts is inappropriate, the desire of families to have the bodies of loved ones returned early and complete, and the interest of society in undertaking whatever investigations may be necessary in determining the cause of death.

- 228 However, the submissions generally accepted our proposal as reasonable. The submission from the Chief District Court Judge's Chambers did note, however, that in authorising the retention of particular body parts, coroners may be dependent on the advice of pathologists as regards the necessity for retention. This raises implications concerning the ability of coroners to control the coronial process as required by the Act. The submission went on to say that this difficulty would be alleviated if there was a general upskilling and upgrading of the status of coroners as we have recommended.
- 229 The concern was raised that the Act should make clear for the family's peace of mind that body parts may not be retained for any purpose outside the objectives of the coronial process. In particular, it was suggested that the Act should be amended to prohibit any practice of collecting and preserving body parts for scientific interest, at least without the consent of the family. The Law Commission agrees that it is important for families to feel as secure and comfortable as possible with the coronial process.

Recommendation 17

We recommend that the Coroners Act be amended to include a new provision that a pathologist authorised by the coroner⁷³ may retain any body part or tissue that the pathologist considers necessary in order to determine any of the matters set out in section 15 of the Act, but for no other purpose without the consent of the family.

NOTIFICATION CONCERNING THE RETENTION OF BODY PARTS

- 230 There was a divergence of views concerning the proposal that the pathologist must notify the coroner which body part the pathologist has retained, the reasons for its retention and also the length of time for which the pathologist proposes to retain the part. While it was agreed that notification was necessary, there was disagreement as to when such notification should occur. Issues were also raised concerning the need to notify and obtain the consent of the family.
- 231 Richard McElrea stated that the pathologist's notification should take place prior to a body part being retained, or if this is not

⁷³ The means by which pathologists obtain authorisation from the coroner is discussed in paras 230–235.

practicable, immediately following the retention but before the release of the deceased's body. Other submitters considered that pathologists should be required to obtain authorisation from the coroner prior to retaining a body part in all cases. If the pathologist retains a body part before notifying the coroner, one submission stated that the Act needs to provide for a minimum timeframe in which such notification is required. A number of submitters argued that the coroner should not authorise the retention of a body part without first obtaining the consent of the family. The Moana District Māori Council stated that pathologists should receive the written approval of the coroner after consultation with the whānau with a copy of this approval available to the whānau.

- 232 In the light of the Law Commission's recommendations to move to a system of full-time coroners (see paragraphs 49–52) and to appoint co-ordinators (see paragraphs 295–302), and the importance under the Act of the coroner exercising control of the process at all stages, we consider that pathologists should be required to notify coroners and obtain their written authorisation before retaining a body part.
- 233 In our preliminary paper, we acknowledged that some Māori advocate the position that body parts should not be retained under any circumstances unless consent from the whānau is first obtained. However, recognising the importance in appropriate cases of ascertaining the cause of death and in order to ensure the timely release of the deceased, we stated that we did not consider that this position was practicable. During consultation, pathologists confirmed that requiring the consent of the family could lead to unacceptable delays, particularly when they have been directed to conduct a post-mortem "forthwith". The Coroners' Council also takes the view that a requirement to give *prior* notification to the family would be unworkable in practice given the delays that would result from an objection process.
- 234 In our view, once a post-mortem is underway,⁷⁴ prominence must be given to a process that ensures the deceased is released to the family as soon as possible. This is the concern most often expressed by Māori in relation to the coronial system. Our recommendations concerning the provision of information to the family (paragraphs 236–240) and the appointment of a co-ordinator (paragraphs 295–302) will ensure that families are better informed of, and able to inform the coroner of their concerns and wishes regarding, the post-

⁷⁴ As distinct from an objection to the post-mortem itself. See paras 254–265.

mortem procedure before it begins. The coroner will then be in the best position to give directions to the pathologist regarding the retention of body parts.⁷⁵

- 235 The Law Commission has considered whether the authorisation from the coroner to retain a body part should be in writing. We do not consider that this is a matter that requires prescription in the Act. We anticipate that it will be the subject of guidelines to be developed by a Chief Coroner.

Recommendation 18

We recommend that a new provision be inserted into the Coroners Act to provide that prior to retaining any body part, the pathologist must notify the coroner:

- a) which body part the pathologist proposes to retain;
- b) the reason for its retention; and
- c) the length of time for which the pathologist proposes to retain the part,

in order to obtain authorisation from the coroner to retain the body part.

If the coroner authorises the retention of any body part, he or she must ensure that the family is advised of this fact immediately and informed of the matters listed above.

PROVIDING INFORMATION TO THE FAMILY

- 236 In the preliminary paper, we commented that it is possible some families will not want to know that a post-mortem examination has been authorised. This opinion was dismissed in the submissions as unlikely. The Funeral Directors' Association of New Zealand stated that few if any families would take this stance. They consider that almost all families understand the need for a post-mortem examination so that the cause of death can be determined. As much information as possible should be given to families to aid their understanding of the process. Te Puni Kokiri stated that:

In times of stress and trauma, such as when a post-mortem is required, there is the possibility that a whānau may not be in a position to decide whether and in how much detail they want information. Given this, we would be concerned if a whānau were not able to receive

⁷⁵ The coroner's options may include directing the pathologist to perform a limited post-mortem. See our discussion at paras 141–145.

information due to failing to indicate at a specific time that they wanted all available information. Whānau must be informed that a post-mortem is about to be carried out.

- 237 All of the submissions addressing this proposal agreed that communication with the family is critical. Indeed, consultation is necessary for the coroner to have regard to the matters set out in section 8 of the Act in deciding whether or not to authorise a doctor to perform a post-mortem examination. Consultation is also an important mechanism for disarming potential conflicts, especially since it enables families to better understand the coronial process and how the separate components interrelate. In its submission, the Ministry of Justice noted that the mismanagement of communication with family members appears to be a major cause of many of the problems that have been experienced within the current regime. The concern was often expressed that the process of communication needs to be made clear. It was stated that our proposals need to clarify who is responsible for liaison with families and the relationship between this proposal and our options concerning the appointment of kaitiaki (paragraphs 275–286) and co-ordinators (paragraphs 295–302). It was emphasised that we should be careful in making recommendations not to further complicate the system by adding another “loop” to the process. It was stressed that the person communicating with the family must be in a position to impart accurate information, including the relevant time frames. Similarly, Dr Martin Sage submitted that it may be appropriate for pathologists to play a more active role in communicating with families to avoid distortion of information about the process and the results of post-mortems.
- 238 As the submissions acknowledged, consultation with the family is essential in enhancing the mutual interest both of the coronial process and the family in ascertaining the cause of death. It is also critical in enhancing a timely post-mortem examination and thereby facilitating the timely release of the body of the deceased. We agree that the process for communication needs to be made clear and accept the need for care in making sure our recommendations do not further complicate the system. We also agree that the conveyance of accurate and ongoing information is essential for communication with the family to be effective.
- 239 The coroner is ultimately responsible for ensuring that each facet of the coronial process operates effectively. This obligation is even more apparent given our recommendations to regionalise coronial districts, reduce the number of coroners and move to a system of

full-time coroners, and appoint a Chief Coroner. It is therefore appropriate that the coroner is responsible for ensuring that ongoing and comprehensive communication with the family takes place.

- 240 In performing their functions, coroners may currently rely on the Police or funeral directors to give information to families about the coronial process. However this may mean that the communication needs of families are mismanaged, with families receiving conflicting or inadequate information. In our view, a co-ordinator located in the coroner's office will be in the best position to assist the coroner in providing information to the family as well as in conveying the wishes of the family to the coroner.

Recommendation 19

We recommend that the coroner be required to ensure that the family is advised a post-mortem examination is to be authorised and that the family receives accurate information and ongoing advice concerning the coronial process.

RETURNING THE DECEASED TO THE FAMILY

- 241 There was little disagreement with the proposal that the deceased, including body parts, be returned to the family as soon as is reasonably practicable. Dr Andrew Tie, Vice President of the New Zealand Committee of the Royal College of Pathologists of Australia, expressed the view that it is not necessary to prescribe this practice in the Act since it is what currently occurs. Graeme Johnstone, the State Coroner for Victoria, cautioned that timeliness in releasing the deceased may need to be balanced against occupational health and safety issues of pathologists, technicians and scientists working with bodies. The Funeral Directors' Association of New Zealand discussed the potential for this proposal to be advocating a "backwards step" if the deceased cannot be released until all body parts are returned. They explain that:

Presently a body may be released without a particular body part which has been retained for coronial purposes to allow the family to begin their funeral rituals . . . If the organ is returned prior to burial it can be dealt with at the family's discretion by either replacement within the body or by separate placement in the casket or by being buried alongside. If the organ is returned after the body has been disposed of, it can be buried alongside the casket. While neither of the above represents a satisfactory situation, it seems that the current proposal could be deemed to mean that both the body and the organ are

retained until the organ is released and this would represent a backward step from the current situation.

- 242 The Law Commission agrees that, in some instances, cautionary measures are necessary to combat risk factors for the professionals working in the coronial system despite the delay that may ensue. We consider that the words “reasonably practicable” in our proposal are sufficient to allow for this event.
- 243 The Law Commission has considered whether prescription of the practice to return the deceased as soon as possible is necessary, or whether the development of appropriate protocols is sufficient. In our view, as far as possible, families should be able to look to the Coroners Act to ascertain their rights in the coronial process. However, we do wish to ensure that our proposal does not unintentionally work to the detriment of families. The practice should remain sufficiently flexible to take into account the possibility that families may prefer to have body parts returned at a later time (in a culturally appropriate manner) so the organising of funeral rituals is not further delayed. Families can then choose either to have a separate service to bury the removed body part or have the deceased lie in state until the body part is returned. Finally, our proposal should not preclude the possibility that the family may not consider it important to have a body part returned. In this case, they can advise the coroner of this fact and appropriate action can be taken.
- 244 The Funeral Director’s Association also raised a related issue concerning the repatriation of the deceased to the place of burial. Under section 13(1) of the Act, the coroner may give any directions that the coroner thinks fit relating to the removal of a body for the purposes of conducting a post-mortem examination. In some cases, it is necessary to transport the deceased to a mortuary some distance from where the deceased is removed. The Funeral Director’s Association explained that:

The coroner directs that the Police arrange the transfer to the mortuary of the deceased. The Police commonly contract a Funeral Director to provide this service for them. Current Police thinking is that they are directed only to remove the body and therefore have no responsibility for the return of the deceased after the post-mortem examination is complete and the release to the family is given. The FDANZ contend this is a highly unfair position for the State to take. It is arguable in many cases as to whether an autopsy is necessary. The State assumes the right to withhold the body often against the strong objections of the rightful “owners” of the body and having done so, adds considerable cost to the family by requiring them to pay for the repatriation of the deceased to the place of the funeral.

245 This concern particularly affects those living in isolated areas. It also affects Māori, who often already bear the costs of transporting the deceased over long distances to an appointed burial place with visits en route to certain marae to allow hapū or whānau to grieve and farewell the deceased. The Law Commission agrees that where the deceased is transported some distance at the direction of the coroner, the State should bear the cost of returning the deceased to the place where the deceased was removed. Funding should be provided to the Police for this purpose.

Recommendation 20

We recommend the Coroners Act be amended to provide that the deceased must be returned to the deceased's family as soon as is reasonably practicable. Before release of the deceased under this section, the coroner must ensure that any body parts retained for further testing have been placed back inside the body of the deceased or are otherwise being dealt with by direction of the family of the deceased.

We also recommend that the State bear the cost of repatriating the deceased in situations where the deceased was initially transported some distance at the direction of the coroner and the family wishes the deceased to be returned to the place of removal.

MICROSCOPIC SAMPLES

246 In general, there was support for the proposal that the terms "body parts" or "tissue" exclude microscopic samples which pathologists retain as a matter of practice. We discussed this proposal with a number of pathologists during consultation who confirmed that the retention of microscopic samples is a necessary and professional practice. It allows further testing where required, and may provide additional benefits to the family including the identification of hereditary diseases and other genetic traits. It is particularly important where the cause and circumstances of death are not entirely clear. On the few occasions when independent examination is required, it was generally agreed that 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 should provide an adequate basis for a second opinion. A number of submissions questioned what we mean by "microscopic samples". One pathologist

stated that there is a need to better define the right to retain microscopic samples to specifically include samples for toxicological (as opposed to histological) analysis. Similarly, Healthcare Otago asked that we clarify whether the envisaged samples include fixed-tissue specimens (paraffin blocks) or larger, treated-tissue specimens.

- 247 Some Māori submitters had concerns with this proposal. Two Māori organisations challenged the right of pathologists to keep any samples without the consent of whānau. Te Mana Hauora o Te Arawa expressed concern about the possibility of samples being accessed for the purposes of genetic engineering and similar practices and Nga Huapae Hou referred us to the debate surrounding the use without consent of heel-prick blood samples taken from babies at birth in a recent paternity case.
- 248 As we noted in our preliminary paper, traditionally Māori believe that every human organism is imbued with a life spirit handed down from the ancestors. As such, every cell contains a life force that continues to exist *ex situ* and needs to be treated accordingly. In discussing Māori concerns, it was explained to us that if whānau are helped to properly understand the coronial process, they can then perform the appropriate rites to accommodate these matters, such as the retention of tissue. In allowing whānau to make proper provision for the spirit of the deceased in this way, many of their concerns are alleviated.⁷⁶ However, we are aware that there will still be occasions where families have concerns about the storage and use of tissue despite reassurances. A pathologist in at least one instance had no difficulty in returning microscopic samples when requested by the whānau as long as a waiver was signed stating that the family understood the implications of this action, particularly as regards future review and the identification of genetic traits in the family.⁷⁷ The pathologist felt that a universal clause could be developed to cover this situation.
- 249 In cases other than suspected homicides, the Law Commission agrees that the development of a waiver for families who wish that microscopic samples be returned is an appropriate balance between the objectives of the coronial system and the rights of families. It also accords with analogous protocols concerning the rights of health consumers developed by the Health and Disability Commissioner. Right 7(9) of the Code of Health and Disability Services Consumers'

⁷⁶ Moe Milne, meeting with the Law Commission, 2 December 1999.

⁷⁷ Dr Thompson, meeting with the Law Commission, 18 November 1999.

Rights gives every consumer the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health-care procedure.

- 250 After considering the issues surrounding the definition of “microscopic samples” and consulting with a pathologist, we accept that there is a need to better define the right to retain microscopic samples to specifically include samples for toxicological analysis. This allows for the preparation of fixed-tissue specimens. However, we consider that the consent of the family is necessary before any larger, treated-tissue specimens could be retained and that larger, treated-tissue specimens should therefore not be included in the definition of microscopic samples.

Recommendation 21

We recommend that the terms “body parts” or “tissue” exclude microscopic samples, which pathologists should retain as a matter of practice. For the purposes of this proposal, the term “microscopic samples” means “samples sufficient for histological and toxicological analysis”.

We recommend that the Office of Chief Coroner design a form of waiver for families who wish microscopic samples to be returned, and that in all cases involving non-suspicious deaths the family be informed of this option.

INDEPENDENT TESTING

- 251 There was no disagreement with the substance of the proposal that persons who have an interest in the matters set out in section 15(1)(a)⁷⁸ of the Coroners Act, such as defence counsel, may apply to the coroner to conduct independent tests on the body or specific body part. As we stated in the preliminary paper, it is our view that

⁷⁸ Section 15(1)(a) provides:

- (1) A coroner holds an inquest for the purpose of—
- Establishing, so far as is possible,—
- (i) That a person has died; and
 - (ii) The person’s identity; and
 - (iii) When and where the person died; and
 - (iv) The causes of the death; and
 - (v) The circumstances of the death.

ensuring 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.

252 However, in his submission, Dr Martin Sage objected to our use of the term “independent” examination when referring to the examination of bodies of homicide victims by pathologists assisting defence counsel. He stated that the pathologist called by the Crown has a responsibility to assist the court in giving expert evidence rather than giving an adversarial view and is as independent as any other pathologist. We accept that this is true. Our intention in using the term “independent” is to refer to tests that are conducted by someone other than the pathologist directed by the coroner. We have re-worded our recommendation to avoid this ambiguity.

253 As we noted previously (see paragraph 203), in cases of suspected homicide the Law Commission has been advised that if a post-mortem is held 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 conduct tests on retained microscopic samples will provide an adequate basis for a second opinion by a defence pathologist for defence purposes. In either case, a second post-mortem is not necessary.⁷⁹ We reflect this fact in our recommendation by referring to further testing “during the post-mortem examination”, where a post-mortem examination includes any necessary testing on body parts (see paragraphs 216–220).

⁷⁹ With regards the issue of a further post-mortem examination in cases of homicide, note a recent case of the High Court of Australia, *Haydon v Chivell* [1999] HCA 39. The applicant in this case was seeking special leave to appeal from a decision of the Full Court of the Supreme Court of South Australia. The Full Court had dismissed an application for orders that would have prevented the burial or cremation of certain deceased persons. The applicant, who was charged with murder, contended that he was denied an opportunity to request the Coroner’s consent to his having a further post-mortem examination conducted on his behalf and that this contravened his right to a fair trial. The High Court dismissed the application. It held that the applicant had not pointed to any circumstance or feature of the case that would suggest that further post-mortem examinations are necessary for a fair trial, as distinct from entailing some possible advantage to him.

Recommendation 22

We recommend the Coroners Act be amended to provide that persons who have an interest in the matters set out in section 15(1)(a) of the Coroners Act, such as defence counsel, may apply to the coroner to have their appointed pathologist conduct tests on the deceased's body or body parts during the post-mortem examination in order to form for their own purposes a second opinion.

RIGHT TO OBJECT

254 Our preliminary paper sought submissions on whether families should have the right to object to the decision to undertake a post-mortem examination where there are no suspicious circumstances surrounding the death. The Australian approach was thought to have merit. In some Australian states, unless the coroner believes that a post-mortem examination needs to be performed immediately, a pathologist must not perform a post-mortem on the body of the deceased if the "senior next-of-kin" objects. The Ministry of Justice, the New Zealand Law Society, Te Puni Kokiri, and others consider that where there is a conflict between the coroner's decision to authorise a post-mortem and the family's wishes, the Australian approach could be followed in New Zealand. The New Zealand Law Society suggested a procedure for such an objection, which included that:

The discretion of the High Court on any application for review should have its parameters set out in the legislation. The criteria for the exercise of discretion would include matters such as the purpose of the Act, the needs of the community to ascertain the cause of death balanced against the wishes of the deceased's family. Where the wishes of the family are based on cultural or religious beliefs, then the Court's inquiry would be directed to ascertaining:

- a) that such beliefs were genuinely part of the culture; and
- b) the cultural or religious beliefs also form part of the belief system of the deceased or the deceased's family (or some of them); and
- c) the extent to which directing the post-mortem be carried out would offend against those beliefs.

The family's wishes are to be weighed with the right of the community to ascertain the cause of death. Where there are clearly suspicious circumstances or a need to ascertain cause of death so as to protect living persons (e.g. risk of epidemic), society's need will weigh heavier in the scales.

Given the need for any application to the High Court to be dealt with expeditiously, and given the need for a simple inexpensive procedure, the committee considers that a standard form of objection should be used. The objection form should be made available to the deceased's family by the coroner and the coroner should be responsible for getting the application before a High Court Judge as soon as possible. If third parties are identified they should also have a right of hearing.

255 The Coroners' Council commented on the procedure suggested by the New Zealand Law Society. The Council submitted that:

At present an objector can apply to the High Court for judicial review of a coroner's decision and we seriously question whether the proposals for a statutory right of objection would effect any improvement. Judicial review (which can be by way of oral application) is probably the quickest means of getting the matter before a High Court Judge. The application of ordinary Wednesbury principles would seem appropriate. If the coroner has misdirected himself then the High Court can intervene but if he has not misdirected himself then the Court should only intervene where the decision is one which no reasonable coroner could reach on the facts. This would recognise the specialist knowledge and experience of the coroner.

We support a requirement for expedition. A simple and inexpensive procedure is always a desirable goal but we can see no reason why it should be any more desirable in this context than in many others. A simple standard form of objection would not get the necessary information before the Judge. The procedure recommended by NZLS would simply invite objections. We believe that objections to the High Court should be serious and considered. Legal Aid in limited circumstances is, and should be available for Coronial proceedings. An objector should have the responsibility of advancing his/her objection.

Any requirement for a coroner to be responsible to promote a form of objection and bring it before the High Court would require appropriate funding for such added responsibilities, which will doubtless be time consuming . . .

256 The Council also commented on the suggestion of the New Zealand Law Society that the discretion of the High Court on any application for review should have its parameters set out in the legislation:

No reason is given for this recommendation. All of the suggested criteria are clearly matters which should be taken into account first by a coroner in deciding to authorise a post mortem examination, and second by the High Court on an application for review. It would be presumptuous and unnecessary to specify in such detail the matters that a High Court Judge ought to take into account. Any specification of criteria should be an "inclusive" specification leaving the Judge also

to take into account other relevant matters that might not be specified.

257 Other submissions were apprehensive about an objection process. Many emphasised that such a process may introduce significant delays. A number of coroners also expressed concerns. Richard McElrea stated:

A coroner's discretion in whether or not a post-mortem is ordered is an onerous one and should be exercised carefully. The process should allow appropriate input from families, but it is important that the coroner can over-ride family wishes in certain circumstances.

258 Dr Martin Sage commented that legal officers need to understand that bodies deteriorate after death and the creation of an absurd situation is possible – that an autopsy be deliberately delayed until such a time as the information that might have been obtained has been lost due to inevitable changes of decomposition. The Police submission makes the point that in determining whether suspicious circumstances exist, the only way foul play can be ruled out entirely is by a post-mortem. For example, an infant may appear to have died from a cot death, when in actual fact one of the parents has suffocated the child. Alternatively, a person may appear to have died from cancer when in fact they have been poisoned to hasten the death.

259 The Law Commission has considered all of these arguments. In our view, a right of objection similar to that in the Australian states of Victoria and Western Australia is an appropriate balance between the legitimate interests of the State in conducting a post-mortem and the cultural, religious or personal views of the family concerning death. While the decision of the coroner to authorise a post-mortem examination is already subject to judicial review, that procedure is concerned with review of the process by which a decision is reached. This is distinct from the right to object to the actual decision to conduct a post-mortem. Although a coroner may make a reasonable decision on the facts that a post-mortem is necessary, those who claim a right to object consider that a post-mortem should not be conducted due to their cultural or religious beliefs.

260 A submission by the Jewish community in support of the right to object commented on the objection procedure in Victoria as follows:

The successful experience of the Victorian legislation . . . dictates its value to both the State and our community. Although the effect of the enactment is to empower the Supreme Court to review in an appropriate case a decision of a coroner to hold an autopsy examination, the result has not been to cause a flood of litigation in this respect. Indeed, we understand, a spirit of co-operation now exists

between the Victoria Coroners Office and the Jewish community . . . such that there is a recognition on both sides of their respective legitimate interests and, in all but a very few instances, matters have been resolved amicably on a case by case basis.

- 261 We acknowledge that if a family decided to object to a decision to conduct a post-mortem, the objection process will introduce significant delays. However, we consider that to be a matter for the family. Armed with the appropriate information, families can decide for themselves whether the advantages of objecting to a post-mortem outweigh the advantages of the coroner directing a pathologist to undertake a post-mortem immediately, thus ensuring the return of the deceased as soon as possible.
- 262 However, we agree that there are situations where it is important that the coroner can override the wishes of the family, most obviously in suspicious deaths and homicide cases. The Australian legislation provides for these exceptions by stating that “unless the coroner believes that an autopsy needs to be performed immediately” it must not be performed if the senior next of kin objects.
- 263 In the interests of flexibility, we envisage that any member of the immediate family⁸⁰ may object to a post-mortem where a general consensus within the family has been reached, rather than a “senior next-of-kin” as prescribed in Australian legislation. A family representative (for example either a family member or minister of religion) or a co-ordinator may play a mediation role in the event that obvious differences of opinion exist within the family.⁸¹
- 264 The Law Commission recognises that the only way foul play can be ruled out entirely is by conducting a post-mortem examination in each case. We also acknowledge the possibility that delays caused by an objection procedure may result in information being lost due to inevitable changes of decomposition of the body. However, these matters do not of themselves outweigh the family’s right to object to a post-mortem. They are simply considerations for the coroner to balance in deciding whether a post-mortem needs to be performed immediately despite the family’s objection.

⁸⁰ See proposed definition at para 310.

⁸¹ We accept that it is not the coroner’s responsibility to resolve differences of opinion where they exist. In extreme instances, where no general view can or is likely to be ascertained, the coroner retains the option of deciding that a post-mortem needs to be performed immediately.

265 We agree with the Coroners' Council that it is unnecessary to specify in any detail in the Coroners Act the matters that a High Court judge ought to take into account when considering an objection to a coroner's decision to authorise a post-mortem. We also agree that it is inappropriate for the coroner to be responsible for bringing an objection before the High Court. However, we envisage that the Office of the Chief Coroner will develop guidelines concerning the practical requirements of an objection process and that a co-ordinator (see paragraphs 295–302) will be available to assist families who wish to object to a decision to authorise a post-mortem.

Recommendation 23

We recommend the Coroners Act be amended to provide families with a right to object to the High Court to the coroner's decision to authorise a post-mortem. We recommend that this provision be modelled on the objection provisions that exist in Victoria (section 29, Coroners Act 1985) and Western Australia (section 37, Coroners Act 1996), except that any member of the immediate family, rather than a "senior next of kin", may object.

TOUCHING THE DECEASED

266 There was much comment on the proposal that the Coroners Act be amended to give the deceased's family, with the consent of the pathologist, the option of viewing and touching the deceased prior to the post-mortem examination. As we explained in our preliminary paper, we envisage that this option would allow *karakia* to be performed. In addition, the ability to remain with a loved one may assist the family in coming to terms with their loss. Submissions were generally accepting of this option. However, there were a few reservations. A number of submitters disagreed that the pathologist should be given the responsibility for providing consent to the viewing and touching of the deceased. Te Puni Kokiri pointed out that this raises important issues in relation to the training of pathologists and is premised on the pathologist having an understanding of the importance of *karakia* and other protocols. From a different perspective, District Court judges noted that the pathologist's power to consent to the viewing and touching of the deceased has the potential of excluding the views of both the coroner and Police in this process.

267 The other most frequent concern regarding this option sought to ensure the security of the body of the deceased. In their submission, the Police stated that:

In homicides or other suspicious deaths it is important to ensure that a body is not contaminated in any way prior to the completion of a post-mortem. In these types of cases, whanau would have to be strictly supervised by Police to ensure that they did not touch or interfere with the body. Security measures in other cases may also be needed to ensure that other problems do not arise e.g. body snatching.

268 Similarly, the Department for Courts and the Ministry of Justice supported the proposal as long as the integrity of the examination was ensured and the coroner and pathologist were not hindered in exercising their functions.

269 The pathologists at Health Waikato had a number of practical reservations. In particular, they explained their hospital has a policy that visitors cannot be left unattended in the mortuary area in the interests of ensuring the premises, specimens and bodies are secure, and that our proposed option would tie up available staff members. They also had difficulties with allowing the deceased to be touched prior to a post-mortem since occasionally it is not discovered until afterwards that the particular case is a homicide. Finally, they were concerned about the time factor and felt that people needed to be mindful that prayers and similar protocols create delay. By way of contrast, Dr Martin Sage stated that in the vast majority of cases there is no medical reason why the family could not view or touch the deceased before the post-mortem and after embalming. He listed a number of special categories where such an option would not be so straightforward, such as suspected homicide, where the deceased is badly deteriorated or incinerated, and where the body of the deceased is infectious. One coroner JM Conradson stated in his submission that there was no problem locally with next-of-kin remaining with the deceased prior to the post-mortem and the facilities were adequate for this purpose. Similarly, in Auckland the pathologists and the coroner had no objections to this proposal in appropriate cases, although they noted that it would be nice for the deceased to be presentable and that there is a need for protocols to give guidance to the police and adequate facilities.⁸²

⁸² Dr Tim Koelmeyer, Dr Alison Cluroe, Dr Jane Vuletic, Dr Simon Stables and Dr Meg Clunie, Auckland pathologists, meeting with the Law Commission, 26 October 1999.

270 It is important to note that none of the submissions objected to this option in principle. The Law Commission is of the view that there are no insurmountable practical reasons that would render this option unworkable in the majority of cases. Indeed, allowing the family to view and touch the deceased before a post-mortem is already the practice in more than one area and is certainly regularly allowed by hospitals in cases involving hospital deaths, such as when a person dies after an operation or while affected by anaesthetic.

271 As we indicated in our preliminary paper, there will be a need for the upgrading of mortuary facilities to accommodate our proposed option of viewing and touching the deceased. The Department for Courts has informed us that:

As a result of the Cabinet decision [CAB (98) M 10/5A(1)] to transfer purchase responsibility for coroner-directed post-mortems from the Health Funding Authority to the Department for Courts, the Department has been required since 1999 to enter into contracts with 19 mortuary service providers nation-wide . . .

With regard to the specific issue of whanau rooms, each contract signed with mortuary providers contains a clause requiring them to provide a whanau room. This is a requirement instigated since the Department for Courts began contracting for the provision of mortuary services. However, additional funding has not been made available either to the Department, or therefore, to mortuary providers for this purpose.⁸³

272 While the management of mortuary facilities is outside the ambit of the Coroners Act, we envisage that a Chief Coroner (see paragraphs 71–79) could be involved in negotiations with interested parties to discuss the funding and other needs of each area.

273 We envisage that protocols will be developed with input from other sectors, such as police, pathologists and hospitals that ensure the security of the body of the deceased and the integrity of the post-mortem examination. In homicide cases and other suspicious deaths, our recommendation that the family be given the option of appointing a representative may reduce the difficulties in keeping the body secure. In these cases, having one person attend to the deceased may be an acceptable balance between the interests of the family in keeping the deceased warm and the concerns of Police in managing security issues.

274 The Law Commission agrees that it is not appropriate for the pathologist to be given the responsibility for providing consent to

⁸³ Dr Jo Lake, Office of the Chief Executive and Judicial Affairs, Department for Courts, letter to the Law Commission, 7 February 2000.

the viewing and touching of the deceased. It is important that coroners retain control of all aspects of the process. This is particularly apposite given our recommendations to increase the status of coroners and enhance the effectiveness of the coronial system. Coroners are in the best position to weigh competing considerations and their training will reflect the need to understand the importance to Māori and other cultures and religions of protocols concerning death. We envisage that cases in which it is not possible to accommodate the needs of the family to view and touch the deceased will be very rare.

Recommendation 24

We recommend that the Coroners Act be amended to give the deceased's family, with the consent of the coroner, the option of viewing and touching the deceased prior to the post-mortem examination.

FAMILY REPRESENTATIVE OR KAITIAKI

- 275 There were many diverse submissions concerning the proposal that the deceased's whānau be given the option of having a family representative or kaitiaki remain with or be in close proximity to the deceased while it is under the coroner's control. The surrounding issues set out in our preliminary paper were also addressed in depth.
- 276 In our preliminary paper, we explained that Māori had suggested to us that there should be provision in the Coroners Act 1988 to permit a whānau representative to act as a kaitiaki⁸⁴ of the deceased while the deceased is under the coroner's control. This suggestion was a response to the distress felt by whānau when they are not allowed to remain with the deceased and to frustration caused by their difficulty in accessing information about the coronial process.
- 277 There was general support for a position of kaitiaki or family representative in principle among all groups with an interest in the coronial process. The Department for Courts stated that:

Allowing a representative of the family to remain with the body demonstrates that coroners recognise and respect cultural and religious

⁸⁴ This term was suggested by Māori and approved by the Law Commission's Māori Advisory Committee. Two submissions commented that it may not be the appropriate term to use. This issue may require further debate amongst Māori.

values other than their own. Such a person could also ensure that the body is treated with respect and that all parts . . . are returned to the family . . .

278 Rabbi Lawrence of the Auckland Hebrew Congregation wrote:

In many respects, I would see that the provisions that you are suggesting regarding the role of the *Kaitiaki* and the *Whanau* could be applied directly to the local Chevra Kadisha [Jewish “religious burial society”].⁸⁵

279 Similarly Bishop Manuhuia Bennett, one of the members of the Law Commission’s Māori Committee, discussed with us the role of the clergy during the coronial process. He explained that, while families may not be able to prevent the coronial process from occurring, the clergy can help families to prepare for all aspects of the coronial process just as they would prepare for death. And for Māori, there is a need for *karakia* to be performed to lift the *tapu* of the deceased.

280 Those who minister the various religions often already provide an important bridge between the coroner and the family.⁸⁶ The family may wish to appoint a member of the religion to which they ascribe as their representative. We envisage that the wording of our proposal will be flexible enough to meet the needs of interested religious and cultural groups. The Chief Coroner in conjunction with relevant organisations will develop protocols to assist coroners when dealing with other cultures and religions and to promote the establishment of links between each Coroner’s Office and religious organisations and ministries in the district.⁸⁷

281 Despite the general support for a *kaitiaki* position, there was a divergence of opinion regarding how such a position would operate in practice. Submitters emphasised that the role of *kaitiaki* needs to be carefully analysed and clear lines of responsibility established. It was noted that care needs to be taken to ensure that the establishment of such a position and the process of appointment do not increase the time involved in the process, and thus cause delays in return of the deceased’s body or body parts.

⁸⁵ Rabbi Lawrence, letter to the Law Commission, 9 November 1999.

⁸⁶ At their recent interdiocesan meeting, members of the Anglican clergy from Rotorua and the Waikato shared with us their experiences in this regard. The point was also made that even people who do not consider they have a faith often respond to the approach of the clergy at the time of death.

⁸⁷ The Anglican clergy emphasised to us that protocols need to cater for all needs, for persons of faith and persons of non-faith who wish to deal with someone who ministers a particular religion, as well as for persons who do not wish religious involvement.

282 The Funeral Directors' Association of New Zealand pointed out that in a number of smaller centres the deceased is often taken to the funeral home for procedural matters, such as identification and photographing, to be carried out before being taken to the regional mortuary. The submission stated that:

The coroner's ability to direct that Kaitiaki contact can/must occur whilst the body is in the custody of a Funeral Director will cause many difficulties for the Funeral Director. These include health and safety, privacy and public liability issues.

The submission did not elaborate further on the Association's concerns. We do not envisage that the difficulties would be much different to those that may arise where the deceased is taken to a mortuary. While procedures such as identification and photographing are being carried out the deceased is under the authority of the coroner. The Chief Coroner will be responsible for issuing guidelines to clarify the process and resolve potential difficulties.

283 The Funeral Directors' Association also considered that care will need to be taken in appointing a representative. It may not be appropriate for certain individuals to carry out this role, such as those who are currently susceptible to opportunistic disease, have low immunity, or are pregnant. They also stated that a certain standard of behaviour and dress will also be required.

284 The Law Commission is conscious that care must be taken to ensure that our recommendations do not have the unintended effect of making the coronial system more complicated. However, we consider that our suggestion that the family should be allowed the option of appointing a family representative or kaitiaki to attend to the deceased while under the coroner's control is justified. The ability for families to identify one person with whom the coroner and others involved in the coronial system can have contact has the potential to simplify the process, improve communication and at the same time benefit families. For example, in cases of suspected homicide where there is a need to ensure potential evidence is not contaminated, Police may be amenable to allowing a single representative of the family to remain with the deceased where otherwise they might object. The presence of a kaitiaki in this instance reassures the family that the deceased is being accorded the appropriate respect and at the same time ensures that the role of the police in securing the body is still manageable. Another possibility is where the family cannot immediately attend to the deceased and wish to authorise someone outside the family to act on their behalf.

- 285 In addition, if members of the deceased's family disagree about particular aspects of the coronial process, the family representative may be able to take on a mediator role. It is in the family's best interests to resolve any disputes quickly to avoid delays in having the deceased returned to them. From the coroner's point of view, a family representative provides a single point of contact if the views or wishes of the family need to be ascertained.
- 286 On the other hand, often families may not see the need to utilise the option of appointing a representative. The family's needs may be met by their ability in most cases to view and touch the deceased (see paragraphs 266–274) and by the co-ordinator attached to the coroner's office (see paragraphs 295–302). Where a representative is seen to be desirable, it will be for the family to resolve who that person should be. We envisage that a Chief Coroner with the assistance of a kaiwhakahaere (see paragraphs 46–48) would need to develop protocols detailing the information that should be provided to families when choosing their representative.

Recommendation 25

We recommend that the deceased's whānau be given the option of having a family representative or kaitiaki remain with or be in close proximity to the deceased while it is under the coroner's control.

We envisage that the Office of Chief Coroner can develop protocols:

- to guide coroners when dealing with interested cultural and religious groups who choose to exercise this option; and
 - detailing the information that should be provided to families when choosing their representative.
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OBSERVERS AT POST-MORTEM EXAMINATIONS

- 287 A number of strong views were expressed regarding the discussion in our preliminary paper of section 10(3) of the Coroners Act.⁸⁸ We suggested that this section be expanded to include any registered health professional or funeral director of the family's choice. We commented in our preliminary paper that we are aware many Māori

⁸⁸ 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 this Act.

would prefer that the section allow any person of the family's choice to fulfil the role of being present during a post-mortem examination. However, we gave a number of reasons why this could be problematic.

- 288 There was general agreement among all groups with an interest in the process that family members should not be allowed to be present during the actual post-mortem examination. A large variety of arguments were made in support of this conclusion. For example, Health Waikato pathologists explained that the configuration of the mortuary in which they worked allowed for more than one body at a time in the dissection room. It would be difficult to avoid a member of the public seeing a body with which they had no connection.
- 289 They also made the point that mortuaries have recently been the subject of controversy in relation to standards of health and safety. It was considered that members of the public would not be able to comply with necessary Health and Safety protocols including the required inoculations and health and safety training. However, by far the most compelling reason given for objecting to the presence of family members during a post-mortem was the mental health argument. As we discussed in our preliminary paper, to watch a post-mortem is a traumatic and extremely unpleasant experience. 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 addressing the concerns of Māori, Dr Martin Sage, stated that the practice in the Christchurch mortuary of encouraging family and friends to remain in an adjacent viewing suite has been acceptable to all whānau, particularly where local kaumatua have had the opportunity to see and bless the entire facility beforehand.
- 290 Māori groups themselves also acknowledged the effects of observation on the mental health of a family member and felt that it was not necessary for a family member to be in actual physical attendance during the post-mortem. The Ngatiwai Trust Board submission stated that to see this procedure being performed on a loved one would be abhorrent to a whānau member and could affect the viewer physically and mentally. At the same time, this group felt that whānau should be informed about how the procedure is carried out, what incisions or cuts are going to be made and how long the procedure will take. Similarly, the Moana District Māori Council explained that being near to the deceased enables whānau to keep their loved one warm and also allows for the reciting of appropriate karakia, but that it is not necessary for the whānau member to be in the same room as the deceased during the actual post-mortem. They

felt that allowing the whānau member to be situated at least in an adjoining room was an acceptable compromise.⁸⁹ Te Mana Hauora o Te Arawa stated that it would be traumatic for a whānau member to watch a post-mortem. They explained that a Tohunga Karakia⁹⁰ could perform all necessary karakia without needing to view the post-mortem.

291 On the other hand, Te Puni Kokiri took a different view:

Te Puni Kokiri supports the statement made regarding the appointment of a Kaitiaki. However, section 10(3) should be wide enough to include any person of the whanau's choice to be appointed [to be present during a post-mortem] rather than limited to a registered health professional or funeral director of the whanau's choice. It is stated that a post-mortem is an unpleasant experience, and pathologists may feel uncomfortable performing an examination in front of whanau members. However, whilst this may be true, in Te Puni Kokiri's view the interests of the whanau should be uppermost and choice and control should, where possible, remain with them.

292 The Law Commission has considered all of these arguments carefully. We agree that families should be involved as far as possible in the process and be empowered to make choices concerning the best interests of the deceased. Our recommendation that the family be allowed the option of appointing a family representative or kaitiaki to attend to the deceased while under the coroner's control (see paragraphs 275–286) is one way that families can be involved. However, as regards having a family member accompany the deceased during the post-mortem examination, we are conscious of the many pragmatic arguments that must be taken into account. In particular, we are persuaded by the argument that in many places the mortuary is designed to allow more than one examination to proceed at the same time. The interests of all families to have their loved ones accorded respect must be acknowledged. We have also taken into account the general agreement among submitters that the mental health risks of allowing lay people to observe a post-mortem are great. It is our view that the most appropriate balance is to limit the categories of persons who may attend post-mortem examinations.

⁸⁹ Flexibility in approach seems to be the key. During consultation, we were told of one pathologist who sometimes erects baffles in the post-mortem room so that the family can be near their loved one.

⁹⁰ They said "This person would be highly practised in karakia and the autopsy process itself. This person would not be there to observe the autopsy, but to karakia and keep the wairua of the deceased settled".

- 293 We were helped in reaching our conclusion by the consensus among Māori submitters that the necessary karakia for the deceased can be performed without a Tohunga Karakia needing to be physically present in the room where the post-mortem examination is being performed. If the family is not satisfied with remaining in close proximity to the deceased and wishes to have an independent person accompany the deceased during the post-mortem examination, they may apply to have a doctor, registered nurse or funeral director of their choice fulfil this function.
- 294 One submission questioned the use in our proposal of the term “registered health professional”. We agree that this terminology may be confusing since a registered health professional is defined very broadly in section 4 of the Health and Disability Commissioner Act 1994. In that Act, it includes, for example, dentists, dental technicians, pharmacists, psychologists, chiropractors, opticians, dietitians, occupational therapists and physiotherapists. We have reworded our recommendation to clarify the categories of persons who we consider may attend a post-mortem under section 10(3).

Recommendation 26

We recommend that the scope of section 10(3) be widened to provide that a doctor, registered nurse, or funeral director may be present at a post-mortem examination as the family’s representative.

CO-ORDINATOR

- 295 In the preliminary paper, we proposed the appointment of a co-ordinator located in the coroner’s office. The role of the co-ordinator as we envisaged it would be to liaise with the various people involved in the coronial process and to ensure that each coroner’s office establish a relationship with local iwi and other Māori, cultural and religious groups. We suggested that the position of co-ordinator would probably best be filled by a trained health professional or some other respected member of the community. As many submissions acknowledged, it is apparent that many of the difficulties with the present system are caused by communication breakdowns. There was therefore general support for a liaison process, although there were different views on how such a process should be structured.
- 296 The submission from Healthcare Otago agreed that a co-ordinator based in the coroner’s office would ease the coronial process for

people of all cultures and beliefs. They stated that given our recommendations to regionalise coronial districts, reduce the number of coroners and move to a system of full-time coroners, a co-ordinator would be necessary in many areas due to the increased workload of the coroner. However, it considered that the role of co-ordinator needed to be made explicit. Similarly, Te Puni Kokiri supported the concept of a co-ordinator provided funding issues are addressed but requested clarity concerning the specifics of the role. Further, Te Puni Kokiri pointed out that the establishment of community relationships, particularly with Māori communities, and the facilitation of debates in a Māori context are huge tasks requiring a high level of skill.

297 A number of submissions outlined procedures for co-ordination that are already in place in their region and questioned how the proposed position of co-ordinator would relate to these and to other staff. For example, Healthcare Otago stated that:

At present, in our situation, some co-ordination and counselling is performed by Dunedin Hospital staff, and we see advantages in this continuing to be available, particularly in instances of hospital based coroners cases.

298 The Ministry of Justice queried the practicality of our proposal. The Ministry emphasised the importance of coroners remaining central to the process. It therefore tentatively took the view that it would be better that such a position be centrally located, taking advantage of modern communication techniques, but with the option of travel if required. Other submissions commented that a trained health professional is not necessarily the best candidate for this position, and that emphasis should be placed on the potential co-ordinator's ability to convey information to families in an understandable way and the extent to which he or she possesses skills in dealing with people in stages of grief, shock, anger and guilt.

299 A few submissions expressed concerns that a co-ordinator as proposed is not the best way to meet the needs of Māori and that further consideration should be given to this issue. In particular, Dr John Armstrong made the point that a whānau advocate employed and operating independently from those involved in the process would more effectively satisfy the concerns of whānau. A submission made on behalf of the Dunedin Community Law Centre stated that:

we find it abhorrent to the spirit of Te Tiriti o Waitangi that the Law Commission proposes to appoint a co-ordinator acting on behalf of the coroner and located in the coroners office. This looks like an attempt to diminish Crown responsibilities to whanau, as the role is clearly designed to be partial towards the interests of coroners.

- 300 Following our discussion concerning the information needs of the family (see paragraphs 236–240), the Law Commission retains the view that some form of liaison process is crucial to the effective operation of the coronial process. While a liaison process should be flexible enough to accommodate the requirements of the community that it serves, we consider that some consistency in approach is also invaluable in ensuring the needs of families are met. We suggest that this is best achieved by establishing a position of co-ordinator in each coroner’s office.
- 301 In our view, this role ensures that there is one person in each coroner’s office who can take *practical* responsibility for maintaining the communication and information links in the coronial process.⁹¹ At present, a number of individuals attempt to take on some of this responsibility with the result that information gets lost or distorted. Further, we have heard from inquest officers that they are often expected to liaise between families and the coroner but that the restructuring of the Police has meant they have little time to devote to this task. A co-ordinator can liaise with families, coroners, pathologists, police and funeral directors to ensure that everyone’s needs are met as far as practicable. This position is therefore designed to further the interests of all of those involved in the coronial system. We therefore disagree that “the role is clearly designed to be partial towards the interests of coroners.” Further, one of the benefits of attaching the position to the coroner’s office is that this ensures that co-ordinators remain accountable to the system.
- 302 A co-ordinator would need to possess a number of special skills, be able to meet the particular needs of the coronial district in which he or she is appointed, and have sufficient training to be able to competently explain the post-mortem procedure and any findings of the pathologist in a way that is understandable to families. In some instances, a co-ordinator will also need to be able to refer families where necessary to pathologists to have any intricacies explained.

⁹¹ A co-ordinator will be aware of support groups and publications that may assist the family. There are some useful publications that are designed to assist with education about coronial practices and procedure, for example the New Zealand Police “Information Guide for Bereaved Families” and the Department for Courts “When Someone Dies”. The New Zealand Police publication has been published in three languages: English, Māori and Samoan.

Recommendation 27

We recommend that the Chief Coroner, in consultation with a kaiwhakahaere,⁹² district coroners, the Police and community groups, as well as the Ministry of Justice and Department for Courts, investigate the logistics of appointing a co-ordinator in each coronial district with a view to establishing such a position.

⁹² See paras 46–48.

Part III
Further Matters

Further amendments to the Coroners Act 1988

303 **I**N ADDITION TO COMMENTING on the matters in our preliminary paper, a number of submissions recommended various amendments to the Coroners Act. While these matters were not raised in our preliminary paper, we consider that we are able to make recommendations concerning many of them with guidance from overseas legislation. We have indicated where comments are not detailed enough for us to make recommendations at this stage. The topics in this chapter are ordered to follow the format of the Coroners Act.

PART I – PRELIMINARY

“Immediate Family” and “Immediate Relatives”

304 A number of submissions commented on matters relating to the terms “immediate family” and “immediate relatives”, including:

- the definition of “immediate family”;
- the uses of the term “immediate family” in the Act and its relationship to the term “immediate relatives”; and
- the range of people to be notified under various sections of the Act.

305 “Immediate relatives” is not defined in the legislation. Section 2 provides that “immediate family”:

in relation to any person, includes persons whose relationship to the person is, or is through one or more relationships that are, that of de-facto spouse, step-child, step-parent, step-brother, or step-sister.

306 The Office of the Privacy Commissioner submitted that the definition of “immediate family” should include same-sex partners. It stated that:

The interpretation provision relating to “immediate family” includes “de facto spouse”. However, this term appears to exclude same-sex partners . . . The definition of “immediate family” should explicitly

include same-sex partners so that in all cases the person closest to the deceased is given these rights of notification, access and the opportunity to be heard.

- 307 The Law Commission agrees that the definition of “immediate family” needs to be reworked, and specifically that it should include same-sex partners.
- 308 Section 3 of the Coroners Act 1997 (Australian Capital Territory) defines “immediate family” as meaning:
- (a) a person who was the spouse of the deceased at the time of the deceased’s death (including de facto and same sex partners), or a parent, grandparent, child, brother or sister, or guardian or ward, of the deceased; and
 - (b) if the deceased was an Aboriginal person or Torrens Strait Islander – a person who, in accordance with the traditions and customs of the Aboriginal or Torrens Strait Island community of which the deceased was a member, had the responsibility for, or an interest in, the welfare of the deceased.
- 309 We consider that the definition of “immediate family” in the New Zealand legislation should follow similar lines, so that the “immediate family” includes persons falling into the following categories:
- (a) a person who was the spouse of the deceased including de facto and same-sex partners, or a parent, grandparent, child, brother or sister, or guardian or ward, of the deceased; and
 - (b) a person whose relationship to the deceased is that of step-child, step-parent, step-brother, or step-sister; and
 - (c) a person who, in accordance with the traditions and customs of the community of which the deceased is a member, had the responsibility for, or an interest in, the welfare of the deceased.
- 310 The terms “immediate family” and “immediate relatives” are used in varying ways throughout the Act regarding who should be notified in particular circumstances. Section 11 provides for a member of the deceased’s immediate family to be given notice that a post-mortem examination has been authorised and for the family to obtain a copy of the doctor’s report. Section 15(2) (a) provides for every member of the “immediate family” who requests notification to be notified of a proposed adverse comment about a dead person and given a reasonable opportunity to be heard. Section 23(2)(a) provides that the “immediate relatives” of the deceased must be notified that an inquest is to be held (the difference in terminology between “family” and “relatives” not being clear).
- 311 The Coroners’ Council submitted that the range of people to be notified should be clearly set out in the legislation. The Council stated that:

At present Section 11 requires notice to “a member” of the immediate family. That is, notification is required to only one person and it is for that person to notify a wider range of family members if he/she thinks fit.

If the responsibility is to notify multiple members of a family (and there is clearly merit in some cases for more than one family member being notified, especially where there has been an estrangement in the family) the Coroners’ Council has concerns about responsibility for gathering information as to who comprises “immediate family” and for notifying such members. It would be an added onus on the police, and coroners do not have the resources to carry out an extended role of this nature. A solution may be to reconsider the definition of “immediate family” and to require extended notification in limited cases, especially where parents of the deceased are living apart or the deceased is separated from his/her spouse.

- 312 We agree that the term “immediate family” should be used consistently throughout the Act, and that the range of people to be notified in particular circumstances should be clearly set out in the legislation.
- 313 Rule 19 of the Coroners Rules 1984 (UK) provides that the coroner must notify a number of people that an inquest is to take place. This includes the spouse or near relative or personal representative of the deceased, and the parents, children, and other interested individuals, if they have asked the coroner to notify them and have given the coroner their contact details. Under section 17 of the Coroners Act 1980 (New South Wales), the coroner must inform the deceased’s “next of kin” of the details of the inquest if the coroner has been informed of the next of kin’s name and address. “Next of kin” is not defined in the legislation. Section 29 of the Coroners Act 1958 (Queensland) provides that the coroner may notify any persons who, in the opinion of the coroner, have a sufficient interest in the subject or result of the inquest.
- 314 In our view, in all cases where notification is required the coroner must ensure that the following people are notified:
- (a) the family representative or kaitiaki,⁹³ where one has been appointed under section [x]; and
 - (b) every member of the deceased’s immediate family who has asked to receive notification and who has left his or her contact details with the coroner or the coroner’s agent; and

⁹³ See paras 275–286.

- (c) any other person or organisation who, in the opinion of the coroner has a sufficient interest in receiving notification and whose contact details are reasonably accessible.

315 We envisage that notification under the Act could appropriately be one of the functions of a co-ordinator.

PART II – REPORTING OF DEATHS

Reporting of deaths

316 Section 5 provides that:

- (1) Subject to subsection (3) of this section, every person who finds a body in New Zealand shall, as soon as is practicable, report the finding to a member of the Police.
- (2) Subject to subsection (3) of this section, every person who learns of a death required by section 4 of this Act to be reported—
 - (a) In New Zealand; or
 - (b) On or from—
 - (i) An aircraft registered in New Zealand under the Civil Aviation Act 1964; or
 - (ii) A New Zealand ship (within the meaning of the Shipping and Seamen Act 1952); or
 - (iii) An aircraft or ship of the Armed Forces (within the meaning of the Armed Forces Discipline Act 1971),—shall, as soon as is practicable, report the death to a member of the Police.
- (3) A person who believes that a death—
 - (a) Is already known to the Police; or
 - (b) Will be reported to a member of the Police,—is not required to report it to a member of the Police.
- (4) A member of the Police—
 - (a) Who finds a body in New Zealand; or
 - (b) To whom a report of a death is made under this section,—shall cause the finding or death concerned to be reported forthwith to the coroner nearest (by the most practicable route) to the presumed place of death or, where the death occurred outside New Zealand and the body is in New Zealand, to the coroner nearest (by the most practicable route) to the place where the body is.
- (5) Any person may report to a member of the Police or to a coroner the death outside New Zealand of a person whose body is in New Zealand.
- (6) Where a death has been reported to a coroner under this section, the Commissioner of Police shall cause to be made all inquiries—
 - (a) Necessary for the due administration of this Act in relation to the death; or
 - (b) Directed by the coroner.

- 317 The submission from the Chief District Court Judge's Chambers suggested that there is a need for clarification of the circumstances of when and how a death is to be reported to a coroner under section 5.
- 318 In our view, clarity concerning the circumstances of when and how a death is to be reported can be achieved by the dissemination of appropriate information from the Office of Chief Coroner as part of the Chief Coroner's role in educating the public about the coronial process. We do not consider that any changes are required to section 5 to achieve this purpose.
- 319 Two submissions specifically addressed section 5(4)(b) of the Act. Section 5(4)(b) provides that a member of the Police shall ensure that reportable deaths are "reported forthwith to the coroner nearest (by the most practicable route) to the presumed place of death . . ." The Coroners' Council stated that Section 5(4)(b) works well as it clearly designates which coroner has jurisdiction to deal with an inquest. However, coroners DW Bain and David Douthwaite commented to us that the Coroners Act needs to be more specific regarding which coroner has jurisdiction over a body. They cited a recent incident where there was some confusion as to which coroner had jurisdiction over the body of a person who died at sea.
- 320 The Law Commission does not consider that any changes are required to section 5(4)(b). Any confusion over which coroner has jurisdiction of the deceased in a particular case will be dealt with by a Chief Coroner in his or her supervisory role and having regard to the coronial districts.

Reporting hospital deaths

- 321 During consultation, Amanda Mark, Legal Counsel for Auckland HealthCare discussed the frustration of doctors in deciding whether a hospital death needs to be reported. Coronial practice is inconsistent as regards this issue. Ms Mark stated that the Act needs to set out the circumstances in which hospital deaths are to be reported.
- 322 The Auckland deputy coroner, Sarn Herdson, accepts that coronial practice is inconsistent in this area. However, she also submitted that the views of medical practitioners themselves are not uniform in terms of which deaths are required to be reported under section 4 of the Coroners Act 1988.⁹⁴ She explained that:

⁹⁴ Sarn Herdson, letter to the Law Commission, 30 May 2000.

The wording of section 4 of the Coroners Act has resulted in difficulties of interpretation. There appears to be no difficulty with deaths that occur “during” a procedure. However, there are different interpretations by medical practitioners as to whether a death “appears to have been the result of” any such operation/procedure.

Some doctors argue that *any* death that follows an operation or procedure could be seen to have “been the result of”, while others argue that some causes of death are distinct from an operation or procedure, and can be ascertained and recorded as such

In addition, there is a common misconception that there is some time limit of “24 hours” or “72 hours” after an operation. In fact, there is no time restriction in New Zealand legislation, as there is in other jurisdictions (eg Australia).

- 323 At the 1999 National Coroners’ Conference, Richard McElrea discussed a process of faxed notifications from hospitals to coroners practised in some areas as a means to ensure consistency of reporting. He stated that:

The process of faxed notifications from a hospital to a coroner’s office provides the coroner with relevant and consistent information, which minimises disruption to daily routine. The process also gives better protection to the Health Professionals. I am aware that some coroners have met resistance to the idea of faxed notifications. I would suggest we are almost at the point where a new standard of practice has been established. It is up to coroners to ensure that they receive proper and timely information, of deaths that are required to be reported in terms of the Coroners’ Act. It is difficult to see how this can be achieved, particularly in larger hospitals, without a form of written notification.⁹⁵

- 324 Similarly, in Sarn Herdson’s view:

there is an expectation from coroners that doctors should always report deaths of that nature, and then discuss them with the coroner. That discussion will provide further information and it is on the basis of that, that a coroner may then exercise his or her discretion to accept jurisdiction. In that sense, it is a “two-step” process. It does not automatically follow that because a “medical treatment” or “hospital death” is reported, that there will therefore be a post mortem examination in every case.⁹⁶

- 325 The Law Commission acknowledges that consistency in the reporting of hospital deaths is important. We accept that

⁹⁵ Richard McElrea “The Coroner and Outside Agencies – An Update” (paper presented at the 1999 National Coroners’ Conference, Wellington, 4–5 September, 1999).

⁹⁶ Sarn Herdson, above n 94.

appropriate reporting protocols that provide further information to the coroner are sufficient to ensure such consistency. We therefore do not consider that legislative change is necessary to resolve issues concerning the circumstances and manner in which hospital deaths are to be reported. Rather, a Chief Coroner can oversee the implementation of reporting protocols in each coroner's office and monitor their effectiveness.

Power of Justices where no coroner available

326 Section 6(1) of the Act provides:

(1) Where—

(a) The coroner to whom a death is required by this Act to be reported is not available to act; or

(b) The office of coroner in the place where a death is required by this Act to be reported is vacant,—

The death shall be reported to a Justice.

327 The Coroners' Council submitted that section 6(1) needs to be reworked. The Council noted that section 6(1) appears to relate to the reporting process by the Police to the coroner concerned (under section 5(4)), but that this needs to be made clear. They also considered that the wording of section 6(1) needs to allow for a death to be reported to another coroner, where the coroner to whom a death is required by this Act to be reported is not available to act or his or her office is vacant.⁹⁷ Finally, they submitted that in practice, certain Justices of the Peace are designated to undertake coronial work where this is necessary and the wording of the Act should reflect this practice.

328 The Law Commission agrees with the Coroners' Council on these points. We recommend that section 6(1) be amended to make clear that it relates to the reporting process under section [x]. We also consider that the section should allow for deaths to be reported to other coroners and District Court judges where appropriate. We agree that section 6(1) should refer to Justices of the Peace who have been designated to assist with coronial work.

⁹⁷ Richard McElrea, Christchurch coroner. telephone conversation with the Law Commission, 7 February 2000.

PART III – POST-MORTEM EXAMINATIONS

“Authorise” versus “Direct”

- 329 The Coroners’ Council noted that sections 7 and 8 of the Act provide that a coroner may “authorise” a doctor to perform a post-mortem examination, but that:

The mandatory provisions of section 9(1) requiring the coroner to direct a doctor to perform an examination forthwith are not consistent with this.

- 330 The Council stated that the issue of “authorisation” versus “direction” of a pathologist to carry out a post-mortem needs to be addressed:

The coroner should authorise. The issue is having authorised a post-mortem to be carried out, what happens if in fact it is not carried out? Perhaps the role of Chief Coroner may be relevant in directing a post-mortem. Perhaps the answer is for a coroner to be authorised to direct and a pathologist required to carry out a post-mortem unless there is good reason to the contrary...

- 331 The legislation in Western Australia, the Australian Capital Territory and Victoria all use the term “direct” in this context.

- 332 In our view, the Coroners Act 1997 (Australian Capital Territory) strikes an appropriate balance between the desirability of the coroner being in control of the coronial process and the possibility that a pathologist is unable to conduct a post-mortem in a particular case. Section 21 of that Act provides that a coroner may, by order in writing, direct a medical practitioner to conduct a post-mortem examination of a person who has died in any of the circumstances in respect of which the coroner has jurisdiction to hold an inquest. Section 22 provides that if a medical practitioner specified in an order under section 21 is, for any reason, unable to conduct the post-mortem examination, the coroner may:

- (a) amend the order by substituting the name of another medical practitioner; or
- (b) direct that a specified medical practitioner conduct the post-mortem.

- 333 We recommend that a similar approach be adopted in New Zealand.

Persons who may perform a post-mortem

- 334 The submission from Dr Martin Sage recommended that the Coroners Act be amended to specify that only a “pathologist” or a

“directly supervised practitioner” may carry out a post-mortem. Similarly, the Coroners’ Council considers that post-mortems should be conducted by specialist anatomical pathologists. Currently, section 7 of the Coroners Act provides that a coroner may authorise a “doctor” to perform a post-mortem. Our consultations revealed that in one or two of the more isolated areas, general practitioners are known to perform post-mortems. The New Zealand Society of Pathologists and the Coroners’ Council are of the view that only properly trained pathologists should carry out post-mortems.

335 This suggestion raises questions about the availability of pathology services in remote areas. Te Puni Kokiri states that they:

would be very concerned at the potential implications for Maori should the availability of pathology services be limited to certain locations. In some areas this may require travelling significant distances in order for post-mortems to be conducted.

336 The distress that a lack of pathology services can cause families was highlighted by an incident in Gisborne late in 1999 when there was a temporary lapse in available services after the resident pathologist departed the area. The *Dominion* relayed the story of a Gisborne family who expressed frustration and anger at a decision to send the body of a family member to Hamilton for a post-mortem.⁹⁸

337 Under sections 19 and 20 of the Coroners Act 1988 (UK), a coroner may request a “legally qualified medical practitioner” to conduct a post-mortem. The coroner may also request “any person whom he considers to possess special qualifications for conducting a special examination of the body to make such an examination”. “Special examination” is defined as meaning a:

special examination by way of analysis, test or otherwise of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other examination with a view to ascertaining how the deceased came by his death (section 20(4)).

338 Rule 6 of the Coroners Rules 1984 (UK) provides that when considering which legally qualified medical practitioner will be requested to perform a post-mortem, the coroner must have regard

⁹⁸ Pat Kitchin “Gisborne Family Upset at Autopsy Decision” *The Dominion*, Wellington, 18 November 1999.

to a number of matters, including that the post-mortem should be conducted, wherever possible, by a pathologist with suitable qualifications and experience.

- 339 In Australia, section 36 of the Coroners Act 1995 (Tasmania) provides that a coroner may authorise the State Forensic Pathologist, an approved pathologist or a medical practitioner under the supervision of the State Forensic Pathologist or an approved pathologist to perform an autopsy. Section 21 of the Coroners Act 1997 (Australian Capital Territory) and section 18 of the Coroners Act 1958 (Queensland) provide that a medical practitioner may be authorised to conduct a post-mortem. “Medical practitioner” is defined as meaning a person who is registered under the appropriate legislation. Section 27 of the Coroners Act 1985 (Victoria) provides that a coroner may authorise the Victorian Institute of Forensic Medicine, a pathologist, or a doctor under the direct supervision of a pathologist, to perform an autopsy.
- 340 The Law Commission agrees with the New Zealand Society of Pathologists and the Coroners’ Council that ideally post-mortems should always be conducted by pathologists. However, we accept that pathologists are not always available in the more remote areas of New Zealand. It is necessary to balance the interests of the State in having properly trained specialists carry out post-mortems in all cases with the wishes of the family to have the deceased returned as soon as possible. In some instances, it may not be appropriate to transport the deceased over long distances to secure the services of a pathologist if a reasonable alternative can be found. We consider that the appropriate balance is to allow for the coroner to authorise a general medical practitioner in rare cases to conduct a post-mortem. We recommend that the term “pathologist” be used throughout the Act, with “pathologist” being defined in section 2 as including a general medical practitioner authorised by a coroner to conduct a post-mortem examination. We envisage that a Chief Coroner, after consultation with the New Zealand Society of Pathologists, would issue guidelines to aid coroners in the exercise of this power. The New Zealand Society of Pathologists in conjunction with the appropriate health authorities may be able to assist in devising a system of supervision for general medical practitioners authorised to conduct post-mortems. These organisations may also have an integral role to play in the co-ordination of pathological services around the country so as to minimise the need for non-pathologist medical practitioners to conduct post-mortems.

Ability of the family to request a post-mortem

- 341 One submission stated that a procedure for allowing families the right to request a post-mortem should be considered.⁹⁹
- 342 Section 37 of the Coroners Act 1995 (Tasmania) provides that any person who the coroner considers has a sufficient interest in a death may request the coroner to direct that an autopsy be performed on the deceased. If the coroner refuses a person's request under this section, within 48 hours after receiving notice of the refusal that person may apply to the Supreme Court for an order that an autopsy be performed.
- 343 Section 37 of the Coroners Act 1996 (Western Australia) provides that if a coroner has jurisdiction to investigate a death, any person may ask the coroner to direct that a post-mortem examination be performed on the deceased. If this request is refused, the person may apply within two days to the Supreme Court for an order that a post-mortem examination be performed.
- 344 We consider that it is appropriate for family members to have the right to request the coroner to direct that a post-mortem be conducted,¹⁰⁰ with a right to apply to the High Court if the request is refused. The right to apply to the High Court can be framed in similar terms to the right of the family to object to a coroner's decision to authorise a post-mortem (see paragraphs 254–265).

Post-mortem examinations performed “forthwith”

- 345 Section 9 provides that:
- (1) A coroner who—
 - (a) Has authorised a doctor to perform a post-mortem examination of a person's body; and
 - (b) Is satisfied that subsection (2) of this section applies to the person or to a member of the person's immediate family,—shall direct the doctor to perform it forthwith; and in that case the doctor shall do so.
 - (2) This subsection applies to a person if persons having the ethnic origins, social attitudes or customs, or spiritual beliefs of the person

⁹⁹ The right for a concerned family member to request the coroner to authorise a post-mortem examination of the deceased may help to prevent a situation such as the “Doctor Death” scenario from occurring. In that scenario, an English doctor concealed the fact that he had murdered a number of his patients by insisting that post-mortems were not required in each case.

¹⁰⁰ This recommendation has funding implications for the State.

customarily require bodies to be available to family members as soon as is possible after death.

- 346 The Coroners' Council stated that section 9 should be expanded to allow a coroner to direct that a post-mortem examination be performed "forthwith" in any case where he or she is satisfied there is good reason to do so. In practice, "forthwith" post-mortems are frequently ordered, for instance, for deaths of babies or young children. The Council also submitted that section 9(2) should be clarified to make clear whether reference to "ethnic origins, social attitudes or customs, or spiritual beliefs" applies to the person who has died or that person's immediate family or both.
- 347 We agree with the Coroners' Council on these points. We consider that section 9 should be expanded to allow a coroner to direct that a post-mortem examination be performed as soon as possible where:
- (a) the deceased is an infant; and
 - (b) in any other case where the coroner is satisfied that there is good reason to do so.
- 348 On our reading of section 9, section 9(2) applies where *either* the deceased or the deceased's immediate family have ethnic origins, social attitudes or customs, or spiritual beliefs that require bodies to be available to family members as soon as is possible after death. However we agree that section 9(2) could be more clearly worded to reflect this intention.
- 349 Dr Martin Sage commented on the use of the term "forthwith" in section 9 of the Act as follows:

The present Act uses the term "forthwith" in the context of direction by a coroner for postmortem examination to expedite early release. Interpretations vary widely as to what time delay this might reasonably accommodate. To some it seems to mean the next morning (for example in a weekend or Public Holiday), to others "within 8 hours", while some pathologists are subject to harassment at any hour of the night by funeral directors ostensibly acting on behalf of whanau on the grounds that they (the pathologist) can be accessed by telephone whereas the coroner (who has the sole authority to make the decision) cannot be so contacted. We favour a reasonable elastic term which might encompass the regional variations in availability of pathologist. The Commission should bear in mind that in many centres (particularly provincial centres without full-time forensic pathologists) pathologists carry a full workload of other laboratory work in a medical system in which there is no longer any slack, and that there are at present no appointments, contracts, retainers or recompense for the time in which these professionals make themselves available for this service . . .

- 350 The uncertainty surrounding the “forthwith” time frame is an issue that came up repeatedly during consultation with pathologists. The pathologists based at Health Waikato commented that “forthwith” calls have markedly increased. They explained that Health Waikato offers pathology services to coroners 24 hours a day, 7 days a week and that therefore there was no reason why sometimes night calls could not be left until the morning. They felt that this was particularly so because often they would perform a post-mortem late at night in response to a “forthwith” request but found that the deceased was still there in the morning because other sectors of the coronial system were not also working on a basis of urgency.
- 351 We agree that an “elastic term” is warranted to take into account regional variations in the practice and availability of pathologists. We consider that the Act should be amended to provide that the coroner may direct a pathologist to perform a post-mortem “as soon as is reasonably practicable”. We envisage that a Chief Coroner, after consultation with the New Zealand Society of Pathologists, would develop guidelines to aid in determining what is “reasonably practicable”.

Removal and disposal of bodies

- 352 Section 13 of the Act relates to the removal and disposal of bodies. It provides that:
- (1) For the purposes of any examination under this Act, a coroner may give any directions the coroner thinks fit relating to the removal of a body.
 - (2) Subject to subsection (3) of this section, a coroner to whom a death has been reported may at any time, by written notice in the prescribed form signed by the coroner, authorise the disposal of the body concerned; and the body may be disposed of accordingly.
 - (3) A coroner who decides not to authorise a doctor to perform a post-mortem examination of a body shall not authorise its disposal earlier than 24 hours after notifying a member of the Police of the decision, unless a member of the Police of the rank of Senior Sergeant or above agrees.
- 353 The Coroners’ Council recommended that this section should be expanded to cover a situation where the coroner concerned is not available. They explained that in practice, a deputy coroner, another coroner, a District Court judge, or a Justice of the Peace could carry out this role but should take account of inquiries already carried out by the coroner concerned.
- 354 A number of submissions commented that the use of the word “disposal” in the Act is insensitive. Capital Coast Health considered

that the word “release” expresses this concept in a more appropriate and positive way.

- 355 We accept that section 13 should be expanded to cover a situation where the coroner concerned is not available. We consider that this is best achieved by providing that, where the coroner is not available, another coroner or a Justice of the Peace by standing arrangement with the coroner who is not available can authorise the release of the deceased’s body, or a Chief Coroner can authorise the release of the body or direct another coroner to do so. We agree that the word “release” should be substituted for “disposal”.

PART IV – INQUESTS

Definition of “inquest”

- 356 A number of submissions commented on the Act’s use of the term “inquest”. This point was also frequently raised during consultation. The submission from the Chief District Court Judge’s Chambers stated that:

It is felt that there is some uncertainty about what is meant by an “inquest”. Throughout the Act the terms “opening”, “holding”, “postponing opening”, “opening and adjourning”, “proceeding with” and “completing” are all used with respect to inquests and this creates uncertainty about precisely what the term “inquest covers and consequently, where the coroner’s function starts and where it ends. Clearly this can have implications with regard to the coroner’s power to retain the body or body parts and it is suggested that the term “inquest” be defined to make it clear that it includes the whole process from initial reporting through to (where appropriate) delivering a verdict after a formal hearing.

- 357 The Christchurch coroner, Richard McElrea, commented that:

The Act and its Regulations are clumsily worded in parts. There is a dual use of the word “inquest” which leads to ambiguity. It has the meaning of the coroner’s enquiry from the time that jurisdiction is accepted to the time that the coroner concludes the enquiry and it also has the meaning of “inquest hearing”. A separate definition for each of these concepts would remove that difficulty.

- 358 In its submission, the Coroners’ Council discussed the issues surrounding the definition of “inquest” in some detail. It discusses the Act’s dual use of the term “inquest” and suggests two ways in which this ambiguity could be avoided:

The Act has numerous contradictory uses of the word “inquest”. In some parts it means the wider coroner’s inquiry or investigation

including a public hearing if the case is not discontinued under s 20 or s 28. In other parts it means the public hearing.

One approach would be for section 2 to differentiate between the definition of “inquest” and “inquest hearing”. The inquest would commence at the time, following notification, that the coroner accepts jurisdiction and determines to carry out an enquiry.

If this approach were adopted the definition of “inquest” should exclude a preliminary notification to a coroner (whether or not followed by preliminary investigation by the coroner) where the coroner determines that the coroner has no further interest in the matter in terms of the Act. The preliminary investigation however is part of the proper function of a coroner and occurs also in Britain (see, for example, Jervis, 11th Edition, paragraphs 6–11). In New Zealand, s 12 authorises a coroner to make “any inquiries”. Any reviewed legislation should empower a coroner to carry out any inquiries or investigations preliminary to determining whether an inquest (as newly defined) should be commenced.

An inquest hearing would then follow the determination by a coroner that the matter should proceed to a formal public hearing and not be otherwise determined in terms of the Act.

An alternative approach would be to adopt the concept used in Victoria, Australia (as understood by the writer following a discussion with Mr Graeme Johnstone, State Coroner). There the coroner has express power to investigate with a requirement to hold an inquest (i.e. in the sense of a hearing) in certain categories of death, and with a discretion to hold an inquest (again meaning a public hearing) in other cases. This is not too far from the scheme under the existing New Zealand legislation.

The Victorian practice differs in the giving of “Chambers Findings” (without a public hearing) in some cases. The closest provisions New Zealand coroners have are sections 20 and 28. The “prescribed form” referred to in s 20(2) does not envisage a more extended finding. The Coroners’ Council notes that there is some discrepancy in practice by New Zealand coroners in exercising discretion under s 20. For example some coroners may not hold an inquest hearing in road crash cases, or deaths by drowning.

In summary the Coroners’ Council recommends that the definition of inquest (however defined) be used consistently in the Act and that coroners be empowered to carry out all investigations and inquiries preliminary to an inquest, and incidentally be properly remunerated for same.

- 359 The Coroners’ Council identified how the term “inquest” is used in various sections of the Act. For example, in sections 7(a), 20 and 25 it has the meaning of “inquest hearing”.

- 360 Several Australian Coroners Acts define the term “inquest”.¹⁰¹ The Acts do not define when an inquest begins or when it ends. Generally, the Acts provide that an “inquest” is or includes a “formal hearing by the court” or is an “inquest for the purpose of inquiring into the death of a person”. Similarly, the Coroners Rules 1984 (UK) provide that an “inquest” means an inquest for the purpose of inquiring into the death of a person.
- 361 The Law Commission accepts that the term “inquest” needs to be clarified in the Act. We favour the first approach proposed by the Coroners’ Council. By including separate definitions for the terms “inquest” and “inquest hearing” in section 2 and using these terms consistently throughout the Act, the role of the coroner at each stage of the coronial process is much more easily ascertained. We also agree that one of the coroner’s powers under the Act should be to carry out any inquiries or investigations preliminary to determining whether an inquest (as newly defined) should be commenced.

Purpose of inquests

- 362 Section 15(1) sets out the purpose of inquests. The Coroners’ Council suggested that the equivalent Victorian provision be examined with a view to the possible extension of section 15(1)(b).
- 363 Section 15(1)(b) provides that a coroner holds an inquest for the purpose of:
- (b) Making 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.
- 364 Section 19(2) of the Coroners Act 1985 (Victoria) provides that:
- (3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
- 365 The Law Commission favours expanding section 15 to provide that a coroner may comment on any matter connected with a death including public health or safety or the administration of justice.

¹⁰¹ Coroners Act 1996 (WA), s 3; Coroners Act 1958 (Qld), s 5; Coroners Act 1997 (ACT), s 3; Coroners Act 1980 (NSW), s 4; Coroners Act 1995 (Tas), s 2; Coroners Act 1985 (Vic), s 2.

Adverse comments

- 366 Section 15(2) deals with comments made by coroners in the course of, or as a consequence of, an inquest. It provides that:
- ...a coroner may in the course of or as part of the findings of an inquest, comment on the conduct, in relation to the circumstances of the death concerned, of any person; but—
- (a) Shall not comment adversely on any dead person without,—
 - (i) Indicating an intention to do so; and
 - (ii) Adjourning the inquest for at least 7 days; and
 - (iii) Notifying every member of the person’s immediate family who during the adjournment requests the coroner to do so of the proposed comment; and
 - (iv) Giving every such member a reasonable opportunity to be heard in relation to the proposed comment; and
 - (b) Shall not comment adversely on any living person without taking all reasonable steps to notify the person of the proposed comment, and giving the person a reasonable opportunity to be heard in relation to the proposed comment.
- 367 The submission from the Chief District Court Judge’s Chambers commented that the requirements of section 15(2)(a) act as a real constraint on coroners and are unworkable in practice. It stated that the mechanism in section 15(2)(a) for adverse comment in relation to dead persons should be drafted in similar terms to the mechanism for adverse comment in relation to living persons detailed in section 15(2)(b).
- 368 The submission from the Office of the Privacy Commissioner stated that instances have been reported in the media where coroners have not followed the procedures set out in section 15(2). It suggested therefore that our report might usefully address the area of “adverse comment” either by reforming section 15 or by considering steps to ensure that its requirements are complied with.
- 369 The Coroners’ Council recommended that section 15(2)(a)(ii) be deleted since section 15(2)(a)(iv) requires the coroner to give designated persons a reasonable opportunity to be heard. Alternatively, they stated that section 15(2)(a) and section 15(2)(b) could be merged to the effect that notice should be given of proposed adverse comment to all parties represented or having an interest in the outcome of an inquest, including the immediate family of a deceased person, with an opportunity to be heard.
- 370 Section 55 of the Coroners Act 1997 (Australian Capital Territories) provides that a coroner cannot include in a report any adverse comment about a person unless the coroner has first taken all reasonable steps to give the person a copy of the proposed

comment. The coroner must also advise the person that within a specified period the person may make a submission to the coroner about the comment.

- 371 The Law Commission agrees that section 15 needs to be reworked. In our view, section 15(2)(a) should be drafted in similar terms to section 15(2)(b). However, the notification requirements of section 15(2)(a) will differ. As suggested previously, under section 15(2)(a) the coroner must ensure that the following people are notified:
- (a) the family representative or kaitiaki (see paragraphs 275–286), where one has been appointed under section [x]; and
 - (b) every member of the deceased’s immediate family who has asked to receive notification and who has left his or her contact details with the coroner or the coroner’s agent; and
 - (c) any other person or organisation who, in the opinion of the coroner, has a sufficient interest in receiving notification and whose contact details are reasonably accessible.

Deaths into which inquests must be held

- 372 Section 17 of the Act provides that a coroner must hold an inquest if a reported death appears to have been a suicide. The Christchurch coroner, Richard McElrea, stated that:

The issue of whether it is necessary to have compulsory inquests for suicides should be considered. This category of inquest is not compulsory in Australia. Suicide cases can be considered as relatively “routine”, but increasingly they are becoming more complex. This is especially so where there is a “mental health” background.

- 373 Mr McElrea also commented that:

There could be a case for a “chambers finding” (to use a colloquial Australian coroners’ phrase) short of holding a full inquest. There already is disparity within New Zealand as to whether inquests are held in cases, for instance, of road crashes. In my opinion there should not be a single road crash which is not subject to an inquest hearing.

- 374 Similarly, the Coroners’ Council submitted that:

Concerning suicide inquests, it is the experience of Coroners’ Council members that family attending suicide hearings frequently obtain comfort and benefit from the process. Suicide hearings have special significance if there are background features such as a mental health history.

Consideration could be given (in the interests of consistency including that of data collection) to increasing the category of “compulsory inquests”. These might include road crashes, drownings, deaths from fire, drug overdoses . . .

375 In our view, this is a matter that a Chief Coroner may wish to explore. It requires further discussion and input from coroners and other interested bodies before it can be progressed, and an Office of Chief Coroner would be best placed to co-ordinate such discussion.

Decision whether or not to hold an inquest

376 Section 20 concerns the coroner's decision whether or not to hold an inquest. Section 20(1) sets out a number of matters that the coroner must have regard to in determining whether or not to hold an inquest. For example, section 20(1)(a) provides that, in determining whether or not to hold an inquest, a coroner shall have regard to whether or not the causes of the death concerned appear to have been natural. Section 20(1)(b) provides that in the case of a death that appears to have been unnatural or violent, the coroner shall have regard to whether or not it appears to have been due to the actions or inaction of any other person.

377 The Coroners' Council submitted that section 20(1)(b) should not be limited to deaths that appear to have been unnatural or violent. Some deaths that appear natural may have been caused by preceding unnatural events. The Council considers that in determining whether or not to hold an inquest, a coroner should be able to have regard to whether or not the death appears to have been due to the actions or inaction of any other person in any case.

378 The Law Commission accepts that there is merit in this suggestion. Accordingly, we recommend that section 20(1)(b) be amended to provide that a coroner shall have regard to "whether or not the death appears to have been due to the actions or inaction of any other person".

Ability of the family to request an inquest

379 One submission stated that families should have the right to request an inquest. This right is provided for in some Australian states.

380 Section 26(2) of the Coroners Act 1995 (Tasmania) provides that within 14 days after receiving notice of a decision by a coroner not to hold an inquest into a death, the senior next of kin of the deceased person may apply to the Supreme Court for an order that an inquest be held. Section 27 provides that a person who a coroner considers has a sufficient interest in a death may request the coroner to hold an inquest into the death. If the coroner decides not to hold an inquest after receiving such a request, the person who requested the inquest may apply to the Supreme Court for an order that an inquest be held.

- 381 Similarly, section 7B of the Coroners Act 1958 (Queensland) provides that the following people may request the coroner to hold an inquest: the commissioner of the Police Service; an inspector of Police; the husband or wife, father, mother, sister, brother, son, daughter, or guardian of the deceased person concerned; or any other person having, in the opinion of the coroner, a sufficient interest in the cause and circumstances of the deceased person's death. The coroner may require a statement in writing of the grounds for such a request. If the coroner is of the opinion that such grounds do not warrant the holding of an inquest, the coroner may refuse to hold the inquest.
- 382 Section 24 of the Coroners Act 1996 (Western Australia) provides that if a person asks a coroner to hold an inquest into a death which a coroner has jurisdiction to investigate, the coroner may hold an inquest or ask another coroner to do so or refuse the request and give reasons in writing within seven days. Within seven days after receiving notice of the refusal, the person who made the request may apply to the Supreme Court for an order that an inquest be held.
- 383 The Law Commission considers that families should have the right to request an inquest. We recommend that provision for this right in the Act be modelled on similar provisions in the Tasmanian and Western Australian legislation.

Joint inquests

- 384 The Coroners' Council commented that provision should be made to enable a Chief Coroner to authorise a joint inquest. This allows for patterns of death to be more thoroughly investigated.
- 385 Section 50 of the Coroners Act 1995 (Tasmania) provides that the Chief Magistrate (equivalent to our proposed Chief Coroner) may direct that two or more deaths, fires and/or explosions be investigated at the one inquest. Section 26 of the Coroners Act 1958 (Queensland) states that where the deaths of two or more people appear to have been caused by the same incident, the coroner may hold the inquests into the deaths concurrently. Section 40 of the Coroners Act 1996 (Western Australia) provides that the State Coroner may direct that more than one death be investigated at one inquest.
- 386 The Law Commission agrees that provision should be made in the Act to enable a Chief Coroner to authorise a joint inquest. Such a provision enhances the potential of the coronial system to identify patterns of death and make recommendations on the avoidance of

circumstances similar to those in which particular deaths occurred. It is one means for the background factors contributing to deaths to be subject to broad appraisal.

Which coroner to hold inquest

387 Section 22(1) provides, with some exceptions, that every inquest shall be held by the coroner to whom the death concerned was reported. Section 22(2) allows a coroner to authorise another coroner to hold an inquest where he or she believes there is good reason to do so.

388 The Coroners' Council stated that section 22(1) is unduly specific:

There are instances where a death is reported to a coroner, and it is appropriate for another coroner to hold the inquest. (For example, in the Christchurch office, two coroners work in the same office and by arrangement one coroner or the other conducts an inquest regardless of who the death was reported to.)

389 The Law Commission accepts that there are instances where it may be appropriate for a coroner other than the coroner to whom a death is reported to hold an inquest. In our view, these situations should be covered by the exception in section 22(2). However, we consider that there is merit in expanding section 22(1) to specifically allow coroners (including deputy coroners) who work in the same region to divide their workload as they think fit or as directed by a Chief Coroner.

Notice of an inquest

390 Section 23 provides:

- (1) The coroner who is to hold an inquest shall fix a date, time, and place for it, and shall direct the Commissioner of Police to cause a member of the Police to give notice of the date, time, and place to every person—
 - (a) Who has a sufficient interest in the inquest or its outcome; or
 - (b) Whom the coroner has directed to be notified.
- (2) Those to be notified under subsection (1) of this section shall include—
 - (a) The immediate relatives of the person concerned; and
 - (b) Any doctor who attended the person—
 - (i) Immediately before death; or
 - (ii) In the case of a person who had been ill before death, during the illness; and
 - (c) Every person whose conduct, in the opinion of the senior member of the Police in the place where the inquest is to be held or the coroner, seems likely to be called into question; and

- (d) Every life insurance company known by the member of the Police concerned or the coroner to have issued a policy on the person's life; and
 - (e) The Life Offices Association of N.Z. Inc.; and
 - (f) Where the person's death appears to have arisen out of the person's employment,—
 - (i) Any industrial union registered under the Labour Relations Act 1987 of which the person was a member; and
 - (ii) The Secretary of Labour; and
 - (g) Where section 206 of the Mining Act 1971 or section 177 of the Coal Mines Act 1979 or section 71 of the Quarries and Tunnels Act 1982 applies to the death, an Inspector of Mines, Coal Mines, or Tunnels (as the case may be).
- (3) A failure to comply with subsection (1) of this section does not affect the validity of any action.
- (4) Subsection (3) of this section does not limit or affect the effect of section 40 of this Act.

391 Richard McElrea commented that some of the provisions of section 23, regarding details and notice of an inquest, appear to be obsolete or now of less relevance than they were in 1988. Similarly, the Coroners' Council stated that section 23(2), which relates to those who must be notified under this section, is unduly prescriptive and contains an emphasis that may no longer be relevant. The Council submitted that a more general provision should be drafted. This should provide for notice to be given to any person or organisation known to the coroner to have a sufficient interest in the inquest.¹⁰²

392 The Law Commission agrees with the Coroners' Council that the notification provisions in section 23 should be drafted more generally. As with other notification requirements in the Act, we recommend that the coroner must ensure that the following people are notified:

- (a) the family representative or kaitiaki (see paragraphs 275–286),¹⁰³ where one has been appointed under section [x]; and
- (b) every member of the deceased's immediate family who has asked to receive notification and who has left his or her contact details with the coroner or the coroner's agent; and
- (c) any other persons or organisations who, in the opinion of the coroner, have a sufficient interest in receiving notification and whose contact details are reasonably accessible.

¹⁰² See also the discussion concerning "immediate family" at paras 304–315.

¹⁰³ See paras 275–286.

393 In our view, it is not necessary to stipulate that it is for the Police to give notice of the date, time and place to every person to be notified under section 23. We envisage that a co-ordinator may take on this role. The practical considerations of giving notice can be addressed in guidelines from an Office of Chief Coroner.

394 The Department of Corrections stated that:

All interested parties should be given a minimum of 10 working days notice of an inquest. Currently section 23 of the Act requires the coroner to direct a member of the Police to give notice to those specified in section 23(1). However there is no requirement for a minimum period of notice. Unfortunately there have been a number of instances when the Department has received minimal notice (less than 24 hours) of an inquest. This has caused problems in terms of arranging for the relevant Inspector of Prisons and prison staff to attend the inquest, and (in some instances) arranging for legal counsel to represent the Department's Public Prisons Service at the inquest. There have also been instances when an inquest, which has been scheduled for some months, has had to be postponed due to an administrative oversight by the inquest officer in booking the courtroom. Needless to say, this has also put undue pressure on the deceased inmate's family.

395 At present, the lack of support systems for coroners means that it is not always possible to give a reasonable amount of notice that an inquest is to be held. In particular, coroners must often make last minute decisions to hold inquests to capitalise on court space as it becomes available. However, under the enhanced system for which the Law Commission contends, we agree that all interested parties should be given a minimum of 10 working days notice of an inquest.

Places where inquests may be held

396 The Coroners Act does not stipulate whether inquests may be held at places other than in a court. Section 25A(2) of the Coroners Act 1958 (Queensland) provides that an inquest may be held in any place whatsoever.

397 The Law Commission considers that there is merit in adopting a similar provision in New Zealand. We recommend that the Coroners Act be amended to allow for an inquest to be held in places other than a court, provided there is access to the facilities necessary for the holding of an inquest, including the giving and recording of evidence, and that the family does not object.

Inquests to be public

398 Section 25 provides that inquests are to be held in public, but a coroner may exclude any persons, or prohibit the publication of any evidence given at the inquest or any other part of the proceedings of an inquest, if “satisfied that it is in the interests of justice, decency, or public order to do so”.

399 The Coroners’ Council submitted that:

The requirement that inquest (hearings) are to be in public is a cornerstone of the inquest process in New Zealand. The Coroners’ Council would be concerned if this was eroded.

The Coroners’ Council has discussed the phrase “justice, decency or public order” and notes that the exercise of the discretion as to prohibition of publication by coroners varies up and down the country.

The Council believes that coroners should have limited power to prohibit publication of evidence. Overseas jurisdictions may be of relevance. Mr Johnstone [the State Coroner for Victoria] advises that the equivalent power in Victoria is limited to where publication is likely to prejudice the fair trial of a person (covered in another way under s 28 of the Coroners Act 1988) or if it is contrary to the public interest. This would appear to have merit in the context of any review of our legislation. (Mr Johnstone advises that it is used sparingly.)

400 The Christchurch coroner, Richard McElrea, stated that the categories in section 25 are too vague and the section needs review. In particular, he comments that:

Some evidence gathered at an inquest hearing is very personal and the coroner should have authority to limit access to . . . material both in terms of class of persons who can access same, and in terms of a time period. For instance, medical records obtained in an inquest invariably contain information obtained under medical privilege. Privacy issues arise.

401 In discussing a recent instance where sensitive personal information about a deceased person was widely published in the media, the submission from the Office of the Privacy Commissioner stated that:

This . . . calls into question how appropriately coroners exercise the discretion to exclude persons or prohibit publication of any evidence under s 25, and whether this provision is wide enough to cover, for example, coroners’ comments made during an inquest prior to making a finding on the cause of death. Consideration might also be given to whether privacy (both of dead and living persons) should be

added to the grounds in s 25 for a coroner to prohibit publication of evidence.

- 402 Each of the Australian Coroners Acts have provisions dealing with the holding of inquests in public.¹⁰⁴ In general, the Acts provide that inquests are to be held in public but that the coroner can exclude any person if the coroner thinks it desirable in the public interest, “in the interests of the administration of justice, national security, or personal security”, or other similar expression. Several of the Acts also provide that the coroner can prohibit the publication of any details of the proceedings.
- 403 The Law Commission acknowledges the importance of the requirement that inquest hearings be in public. Notwithstanding this fact, in some instances we consider that the interests of justice are best served by restricting access to particularly sensitive information. Intensely private information is not disclosed in cases of natural death and so should not be easily accessible in coronial cases. We agree with the Office of the Privacy Commissioner that privacy should be added to the grounds in section 25 for a coroner to prohibit publication of evidence. However, it is important that the power to prohibit publication of evidence is used sparingly and that practices around the country are consistent. We envisage that a Chief Coroner would develop guidelines to assist coroners to strike an appropriate balance between the interests of the public in accessing information and the rights of individuals to privacy.

Evidence at inquests

- 404 Section 26 deals with the way evidence is given and recorded. Section 26(6) provides:

A coroner shall not admit any evidence at an inquest unless satisfied that its admission is necessary or desirable for the purpose of establishing any matter specified in section 15 (1) (a) of this Act.

- 405 Section 15(1) provides:

- (1) A coroner holds an inquest for the purpose of—
- (a) Establishing, so far as is possible,—
 - (i) That a person has died; and
 - (ii) The person’s identity; and
 - (iii) When and where the person died; and

¹⁰⁴ Coroners Act 1958 (Qld), s 30A; Coroners Act 1997 (ACT), s 40; Coroners Act 1996 (WA), s 45; Coroners Act 1985 (Vic), s 47; Coroners Act 1997 (NT), s 42; Coroners Act 1995 (Tas), s 56; Coroners Act 1980 (NSW), s 44; Coroners Act 1975 (SA), ss 16, 18.

- (iv) The causes of the death; and
- (v) The circumstances of the death; and
- (b) Making 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.

406 The submission from the Chief District Court Judge's Chambers suggested that section 26(6) should also be extended to section 15(1)(b). It stated that the function of a coroner in making recommendations and comments under section 15(1)(b) is also an important one and one which realistically requires the hearing of evidence.

407 The Law Commission agrees that there is merit in extending section 26(6) to section 15(1)(b).

408 The Invercargill coroner, Trevor Savage, commented on other aspects of section 26 of the Act. He submitted that the procedure permitted by section 26(7) is nearly always adopted in practice. He stated that whether the procedure is adopted should be totally within the discretion of the coroner and therefore section 26(7)(b) should be removed. Section 26(7) provides that:

- (7) Notwithstanding subsection (1) of this section, a witness at an inquest may give any evidence by tendering a previously prepared written statement and confirming it on oath if—
 - (a) The coroner is satisfied that there is no reason making it desirable for the witness to give the evidence orally; and
 - (b) No person attending the inquest who is entitled to cross-examine the witness objects.

409 In the light of section 35 of the Act, which clothes coroners with the powers, privileges, authorities and immunities of District Court judges, the Law Commission accepts that the procedure to be adopted in the giving of evidence should appropriately be within the discretion of the coroner. We recommend that section 26(7)(b) be removed.

410 Mr Savage also commented on section 26(9), which requires that any transcript of evidence given orally at an inquest be read over and signed by a witness. He stated that this requirement is very cumbersome in practice and that:

It is not a requirement that applies in the High Court or the District Court¹⁰⁵ and I see no reason why inquests should be any different.

¹⁰⁵ It is a requirement for the taking of depositions only.

411 Similarly, the Coroners' Council stated that, while section 26 works well in practice, section 26(9) needs to be adjusted to take account of varying processes for recording evidence:

It is not necessary in all situations that evidence be read over and signed. We query why the Coroner's Court has different requirements in this regard compared to the District Court or High Court. The complexity of modern inquests requires immediate access to notes of evidence.

412 The Law Commission accepts that the complexity of modern inquests requires immediate access to notes of evidence. Given that our recommendations are intended to integrate the Coroner's Court into the general court system, we agree that the requirements concerning the recording of evidence in the Coroner's Court should reflect similar requirements in the District and High Court.

Expert evidence

413 The Land Transport Safety Authority (LTSA) noted that:

the review does not appear to address the issue of coroners identifying appropriate experts from whom to seek technical advice. The LTSA is particularly concerned that appropriate engineering expertise is used before coroners make recommendations on changes to motor vehicle or roading safety standards.

414 The LTSA considered that the development of "preferred providers" lists would be beneficial.¹⁰⁶

415 The Law Commission considers that this is a matter for guidelines from an Office of Chief Coroner.

Disclosure of documents

416 The Coroners' Council submitted that:

Coroners presently have no statutory power to order the disclosure of documents by persons or bodies having an interest in an inquest. There is power pursuant to s 20 of the Summary Proceedings Act 1957 (by virtue of s 35 of the Coroners Act) to issue summonses for the attendance of witnesses and the production of documents. There may be several persons or bodies having an interest in an inquest, each of which holds papers or records which the Court and other interested persons need to see. The Coroners' Council recommends that coroners be clothed with such power.

¹⁰⁶ Land Transport Safety Authority, meeting with the Law Commission, 16 November 1999.

- 417 The Department of Corrections made a similar point with regards to government agency reports. They stated that there is a need to clarify the Coroners Act in relation to a coroner's ability to require a government agency to provide a copy of a report for the purposes of an inquest, where that report has been primarily prepared for the agency's internal purposes.
- 418 Section 46(1) of the Coroners Act 1996 (Western Australia) provides:
- (1) If a coroner reasonably believes it is necessary for the purpose of an inquest, the coroner may—
 - (a) summon a person to attend as a witness or to produce any document or other materials;
 - (b) inspect, copy and keep for a reasonable period any thing produced at the inquest;
 - (c) order a witness to answer questions;
 - (d) order a witness to take an oath or affirmation to answer questions; and
 - (e) give any other directions and do anything else the coroner believes necessary.
- 419 The Law Commission considers that one of the coroner's powers under the Act should be to order any person or body having an interest in the inquest to disclose documents relevant to the inquest where the coroner believes it is necessary for the purpose of an inquest.

Power to impound documents

- 420 The Invercargill coroner, Trevor Savage, commented that a coroner can summons a witness to give evidence and to produce documents, and he or she can also commission reports. He noted, however, that there is no power to impound documents or other items likely to be useful as evidence.¹⁰⁷
- 421 The Coroners' Council stated that:
- The Police, as the coroner's officers, have no power to enter private property and to seize documents or things relevant to a coroner's enquiry. Australian coroners have such a power. The Council recommends that the Act be amended so as to empower the Police to act accordingly.
- 422 The Council noted that Police may currently enter private property only pursuant to a search warrant issued upon proof of a reasonable

¹⁰⁷ Trevor Savage, letter to the Law Commission, 11 January 2000.

belief that there has been the commission of a crime. However, suicide, for example, is not a crime. A person who later commits suicide may leave notes on a computer at their home or work place. If a resident at that person's home or the employer of such a person refuses the Police access to premises, the Police are unable lawfully to seize evidence that may be vital to the inquest that the coroner is required to hold.

- 423 Section 59 of the Coroners Act 1995 (Tasmania) sets out a number of powers of entry, inspection and possession of documents. Section 66 of the Coroners Act 1997 (Australian Capital Territory) provides that a coroner may issue a warrant authorising a police officer to do a number of things, including to seize any document or thing relevant to the inquest. The coroner is authorised to retain possession of the document or thing for such period as is necessary for the purposes of the inquiry or inquest. Section 33 of the Coroners Act 1996 (Western Australia), section 19 of the Coroners Act 1997 (Northern Territory), and section 26 of the Coroners Act 1985 (Victoria) provide that a coroner may enter any place and take possession of anything which the coroner reasonably believes is relevant to the investigation and keep it until the investigation is over. Section 13(1)(c) of the Coroners Act 1975 (South Australia) provides that the coroner may enter any place and remove anything.
- 424 The Law Commission accepts the arguments of the Coroners' Council regarding powers of entry, inspection and possession of documents. However, before coroners are clothed with similar powers to their Australian counterparts, we consider that further investigation as to the ramifications of a power to impound documents is required.

Procedure where person charged with offence

- 425 Section 28 sets out the procedure to be followed where a person is charged with an offence relating to the death or some other inquiry into the death is to be held. The Coroners' Council stated that section 28 needs redrafting as it is convoluted and very difficult to follow. Section 28 provides:
- (1) Subject to subsection (4) of this section, a coroner to whom a death has been reported may postpone opening an inquest into the death, open an inquest into the death and then adjourn it, or adjourn an inquest already opened into the death, if the coroner—
 - (a) Has been informed that some person has been or may be charged with a criminal offence relating to the death or its circumstances; and

- (b) Is satisfied that to open or (as the case requires) proceed with the inquest might prejudice the person;—
and in that case the coroner shall not open or proceed with the inquest until criminal proceedings against the person have been finally concluded.
- (2) Subsection (1) of this section does not limit or affect the effect of section 31 of the Births and Deaths Registration Act 1951.
- (3) Subject to [subsection (5)] of this section, a coroner to whom a death has been reported may postpone opening an inquest into the death, or adjourn an inquest already opened into it, if satisfied that—
- (a) An inquiry into the death or the circumstances in which it occurred is being or is likely to be held under some enactment other than this Act; and
- (b) Either—
- (i) The matters specified in section 15 (1) (a) of this Act are likely to be established in respect of the death at the inquiry; or
- (ii) To open or continue with the inquest would be likely to prejudice the inquiry or some person interested in it.
- (4) A coroner who has postponed or adjourned an inquest under subsection (1) of this section may later open or resume it if satisfied that to do so would not prejudice the person charged or thought likely to be charged with a criminal offence relating to the death or its circumstances.
- (5) A coroner who has postponed or adjourned an inquest under subsection (3) of this section may open or resume it if satisfied that—
- (a) An inquiry into the death or the circumstances in which it occurred is not likely to be held under any enactment other than this Act; or
- (b) Such an inquiry is being or is to be held, but—
- (i) The matters specified in section 15 (1) (a) of this Act are unlikely to be established in respect of the death at the inquiry; and
- (ii) To open or resume the inquest will not prejudice the inquiry or any person interested in it.
- (6) Notwithstanding section 17 of this Act, a coroner may decide not to open or resume an inquest postponed or adjourned under this section if satisfied that the matters specified in section 15 (1) (a) of this Act have been adequately established in respect of the death concerned in the course of the criminal proceedings or inquiry concerned (whether finally concluded or not).
- (7) A coroner who decides not to open or resume an inquest under subsection (6) of this section shall give the Secretary written notice of the decision.
- (8) If no appeal (or, as the case requires, no further appeal) can be made in the course of any criminal proceedings unless the High Court or Court of Appeal grants an extension of time, the proceedings are finally concluded for the purposes of this section.

426 The Christchurch coroner, Richard McElrea, commented that section 28 is “obtuse and obscure”. In his presentation to the 1999 Coroners’ Conference, David Crerar discussed some of the problems with the section. He noted that:

Trevor Savage has looked at the problem and considers the wording of section 28(1) which seems to apply when criminal charges are brought as curious . . . What started out as discretionary becomes mandatory. Section 28(4) deals expressly with continuing the inquest if criminal proceedings have been brought but seems to contemplate that those criminal proceedings have not yet been concluded . . .

Section 28(3) . . . has become the focus of recent attention within the Wellington coroner’s jurisdiction in relation to the Maria Luisa Fishing Boat sinking. The coroner’s office was under pressure from one party to hold an inquest and from another party not to hold an inquest. A coroner should following sub section 3 postpone or adjourn an inquest if the coroner is satisfied as to both (a) and one of the alternatives in (b).

The attention of coroners . . . is drawn to the decision of *Hugel v Cooney*. This is the definitive legislation confirming the decision of Tauranga coroner, Michael Cooney, to continue with [an inquest into a particular death after the anaesthetist involved was prosecuted for manslaughter].

Section 28(5) deals with the coroner resuming an inquest where there is some other inquiry but again the sub clause deals only with the situation where the other inquiry has not yet been concluded. Where the other inquiry has been concluded a discretion not to continue the inquest arises under section 28(6) if the coroner is satisfied that the matters specified in section 15(1)(a) have been adequately established. The decision not to continue is still discretionary so that even if a coroner was satisfied as to section 15(1)(a) matters the coroner could still continue for the purposes of considering section 15(1)(b).¹⁰⁸

427 Section 53 of the Coroners Act 1996 (Western Australia) provides that:

- (1) Where a coroner is informed that some person has been charged with an offence in which the question whether the accused person caused a death is in issue—
 - (a) the coroner must not commence to hold an inquest into the death until the proceedings in respect of the offence have been concluded; or
 - (b) if the coroner has already commenced an inquest into the death, the coroner must adjourn the inquest until the proceedings in respect of the offence have been concluded.

¹⁰⁸ David Crerar (paper presented to the 1999 National Coroners’ Conference, Wellington, 4–5 September 1999).

- (2) The finding of the coroner on an inquest into a death must not be inconsistent with the result of any earlier proceedings where a person has been charged on indictment or dealt with summarily for an indictable offence in which the question whether the accused person caused the death is in issue.
- (3) In this section, proceedings are to be taken to have been concluded when no appeal, or no further appeal, can be made, without an extension of time being granted.

428 The Law Commission agrees section 28 is difficult to follow and needs redrafting. We consider that it is appropriate for this provision to be drafted in more general terms, along similar lines to section 53 of the Coroners Act 1996 (Western Australia). An Office of Chief Coroner could issue guidelines to assist in the application of this section.

Counsel to assist the coroner

429 The Crown Law Office commented that there should be an express provision in the Act authorising coroners to appoint legal counsel to assist, but with controls so that counsel are not appointed unnecessarily. It reasons that such specific authorisation is necessary:

given the increasing trend toward legal representation of parties at inquests and the consequential requests for coroners (even those with a legal background) to seek counsel to assist . . .

430 Similarly, the Deputy coroner in Auckland, Sarn Herdson, made the point that the Act should allow a coroner to obtain independent legal advice where necessary. She expanded on this point in a separate submission. She explained that:

Very occasionally, there may be a special fixture inquest which involves a number of parties, and is beyond the ordinary, and is one where the coroner needs independent legal assistance for himself/herself.

431 Sarn Herdson cited one of her recent files where criticisms had been directed at a District Court judge and the Department for Courts, both of whom were legally represented, as well as at the Police and the Department of Corrections. The Police instructed the Crown Solicitor's office to represent their interests. Once that had occurred, Sarn Herdson considered it inappropriate for the coroner to also seek advice from the Crown Solicitor's Office:

It felt too close for comfort to have [the Crown Solicitor's Office] representing the Police, and at the same time to also be advising me about things which could have resulted in my needing to criticise the Police . . . I felt it was important to have some distance between "the

Court” and “the Police” in this particular situation. Furthermore, there was a very real awkwardness with criticism of the District Court judge and/or the Department for Courts, and those matters being put before me in the Coroner’s Court.

432 Sarn Herdson noted that the Department for Courts and the Crown Law Office agree the Coroners Act is unhelpful in providing for a situation where a coroner requires independent representation. She emphasised that an inferior court has the right to do what is necessary to enable it to exercise the functions, powers and duties conferred on it by statute.¹⁰⁹ She also pointed out that while the inquest process is inquisitorial rather than adversarial, there are examples of counsel assisting in Royal Commissions as well as lesser status inquiries.¹¹⁰

433 In conclusion, Sarn Herdson stated that:

Certainly the simple issue of counsel assisting the Court needs attention, even if my particular example above is considered extraordinary and the exception rather than the rule. This might require a change in legislation, or regulation, or formal legal opinion. Whatever occurs, I think that some thought needs to be given to how such a situation is dealt with and the process a coroner needs to go through to obtain help of this nature, who pays etc.

434 The Law Commission recommends that the Act be amended to enable a coroner to obtain independent legal advice where necessary. We consider that this is best achieved by authorising a Chief Coroner, on the application of a coroner, to appoint independent legal counsel to assist the coroner if the Chief Coroner is satisfied that it is necessary or desirable to do so. We envisage that an Office of Chief Coroner will issue guidelines to assist coroners in deciding when they need to obtain independent legal advice. A Chief Coroner could liaise with the Department for Courts and the Ministry of Justice in order to devise an appropriate process for a coroner to go through to obtain help of this nature and to discuss funding implications.

¹⁰⁹ Sarn Herdson, email to the Law Commission, 23 February 2000. Ms Herdson referred to a recent paper by Raynor Asher QC where authority for this point is cited and the *amicus curiae* (the District Court equivalent of counsel to assist) is discussed.

¹¹⁰ Such as the “Winebox” inquiry and the inquiry into the physiotherapy treatment of babies at National Women’s Hospital.

Publication of details of self-inflicted deaths

- 435 Sections 29 and 30 concern publication of details of self-inflicted deaths. The submission of the Office of the Privacy Commissioner commented that:

Where a coroner has found a death to be self-inflicted, s.29 provides that without the authority of a coroner no person shall make public any particular of the death other than the name, address and occupation of the person concerned, and the fact that the coroner has found the death to be self-inflicted. No criteria are set out for when a coroner could give authority for such publication. It may be beneficial that criteria for such authority be set out, either in the provision itself, or in guidelines issued by a Chief Coroner, to ensure that the privacy of the dead person and of living persons connected with them be suitably, and consistently, protected.

- 436 In the interests of consistency and protecting the privacy of deceased persons and of living persons connected with them, the Law Commission recommends that an Office of Chief Coroner develop guidelines governing when a coroner can or should give authority for the publication of details relating to a potentially self-inflicted death.

Interim findings

- 437 The Christchurch coroner, Richard McElrea, informed us that he sometimes makes an interim finding, where it is necessary to adjourn an inquest for a written decision (or other reason), to assist the family in achieving some form of “closure” at the conclusion of a hearing.
- 438 Section 53 of the Coroners Act 1997 (Australian Capital Territory) provides that a coroner may, at any time before concluding an inquest or inquiry, make an interim finding on any matter connected with the inquest or inquiry.
- 439 The Law Commission recommends that a provision similar to section 53 of the Coroners Act 1997 (Australian Capital Territory) be adopted in New Zealand.

Interim death certificates

- 440 The Invercargill Coroner, Trevor Savage, recommended that there should be a power in the Act to issue some sort of interim death certificate. He noted that where there is to be a formal inquest hearing it is often not possible to avoid delays of several months.

This can cause inconvenience and even hardship to the families of deceased persons because the only death certificate that will be available in the meantime is noted “subject to coroner’s finding”. Insurance companies will not normally pay out without a full death certificate, which is not available until after the conclusion of the inquest.¹¹¹ The informal practice in Christchurch, Rangiora and Invercargill is on limited occasions on request to issue a certificate stating the provisional cause of death. The certificate expressly states that it is issued for limited purposes such as dealing with banks and insurance companies.

- 441 The Law Commission agrees that the Coroners Act should specifically authorise coroners to issue interim death certificates.

PART V – CORONERS

Appointment of deputy coroners

- 442 Richard McElrea submitted that:

The Act provides for a deputy coroner to be appointed (section 32) but does not spell out the relationship between a coroner and the deputy. The whole section needs to be rethought.

- 443 Section 32 provides:

- (1) The Governor-General may from time to time by warrant appoint any person to be a coroner.
- (2) The Governor-General may from time to time by warrant appoint any person to be the deputy of a coroner.
- (3) Subject to the directions (if any) of the coroner, the deputy of a coroner has and may exercise and perform all the powers, duties, and functions of the coroner.
- (4) Neither a vacancy in the office of coroner at any place nor the appointment of a new coroner at any place affects the powers, duties, and functions of a deputy appointed under subsection (2) of this section.
- (5) The fact that the deputy of a coroner exercises or performs any power, duty, or function is conclusive evidence of the deputy’s authority to do so.

- 444 We accept that there are inherent difficulties with section 32 as currently drafted. The section does not stipulate to whom a deputy is responsible, the status of a deputy if a coroner vacates his or her office, or the role of the deputy and his or her relationship to a coroner.

¹¹¹ Trevor Savage, above n 107.

445 Sections 6 and 7 of the Coroners Act 1988 (UK) set out rules in relation to deputy coroners. Section 6 provides that a coroner may revoke a deputy's appointment at any time as long as a replacement is found. Section 7 sets out the deputy coroner's functions. Section 7 provides:

- (1) A deputy coroner may act for his coroner in the following cases but no others, namely—
 - (a) during the illness of the coroner;
 - (b) during the coroner's absence for any lawful or reasonable cause; or
 - (c) at an inquest for the holding of which the coroner is disqualified.
- (2) Where a coroner vacates office, his deputy—
 - (a) shall continue in office until a new deputy is appointed;
 - (b) shall act as coroner while the office remains vacant; and
 - (c) shall be entitled to receive in respect of the period of the vacancy the same remuneration as the vacating coroner.

446 Section 6 Coroners Act 1958 (Queensland) provides that deputy coroners may be appointed. A deputy may be appointed for a fixed time and be for a limited purpose. The deputy coroner has all of the jurisdiction, powers, functions and authorities of the coroner. The deputy coroner is subject to all the obligations and liabilities of the coroner. The deputy may not act as coroner when the coroner is present except at the direction of the coroner. Section 9 of the Coroners Act 1980 (New South Wales) sets out the functions of the assistant coroner. Under the Act, the assistant coroner may provide administrative assistance to the coroner, issue orders for the disposal of dead bodies, issue orders for the performance of post-mortems, and may also dispense with the holding of an inquest if the death is from natural causes.

447 The Law Commission recommends that the Act set out the functions of deputy coroners and clarify the relationship between coroners and deputies.¹¹²

Retirement of coroners

448 Section 33 provides that coroners and their deputies must retire at the age of 68. The Coroners' Council submitted that there should be a provision whereby a coroner who has reached the age of retirement can have his or her warrant renewed, as with District

¹¹² The need for deputy coroners would be one aspect of discussions between a Chief Coroner, the Ministry of Justice and the Department for Courts when reviewing the number of coroners and coronial districts currently in existence, see paras 49–52.

Court judges. Section 33 currently provides that a retired coroner can have his or her warrant renewed for a term not exceeding 12 months. The warrant can not be renewed in consecutive years.

- 449 The Law Commission agrees that coroners should be subject to the same retirement restrictions as District Court judges.

Immunity and indemnity of coroners

- 450 Section 35 of the Coroners Act provides that, for the purposes of exercising or performing any power, function, or duty under this Act, a coroner has the powers, privileges, authorities and immunities of a District Court judge exercising jurisdiction under the Summary Proceedings Act 1957.
- 451 Coroners have for some time been concerned at the effect the Constitution Amendment Bill 1999¹¹³ will have on their immunity if passed into legislation. The Coroners' Council has also noted that section 35 of the Coroners Act neglects to give an indemnity to coroners.
- 452 As with District Court judges, coroners presently enjoy immunity from suit provided they act within their jurisdiction. However, the Constitution Amendment Bill 1999 aligns the immunity of District Court and other judges to that of High Court judges, with the exception of Justices of the Peace, Community Magistrates and coroners. The Coroners' Council submitted that coroners should continue to enjoy the same immunities as District Court judges and therefore that the Constitution Amendment Bill should also align coroners' immunity to that of High Court judges.
- 453 After hearing submissions from interested parties, the Government Administration Committee commented on the position of coroners under the 1999 Amendment Bill. It stated that:

The bill does not align coroners with High Court judges because the Government believes the level of protection for coroners is adequate for a number of reasons. Firstly, coroners largely work on a fee for service basis, and are not necessarily legally qualified. Approximately three or four work full time and the rest work part-time. Secondly, their jurisdiction is relatively narrowly defined by statute, and there is a significant scope for actions without or in excess of jurisdiction.¹¹⁴

¹¹³ At the time of writing, this Bill had been to Select Committee and had its second reading.

¹¹⁴ Constitution Amendment Bill 1999, As Reported from the Government Administration Committee, 274-2, x.

- 454 The reasoning of the select committee accords with the view of the Law Commission, expressed in its 1997 report, *Crown Liability and Judicial Immunity: A Response to Baigent's Case and Harvey v Derrick*. In that report, we stated that coroners should receive the same protection as Justices of the Peace.¹¹⁵ This conclusion was largely based on the fact that a number of submissions on the preliminary paper to that report questioned whether the work of Justices of the Peace and other judicial officers was of sufficient quality, and whether they had sufficient training and experience, to be given blanket immunity from suit.
- 455 The Law Commission has reconsidered the issues surrounding immunity of coroners. We reiterate that the recommendations in this report work as a package to improve the status of coroners and enhance the coronial system generally. Provision is made in this report for coroners to be legally trained, to work full-time, and to receive appropriate training and supervision through an Office of Chief Coroner. An upgrade of the coronial system in this manner is particularly warranted in recent times given the increasing complexity of inquests and the mounting workloads of coroners. In the light of our overall recommendations, we consider that coroners should continue to receive the same immunities as District Court judges. For similar reasons, we recommend that section 35 be amended to provide that coroners have the same indemnities as District Court judges.

Coroners' remuneration and recovery of costs

- 456 The issues of appropriate remuneration and cost recovery mechanisms for coroners were raised consistently by coroners, both in submissions and during consultation. While these matters were not comprehensively dealt with in our preliminary paper, they are crucial in supporting the objectives of this report to improve the coronial system and give coroners a more professional status.
- 457 Coroners' remuneration and ability to recover costs are discussed in Part I of this report (see paragraphs 53–62). We recommend that:
- the Act provides for coroners' remuneration to be fixed by the Higher Salaries Commission as occurs with other judicial officers; and
 - section 45, which allows the Governor-General to make regulations, be amended to authorise the making of regulations

¹¹⁵ New Zealand Law Commission, above n 15, 57.

providing for administrative services to support coroners in carrying out their functions under the Coroners Act, and that such regulations be made.

MISCELLANEOUS PROVISIONS

Solicitor-General may require inquest where new facts discovered

- 458 The Coroners' Council submitted that the Solicitor-General should have the power under section 38 to refer an inquest back to the coroner who heard the case in the first place. They also stated that there may be a role for a Chief Coroner in the context of this section.
- 459 Section 38 provides:
- (1) If satisfied that since a coroner decided not to hold an inquest into a death new facts have been discovered that make it desirable to hold one, the Solicitor-General may order one to be held; and in that case an inquest shall be held.
 - (2) If satisfied that since an inquest was completed new facts have been discovered that make it desirable to hold another, the Solicitor-General may order another to be held; and in that case another shall be held.
 - (3) An order under this section shall be in writing and shall either—
 - (a) Specify the coroner who is to hold the inquest, and be served on that coroner; or
 - (b) Specify that it is to be held by a coroner (being a coroner who has not previously held an inquest into the death concerned) authorised by the Secretary, and be served on the Secretary, who shall serve it on the coroner authorised;—and, subject to section 36 of this Act, the inquest shall be held accordingly.
 - (4) Subsections (1) and (2) of this section are subject to section 16 of this Act [which relates to the jurisdiction of coroners to hold inquests].
- 460 The Law Commission agrees with both of the points made by the Coroners' Council in relation to section 38. In our view, if the Solicitor-General is satisfied that since an inquest was completed new facts have been discovered that make it desirable to hold another, section 38 should provide that the Solicitor-General may direct the Chief Coroner to:
- (a) hold another inquest, or direct any coroner (including the coroner who held or decided not to hold the inquest in the first instance) to hold a new inquest; or

- (b) to re-open, or direct any coroner (including the coroner who held or decided not to hold the inquest in the first instance) to re-open the inquest and re-examine any finding.

Complaints mechanism

461 The Crown Law Office and the Office of the Privacy Commissioner suggested that a Chief Coroner's functions should also extend to include jurisdiction to determine complaints about coroners.

462 The Office of the Privacy Commissioner notes that:

In terms of information issues, there is a review provision in s.30 in regard to coroners' prohibitions of publication of any evidence or proceedings in s.25 and refusals to give authority to make public details of self-inflicted deaths in s.29. There are also a few offence provisions in s.43 including one relating to contravening prohibitions on publishing information. However, there are no readily accessible complaints mechanisms in regard to coroners.

463 The Crown Law Office states that:

Matters relating to procedure or decisions taken at inquests can be addressed under sections 38 and 40 of the Coroners Act or be the subject of an application to the High Court for review. From time to time however there are complaints about coroners that are not really addressed by these options.

While the coronial inquest is an inquisitorial procedure, the coroner is still a judicial officer. In respect of other judges, the practice is for any complaints not appropriate to be dealt with through the appellate structure, to be addressed either to the Chief District Court Judge or to the Chief Justice as the case may be. There is formal provision now for any complaint that should be looked at independently to be referred to the Attorney-General.

In the context of a complaints procedure, I note that coroners can be removed from office for inability or misbehaviour. That is a similar expression to what is used in the District Courts Act. The position in respect of High Court judges is contained in section 23 of the Constitution Act and refers to "grounds of that judge's misbehaviour or of that judge's incapacity to discharge the functions of that judge's office." Given the statutory similarities, a similar complaints process may also be appropriate for coroners as it is for the judges.

464 In the light of the increased status for coroners for which this paper contends, the Law Commission considers that a complaints process similar to that in relation to judges is appropriate for coroners. We agree that the Chief Coroner's functions should extend to include jurisdiction to determine complaints about coroners.

Offences and penalties

- 465 Section 43 sets out a number of offences and penalties for failure to comply with various provisions of the Act.
- 466 The Invercargill coroner, Trevor Savage, noted that there is no sanction in section 43 against anyone other than a doctor who refuses to give a report required under section 12. Section 12 provides:
A coroner may cause to be made any inquiries or examinations, or commission any reports, (medical or otherwise), the coroner thinks proper—
- (a) For the purpose of deciding whether or not to hold an inquest; or
 - (b) Where the coroner is to hold an inquest or has opened and not completed one.
- 467 The Coroners' Council stated that the fines referred to in section 43 should be reviewed.
- 468 In keeping with moves to enhance the status of coroners, the submission from the Chief District Court Judge's Chambers considered that it is now appropriate to increase the penalty for non-compliance with a warrant issued by a coroner to enforce a summons from \$40 to \$1000. The Coroners' Council agrees with this proposition.
- 469 The Law Commission accepts the suggestion of District Court judges that the penalty for non-compliance with a warrant should be increased to \$1000. We also agree with the Coroners' Council that the other penalties in the Act are in need of review. We consider that this is a matter for the Department for Courts and the Ministry of Justice.

Inspection of certificates issued under the Act

- 470 Section 44 provides:
- (1) During ordinary office hours, any person may, without charge, inspect and, upon payment of the prescribed fee, obtain a copy of any certificate or notice given to the Secretary under this Act.
 - (2) During ordinary office hours, any person may inspect and, upon payment of the prescribed fee, obtain a copy of any—
 - (a) Document given by a coroner to the Secretary under this Act, relating to an inquest that was completed during the previous 12 months; or
 - (b) Document given by a coroner to the Secretary under this Act during the previous 12 months relating to a death in respect of which the coroner decided not to hold an inquest.

- (3) Subject to subsection (2) of this section, the availability of documents given to the Secretary under this Act shall be determined in accordance with the Official Information Act 1982.
- (4) Subsections (2) and (3) of this section apply to depositions transmitted to the Secretary under section 24 (2) of the Coroners Act 1951.
- (5) Nothing in this section authorises the publication of any information in contravention of section 29 of this Act or of a prohibition under section 25 (2) (b) of this Act.

471 The submission from the Office of the Privacy Commissioner made a number of comments about section 44. These will be dealt with in turn and relate to:

- whether it is appropriate to make section 44 a public register provision;
- whether it would be possible to restrict access to information that is presently available under section 44;
- the relationship between the Coroners Act, the Privacy Act and the Official Information Act; and
- statutory guidelines for the withholding or release of information under section 44.

472 The Department of Corrections also expressed a number of concerns about the release of information, specifically as regards government agency reports.

473 The Coroner's Court is not an "agency" for the purposes of the Privacy Act 1993. Provisions of the Coroners Act relating to restrictions of the publishing or accessing of information and the making available of information prevail over any inconsistent privacy principles by virtue of section 7 of the Privacy Act. It is therefore to the Coroners Act that one must principally look for an applicable framework of information handling rules, not the Privacy Act.

474 The first suggestion of the Office of the Privacy Commissioner was that it may be appropriate to make the provision under section 44(1) a public register provision by adding it to the Second Schedule of the Privacy Act. The effect of this suggestion is that the privacy principles in Part 7 of the Privacy Act would apply to requests to inspect or obtain a copy of any certificate or notice under section 44(1). The Assistant Privacy Commissioner, Blair Stewart, explained that requests under section 44(1) appear to be straightforward and similar to requests for information held in public registers, where on payment of a fee a person may obtain copies of

particular certificates and notices. Making section 44(1) a public register provision will bring it into line with other legislation.¹¹⁶ A Code of Practice could later be issued by the Office of the Privacy Commissioner after consultation with a Chief Coroner in respect of requests under section 44(1).

- 475 The Law Commission accepts that the suggested change may be sensible as a housekeeping measure. We do not object to section 44(1) being included as a public register provision provided this action does not limit the powers of coroners under the Coroners Act to place restrictions on the publishing or accessing of information.
- 476 Secondly, the Office of the Privacy Commissioner questioned whether it would be possible to restrict access to sensitive information under section 44 to those with a need to know. With certain conditions, section 44 currently allows any person to obtain a copy of any document given by a coroner to the Secretary under the Act. The Office of the Privacy Commissioner stated that:

At present, all documents admitted in evidence at an inquest are publicly available under s.44 for a period of 12 months. Although inquests are conducted in public, subject to s.25, I raise the question of whether all the documentation relating to inquests (and where inquests are decided not to be held) should be so widely available. Perhaps it would be possible to restrict access to some of the sensitive information to those with a need to know, according to the purposes for which inquests are held (as set out in s.15(1)). For example, it may be that immediate family could obtain most or all of the information; agencies that need access to coroners' reports, such as health and safety research agencies, executors and insurance companies, would receive the information they needed for their purposes.

- 477 Similarly, the Department of Corrections stated that the Act needs to be clarified as regards the coroner's ability to direct the release or withholding of government agencies' reports (or parts thereof) which have been provided to a coroner for the purposes of an inquest.
- 478 The restriction of access to sensitive information is a concept supported by the Christchurch Coroner, Richard McElrea. In the context of discussing section 25 of the Act (see paragraphs 399–404), he stated that:

Some evidence gathered at an inquest hearing is very personal and the coroner should have authority to limit access to . . . material both in terms of class of persons who can access same, and in terms of a time

¹¹⁶ Blair Stewart, Assistant Privacy Commissioner, telephone conversation with the Law Commission, 3 April 2000.

period. For instance, medical records obtained in an inquest invariably contain information obtained under medical privilege. Privacy issues arise.

- 479 In general, the Law Commission supports processes that enhance the transparency of the coronial system. However, notwithstanding public accountability issues, much of the information provided to the Secretary under section 44 concerns intensely private matters. Such information is not disclosed in cases of natural death and should not be so widely available in coronial cases. We therefore agree that in some instances, the interests of justice are best served by limiting or restricting access to particularly sensitive information. In our view, coroners should have the ability to place conditions on access to information under section 44. We envisage that a Chief Coroner, after consultation with the Office of the Privacy Commissioner, would develop guidelines to assist coroners in determining when and what conditions are appropriate, including any time limit to be placed on such restrictions.¹¹⁷
- 480 Thirdly, the submission from the Office of the Privacy Commissioner considered that section 44 needs to be amended to bring it into line with the Privacy Act 1993 and the Official Information Act 1993:

Coronial documentation may be accessed under s.44(2). Section 44(3) provides that it is to be made publicly available in accordance with the Official Information Act which would permit privacy grounds to be a reason for withholding personal information. However, s.44(3) is anomalous and should provide that requests for personal information by the individual concerned be determined in accordance with the Privacy Act 1993, with all other requests determined in accordance with the Official Information Act 1982. At the same time s.44(3) was enacted both types of request were dealt with in the Official Information Act. My suggested amendment would bring the provision into line with the general access arrangements Parliament settled in the Privacy Act 1993 and Official Information Amendment Act 1993.

- 481 The Law Commission agrees that the suggested amendment is sensible and ensures that the Coroners Act is not out of line with practices developed by the Privacy Commissioner elsewhere.

¹¹⁷ The Law Commission notes that the Health Information Privacy Code 1994, which came into force on 10 April 2000, incorporates the Department for Courts under s 4(2)(n) in respect of information contained in documents referred to in s 44(2) of the Coroners Act 1988. This amendment applies disclosure controls to the such information, but does not appear to directly affect search requests under s 44.

482 Further, the Office of the Privacy Commissioner considered that it may be desirable for the Act to set out directions for the withholding or release of information under section 44. It stated that:

it may be desirable to supplement s 44(3) with some express statutory guidance about withholding or release of information. At present a 12 month limit is the only express statutory limit (and even that leaves the legal position a little unclear in relation to later requests).

483 We agree with the Office of the Privacy Commissioner that the Act leaves the legal position unclear as regards requests made after the 12-month time frame. We consider that section 44 should provide that where the 12-month limit has expired, information may only be inspected or obtained under section 44 with the written permission of the Secretary. Further, we have recommended above that the withholding or release of information under section 44 should be subject to any directions by the coroner concerned.

APPENDIX A

Summary of part I and part II recommendations

PART I – SYSTEMS AND SERVICES

Chapter 2

- R1 **W**E RECOMMEND THAT the Coroners Act 1988 be amended to provide that coroners be legally qualified.
- R2 We recommend that the Coroners Act, or regulations made under it, set out the appointment process for coroners and the criteria according to which coroners will be selected. Such criteria will include an awareness of tikanga Māori.
- R3 We recommend that the Department for Courts establish suitable post-appointment and ongoing training programmes for coroners. There is a future role for a Chief Coroner to monitor and further develop training programmes.
- R4 We recommend that the Attorney-General's Judicial Appointments Unit publish an application form for those interested in applying for the position of coroner as well as a pamphlet setting 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 for District Court judges by the Unit.
- R5 We recommend that more Māori and persons of other cultures and backgrounds be appointed as coroners.
- R6 We recommend that the Chief Coroner's Office establish a kaiwhakahaere (co-ordinator) position.
- R7 We recommend that the Ministry of Justice and the Department for Courts, in consultation with the Chief Coroner, review the number of coroners and coronial districts currently in existence with a view to regionalising the coronial districts, reducing the number of coroners, and moving to a system of full-time coroners.

R8 We recommend that the Act be amended to provide for coroners' remuneration to be fixed by the Higher Salaries Commission as occurs with other judicial officers.

We also recommend that the Act be amended to authorise the Governor-General to make regulations providing for administrative services to support coroners in carrying out their functions under the Coroners Act 1988 and for the recovery of actual and reasonable disbursements by coroners and that such regulations should be made.

R9 We do not recommend any change to the current arrangement between coroners and Justices of the Peace at this time.

R10 We do not recommend any change to section 34 of the Coroners Act regarding the removal of coroners.

Chapter 3

R11 We recommend that a section be added to the Coroners Act 1988 providing for the appointment of a Chief Coroner. The section should set out a Chief Coroner's functions, which would include the functions listed in paragraphs 72, 73 and 75.

Chapter 4

R12 We recommend that a Chief Coroner's functions include:

- where a coronial recommendation affects an agency or individual, giving notice of that recommendation to the relevant agency or person and taking reasonable steps to ensure that such notification is given before the recommendation is publicly released; and
- inquiring as to the implementation of coronial recommendations, or the reasons why implementation has been postponed or rejected.

R13 We recommend that a section be added to the Coroners Act 1988 that requires a Chief Coroner to produce an annual report from the Office of Chief Coroner. The section would provide that the report may:

- include details of coronial recommendations including the progress of recommendations, the responses received from agencies, and any practical problems with implementing particular recommendations;
- identify the agencies that have chosen not to comply or that, in the opinion of the Chief Coroner, have obstructed the process of compliance; and

- 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.

We also recommend that a synopsis of the annual report from the Office of Chief Coroner be included in the annual report of the New Zealand Judiciary.

- R14 We recommend that where a coronial recommendation concerns a government agency, the Chief Coroner must give notice of that recommendation to the agency concerned, the Minister responsible for that agency, the Attorney-General, and any other agency or individual affected by the recommendation. The government agency must, within three months, report to its Minister the steps it intends to take in relation to the coronial recommendation and a copy of that report must be provided to the Chief Coroner. The Chief Coroner must include particulars of the government agency's response in the annual report from the Office of the Chief Coroner.

PART II – CULTURAL CONCERNS

Chapter 6

- R15 We recommend that a section be inserted into the Coroners Act 1988 to provide that coroners have temporary control of the deceased's body and body parts from the time a death reportable under section 4 of the Coroners Act 1988 occurs until:

- (a) the post-mortem examination is completed; and
- (b) all body parts have been placed back inside the body of the deceased or are otherwise being dealt with by direction of the family of the deceased; and
- (c) the coroner is satisfied that all necessary formalities have been completed,

or, the coroner sooner authorises the release of the deceased under section 14 of the Coroners Act.

We also recommend that for the purposes of this Act the definition of a "post-mortem" include any necessary testing on body parts.

- R16 We recommend that the Coroners Act be amended to stipulate that retrieval of the deceased's body following release by the coroner can only occur with the consent of the family.
- R17 We recommend that the Coroners Act be amended to include a new provision that a pathologist authorised by the coroner may retain

any body part or tissue that the pathologist considers necessary in order to determine any of the matters set out in section 15 of the Act, but for no other purpose without the consent of the family.

R18 We recommend that a new provision be inserted into the Coroners Act to provide that prior to retaining any body part, the pathologist must notify the coroner:

- (a) which body part the pathologist proposes to retain;
- (b) the reason for its retention; and
- (c) the length of time for which the pathologist proposes to retain the part,

in order to obtain authorisation from the coroner to retain the body part.

If the coroner authorises the retention of any body part, he or she must ensure that the family is advised of this fact immediately and informed of the matters listed above.

R19 We recommend that the coroner be required to ensure that the family is advised a post-mortem examination is to be authorised and that the family receives accurate information and ongoing advice concerning the coronial process.

R20 We recommend the Coroners Act be amended to provide that the deceased must be returned to the deceased's family as soon as is reasonably practicable. Before release of the deceased under this section, the coroner must ensure that any body parts retained for further testing have been placed back inside the body of the deceased or are otherwise being dealt with by direction of the family of the deceased.

We also recommend that the State bear the cost of repatriating the deceased in situations where the deceased was initially transported some distance at the direction of the coroner and the family wishes the deceased to be returned to the place of removal.

R21 We recommend that the terms "body parts" or "tissue" exclude microscopic samples, which pathologists should retain as a matter of practice. For the purposes of this proposal, the term "microscopic samples" means "samples sufficient for histological and toxicological analysis".

We recommend that the Office of Chief Coroner design a form of waiver for families who wish microscopic samples to be returned, and that in all cases involving non-suspicious deaths the family be informed of this option.

- R22 We recommend the Coroners Act be amended to provide that persons who have an interest in the matters set out in section 15(1)(a) of the Coroners Act, such as defence counsel, may apply to the coroner to have their appointed pathologist conduct tests on the deceased's body or body parts during the post-mortem examination in order to form for their own purposes a second opinion.
- R23 We recommend the Coroners Act be amended to provide families with a right to object to the High Court to the coroner's decision to authorise a post-mortem. We recommend that this provision be modelled on the objection provisions that exist in Victoria (section 29, Coroners Act 1985) and Western Australia (section 37, Coroners Act 1996), except that any member of the immediate family, rather than a "senior next of kin", may object.
- R24 We recommend that the Coroners Act be amended to give the deceased's family, with the consent of the coroner, the option of viewing and touching the deceased prior to the post-mortem examination.
- R25 We recommend that the deceased's whānau be given the option of having a family representative or kaitiaki remain with or be in close proximity to the deceased while it is under the coroner's control.
- We envisage that the Office of Chief Coroner can develop protocols:
- to guide coroners when dealing with interested cultural and religious groups who choose to exercise this option; and
 - detailing the information that should be provided to families when choosing their representative.
- R26 We recommend that the scope of section 10(3) be widened to provide that a doctor, registered nurse, or funeral director may be present at a post-mortem examination as the family's representative.
- R27 We recommend that the Chief Coroner, in consultation with a kaiwhakahaere, district coroners, the Police and community groups, as well as the Ministry of Justice and Department for Courts, investigate the logistics of appointing a co-ordinator in each coronial district with a view to establishing such a position.
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APPENDIX B

Summary of part III recommendations

PART III – FURTHER MATTERS

Chapter 7

“Immediate Family”

1 **WE** RECOMMEND that the definition of “immediate family” in the Act be amended so that it includes persons falling into the following categories:

- (a) a person who was the spouse of the deceased including de facto and same sex partners, or a parent, grandparent, child, brother or sister, or guardian or ward, of the deceased; and
- (b) a person whose relationship to the deceased is that of step-child, step-parent, step-brother, or step-sister; and
- (c) a person who, in accordance with the traditions and customs of the community of which the deceased is a member, had the responsibility for, or an interest in, the welfare of the deceased.

Notice

2 We recommend that, in all cases where notification is required under the Act (such as in section 11,¹¹⁸ section 15(2)(a)¹¹⁹ and section 23)¹²⁰ the coroner must ensure that the following people are notified:

¹¹⁸ Section 11 requires notice to be given where a post-mortem examination has been authorised.

¹¹⁹ Section 15(2)(a) relates to adverse comments concerning any dead person.

¹²⁰ Section 23 relates to details and notice of an inquest.

- (a) the family representative or kaitiaki, where one has been appointed under section [x];¹²¹ and
- (b) every member of the deceased's immediate family who has asked to receive notification and who has left his or her contact details with the coroner or the coroner's agent; and
- (c) any other person or organisation who, in the opinion of the coroner has a sufficient interest in receiving notification and whose contact details are reasonably accessible.

Power of Justices where no coroner available

- 3 We recommend that section 6(1), which relates to the power of Justices of the Peace where no coroner is available, be amended:
- to make clear that it relates to the reporting process under section 5(4);
 - to allow for deaths to be reported to other coroners and District Court Judges where appropriate; and
 - so that it specifically refers to those Justices of the Peace who have been designated to assist with coronial work.

“Authorise” versus “Direct”

- 4 We recommend that the Act be amended to provide that a Coroner may, by order in writing, direct a pathologist to conduct a post-mortem examination of a person who has died in any of the circumstances in respect of which the coroner has jurisdiction to hold an inquest. If the pathologist is, for any reason, unable to conduct the post-mortem examination, we recommend that the coroner be authorised to:
- (a) amend the order by substituting the name of another pathologist; or
 - (b) direct that a specified pathologist conduct the post-mortem.

Persons who may perform a post-mortem

- 5 We recommend that the term “pathologist” be used throughout the Act, with “pathologist” being defined in section 2 as including a

¹²¹ See paras 275–286.

general medical practitioner authorised by a coroner to conduct a post-mortem examination.

Ability of the family to request a post-mortem

- 6 We recommend that family members be given the right to request the coroner to direct that a post-mortem be conducted, with a right to apply to the High Court if the request is refused.¹²²

Post-mortem examinations performed “forthwith”

- 7 We recommend that section 9, which allows the coroner to direct that a post-mortem be conducted “forthwith”, be expanded to allow a coroner to direct that a post-mortem examination be performed as soon as possible where:
- (a) the deceased is an infant; and
 - (b) in any other case where the coroner is satisfied that there is good reason to do so.
- 8 We recommend that section 9(2) be clarified to make it absolutely clear that section 9 applies where *either* the deceased or the deceased’s immediate family have ethnic origins, social attitudes or customs, or spiritual beliefs that require the deceased to be available to family members as soon as is possible after death.
- 9 We agree that an “elastic term” is warranted to take into account regional variations in the practice and availability of pathologists. We recommend that the phrase “as soon as is reasonably practicable” be substituted for the term “forthwith” in section 9.

Removal and disposal of bodies

- 10 We recommend that section 13, which relates to the removal and disposal of bodies, be expanded to cover a situation where the coroner concerned is not available. We consider that this is best achieved by providing that, where the coroner is not available, another Coroner or Justice of the Peace by standing arrangement with the Coroner who is not available can authorise the release of the deceased’s body, or the Chief Coroner can authorise the release of the body or direct another coroner to do so.

¹²² The right to apply to the High Court can be framed in similar terms to the right of the family to object to a coroner’s decision to authorise a post-mortem – see paras 254–265.

- 11 We also recommend that the word “release” should be substituted for “disposal.”

Definition of inquest

- 12 We recommend that separate definitions for the terms “inquest” and “inquest hearing” be included in section 2 and that these terms be used consistently throughout the Act.
- 13 We also recommend that the Act provide that one of the coroner’s powers is to carry out any inquiries or investigations preliminary to determining whether an inquest (as newly defined) should be commenced.

Purpose of inquests

- 14 We recommend that section 15(1), which sets out the purpose of inquests, be expanded to provide that a coroner may comment on any matter connected with a death including public health or safety or the administration of justice.

Adverse comments

- 15 Section 15(2) deals with comments made by coroners in the course of, or as a consequence of, an inquest. We recommend that section 15(2)(a) (adverse comments concerning any dead person) be drafted in similar terms to section 15(2)(b) (adverse comments concerning any living person), except that the notification requirements of section 15(2)(a) will differ.¹²³

Decision whether or not to hold an inquest

- 16 We recommend that section 20(1)(b) be amended to provide that, in determining whether or not to hold an inquest, a coroner shall have regard *in all cases* to “whether or not the death appears to have been due to the actions or inaction of any other person”, not just where a death appears to have been unnatural or violent.

¹²³ See the recommendation above concerning notification.

Ability of the family to request an inquest

- 17 We recommend that the Act provide that families have the right to request an inquest.¹²⁴

Joint inquests

- 18 We recommend that the Act provide for the Chief Coroner to authorise a joint inquest.

Which coroner to hold inquest

- 19 We recommend that section 22, concerning which coroner must hold an inquest, be expanded to specifically allow coroners (including deputy coroners) who work in the same region to divide their workload as they think fit or as directed by the Chief Coroner.

Notice of an inquest

- 20 We recommend that all interested parties be given a minimum of 10 working days notice of an inquest under section 23¹²⁵ of the Act.

Places where inquests may be held

- 21 We recommend that the Coroners Act be amended to allow for an inquest to be held in places other than a court, provided there is access to the facilities necessary for the holding of an inquest, including the giving and recording of evidence, and that the family does not object.

Inquests to be public

- 22 We recommend that privacy be added to the grounds in section 25 for a coroner to prohibit publication of evidence.

Evidence at inquests

- 23 Section 26 deals with the way evidence is given and recorded. We recommend that section 26(6) be extended to section 15(1)(b), so

¹²⁴ We suggest that provision for this right in the Act be modelled on similar provisions in the Tasmanian and Western Australian legislation.

¹²⁵ See also the recommendation above concerning who should be notified.

that a coroner can admit evidence necessary or desirable for the purpose of making 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.

- 24 We recommend that section 26(7)(b) be removed so that the procedure to be adopted in the giving of evidence is within the discretion of the coroner.
- 25 We recommend that section 26(9) be adjusted to take account of varying processes for recording evidence. We consider that the requirements concerning the recording of evidence in the Coroner's Court should reflect similar requirements in the District and High Court.

Disclosure of documents

- 26 We recommend that the Act be amended to provide that a coroner may order any person or body having an interest in the inquest to disclose documents relevant to the inquest where the coroner believes it is necessary for the purpose of an inquest.

Power to impound documents

- 27 We consider that further investigation as to the ramifications of a power to impound documents is required before coroners are clothed with such a power.

Procedure where person charged with offence

- 28 Section 28 concerns the procedure to be adopted where a person is charged with an offence relating to the death or some other inquiry into the death is to be held. We recommend that this provision be drafted in more general terms, along similar lines to section 53 of the Coroners Act 1996 (Western Australia).

Counsel to assist the coroner

- 29 We recommend that the Act be amended to enable a coroner to obtain independent legal advice where necessary. We consider that this is best achieved by authorising the Chief Coroner, on the application of a coroner, to appoint independent legal counsel to assist the coroner if the Chief Coroner is satisfied that it is necessary or desirable to do so.

Publication of details of self-inflicted deaths

- 30 We recommend that a Chief Coroner develop guidelines governing when a coroner can or should give authority under section 29 for the publication of details relating to a potentially self-inflicted death.

Interim findings

- 31 We recommend that the Act provide that a coroner may, at any time before concluding an inquest or inquiry, make an interim finding on any matter connected with the inquest or inquiry.

Interim death certificates

- 32 We recommend that the Act specifically authorise coroners to issue interim death certificates.

Appointment of deputy coroners

- 33 We recommend that the Act set out the functions of deputy coroners and clarify the relationship between coroners and deputies.

Retirement of coroners

- 34 We recommend that Coroners be subject to the same retirement restrictions as District Court Judges.

Immunity and indemnity of coroners

- 35 We recommend that coroners continue to receive the same immunities as District Court judges. We also recommend that section 35 of the Act be amended to provide that coroners have the same indemnities as District Court judges.

Solicitor-General may require inquest where new facts discovered

- 36 Section 38 relates to the Solicitor-General's power to require an inquest where new facts are discovered. We recommend that section 38 be amended to provide that if the Solicitor-General is satisfied that since an inquest was completed new facts have been discovered that make it desirable to hold another, the Solicitor-General may direct the Chief Coroner to:

- (a) hold another inquest, or direct any coroner (including the coroner who held or decided not to hold the inquest in the first instance) to hold a new inquest; or
- (b) to re-open, or direct any coroner (including the coroner who held or decided not to hold the inquest in the first instance) to re-open the inquest and re-examine any finding.

Complaints mechanism

- 37 We recommend that a Chief Coroner's functions should extend to include jurisdiction to determine complaints about coroners.

Offences and penalties

- 38 We recommend that the Department for Courts and the Ministry of Justice review the penalties in the Act for failure to comply with various provisions.

Inspection of certificates issued under the Act

- 39 We do not object to section 44(1), which relates to the inspection of certificates issued under the Act, being included as a public register provision in the Privacy Act provided this action does not limit the powers of coroners under the Coroners Act to place restrictions on the publishing or accessing of information.
- 40 We recommend that the Act give coroners the power to place conditions on access to information under section 44.
- 41 We recommend that section 44(3) be amended to provide that requests for personal information be determined in accordance with the Privacy Act 1993, with all other requests determined in accordance with the Official Information Act 1982.
- 42 We recommend that section 44 be amended to provide that where the 12 month limit for requests has expired, information may only be inspected or obtained under section 44 with the written permission of the Secretary.
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APPENDIX C

Summary of the role and responsibilities of Chief Coroner

- 1 **O**VERSEE the coronial system:
- Ensure that the coronial process complies with the Treaty of Waitangi.
 - Promote education concerning cultural issues, values and practices relating to death and the coronial process.
 - Act as a point of contact for coroners and members of the public concerned with the operation of the Coroners Act 1988.
 - Act as a liaison point between coroners, the public, the Ministry of Justice, the Department for Courts and other agencies.
 - Ensure consistency in terms of coronial findings, recommendations, practices and processes.
 - Ensure the efficient administration of the Coroners Act 1988.
 - Enhance the ability of the coronial system to identify and prevent potential harm and unsafe practices.
 - Ensure that reports from coroners are properly appraised and that they are publicly available.
 - Maintain an overview of patterns of sudden deaths and their fundamental causes and consider whether additional inquiries are required.
 - Receive and determine complaints about coroners.
 - Monitor investigatory standards for coronial inquiries.
 - Ensure that all deaths which should be referred to a coroner are in fact referred.
 - Create and maintain a coronial database.
- 2 Ensure that coroners and the Coroners Court operate effectively and efficiently:

- Liaise with the Department for Courts and the Ministry of Justice in determining how many coronial districts and full-time coroners are required.
- Liaise with the government in relation to the appointment of coroners.
- Engage in research and planning to ensure coroners are equipped to perform their functions systematically and properly.
- Monitor and develop training programmes for coroners.
- Prepare a plan for coroners in anticipation of a major disaster.
- Practice as a coroner on a regular basis.
- Supervise which coroner has jurisdiction of the deceased in particular cases having regard to the coronial districts.
- Oversee the implementation of reporting protocols in each Coroner's office to ensure consistency in the reporting of hospital deaths and monitor their effectiveness.
- Design a form of waiver for families who wish microscopic samples to be returned.
- Investigate the logistics of appointing a co-ordinator in each coronial district, in consultation with a kaiwhakahaere, district coroners, the Police and community groups, as well as the Ministry of Justice and Department for Courts, with a view to establishing such a position.
- Assess the need for future developments of the coronial system and the implications of such developments.
- Investigate ways to achieve an expanded focus to the investigation of deaths and, in particular, assist in co-ordinating and promoting a multi-disciplinary approach to SUDI death investigations.
- Where a coronial recommendation affects an agency or individual, give notice of that recommendation to the relevant agency or person and take reasonable steps to ensure that such notification is given before the recommendation is publicly released.
- Inquire as to the implementation of coronial recommendations, or the reasons why implementation has been postponed or rejected.
- Produce an annual report from the Office of Chief Coroner,

which would: include details of coronial recommendations including the progress of recommendations, the responses received from agencies, and any practical problems with implementing particular recommendations; identify the agencies that have chosen not to comply or that, in the opinion of the Chief Coroner, have obstructed the process of compliance; and 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.

- Where a coronial recommendation concerns a government agency, the Chief Coroner must give notice of that recommendation to the agency concerned, the Minister responsible for that agency, the Attorney-General, and any other agency or individual affected by the recommendation and include particulars of the agency's response in the annual report from the Office of the Chief Coroner.

3 Issue guidelines or protocols to coroners in relation to their role and the performance of their functions, including:

- the exercise of the coroner's discretionary powers, including their statutory discretion in deciding whether or not there is need for a post-mortem;
- the circumstances in which it would be appropriate for medical practitioners to give and coroners to accept a certificate as to probable cause of death;
- the coroner's power to authorise a medical practitioner in rare cases to conduct a post-mortem;
- the coroner's power to prohibit publication of evidence under the Coroners Act 1988;
- the circumstances in which a coroner can or should give authority for the publication of details relating to a potentially self-inflicted death;
- the judicial ethics of coroners;
- how coroners should liaise with other organisations and family members;
- the needs of interested cultural and religious groups and families in general;
- procedures concerning the retention of body parts;
- procedures for the release of the deceased;

- the option for the family to view and touch the deceased;
- the information that should be provided to families when choosing a kaitiaki or representative and assistance for coroners when dealing with interested cultural and religious groups who choose to exercise this option;
- the practical requirements of an objection process;
- the practical considerations of giving notice under the Coroners Act 1988;
- the identification and use of recognised experts from whom coroners could seek technical advice;
- the procedure where a person has been charged with an offence;
- the circumstances in which coroners should obtain independent legal advice;
- standardisation of procedures for the creation and maintenance of coronial records;
- the availability of coroners during weekends and holidays;
- the roles of the many agencies with an interest in the coronial system and their interaction with coroners; and
- the conditions to apply to requests for information under the Coroners Act 1988.

4 Enhance the working of the coronial process generally:

- Liaise with the public, media, government departments, health professionals, other judicial officers and other relevant agencies.
- Co-ordinate relations between coroners and administrative agencies with an interest in coronial work.
- Assist in a review of the functions and requirements of pathologists and the relationship between pathology services and the Office of Chief Coroner.
- Assist in a review of the role of the Police under the Coroners Act 1988.
- Assess the role of Justices of the Peace under the Coroners Act 1988.
- Report 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 needed for their prevention or reduction.

- Liaise with the Department for Courts and the Ministry of Justice in order to devise an appropriate process for a coroner to go through to obtain independent legal advice.
 - Where a pathologist has been directed to perform a post-mortem as soon as is reasonably practicable, develop guidelines in consultation with the New Zealand Society of Pathologists to aid in determining what is “reasonably practicable”.
 - Investigate the circumstances in which partial post-mortems may be acceptable.
 - Discuss with interested individuals and organisations issues that impact on the coronial system, such as SIDS.
 - Investigate the desirability of expanding the category of “compulsory inquests” under the Coroners Act 1988.
 - Disseminate information concerning the circumstances of when and how a death is to be reported.
 - Be involved in negotiations with interested parties to discuss the funding and other needs of each area as regards mortuary facilities.
 - Develop protocols with input from other sectors, such as police, pathologists and hospitals to ensure the security of the body of the deceased during the coronial process and the integrity of the post-mortem examination.
 - Liaise with the Privacy Commissioner concerning the development of a Code of Practice in respect of information requests under the Coroners Act 1988.
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APPENDIX D
List of those who made
submissions

Dr John Armstrong – general medical practitioner, Owhata, Rotorua
Auckland Hebrew Congregation
CH Ayrton – coroner
Bailey Partnership
DW Bain – coroner
Coral Beadle
Wendy Brandon
Canterbury Health Limited
Capital Coast Health Limited (Māori Health Unit)
Caroline Everard
Chief District Court Judge’s Chambers
Coast Health Care Limited
JM Conradson – coroner
Coroners’ Council
G Crabbe – coroner
David Crerar – coroner
Crown Law Office
Department of Corrections
Department for Courts
David Dowthwaite – coroner
Dunedin Community Law Centre
GL Evans – coroner
Forensic Pathology Services
Funeral Directors’ Association of New Zealand
Good Health Wanganui
AJ Hall – coroner
Penelope Hansen
Health and Disability Commissioner
Health Waikato
Healthcare Otago Limited

Healthlab Otago
Sarn Herdson – coroner
Professor John D Langley, Injury Prevention Research Unit,
University of Otago
Institute of Environmental Science and Research Limited
Invercargill Safer Community Council
William Alexander King – coroner
Land Transport Safety Authority
Lone Parents Generating Solutions
Alan Macalister – coroner
Richard McElrea – coroner
Ministry of Health
Ministry of Justice
Moana District Māori Council (Tauranga)
FR Mori – coroner
Nelson Marlborough Health Services Limited
New Zealand Air Line Pilots' Association Inc
New Zealand Health Information Service
New Zealand Law Society
New Zealand Police
Nga Huapae Hou
Ngatiwai Trust Board
New Zealand SIDS Study Group
Occupational Safety and Health Service, Department of Labour
Office of the Privacy Commissioner
Office of Veterans' Affairs
Paediatric Society of New Zealand
GM Palmer, CH Ayrton, and DR Fountain – coroners
Principal Youth Court Judge David Carruthers
Gordon Ramage MNZM – coroner
Colin Riddet – coroner
Faith Roberts
Peter Roselli – coroner
Safekids
Dr MD Sage – Chairperson of the Forensic Subcommittee of the
Royal College of Pathologists of Australasia (NZ) and the New
Zealand Society of Pathologists
Trevor Savage – coroner
T Scott – coroner
State Coroner's Office, Victoria

Emeritus Professor AJW Taylor
Te Mana Hauora o Te Arawa
Te Puni Kokiri
Dr Ken Thompson – pathologist
Dr ABM Tie – Vice President (NZ), Royal College of Pathologists
of Australasia (NZ)
Transport Accident Investigation Committee
Harry Waalkens
Wellington School of Medicine
Whangarei Hospital (MO Atkinson)
Lester White
Dr David Williams (University of Auckland)
Peter Williams

APPENDIX E

List of those consulted

- 1 Alcohol Advisory Council of New Zealand
Anglican Clergy – Interdiocesan Meeting (Rotorua/Waikato)
Auckland Healthcare
Auckland Healthcare Legal Counsel (Amanda Mark)
Bailey Partnership Limited
DW Bain – coroner
David Dowthwaite – coroner
Canterbury Health Limited – Michael Hundleby, Jeannie Bayly
Department for Courts – Vanessa Blakelock, Paula Matenga,
Hiria Pointon
Department of Corrections – Vicki Owen, Lesley Ashworth-
Lawson
Dr Dawn Elder (paediatrician) and Dr Jane Zuccollo (paediatric
pathologist)
Mate Frankovich – coroner
Funeral Directors’ Association
Health and Disability Services Commission – Moe Milne
(Kaiwhakahaere)
Health Waikato Limited – Drs Mayall, Hasan, Thorburn, de Beer,
and Chang (pathologists); Mr Adrian Featherstone (Mortuary
Manager)
Sarn Herdson – coroner
Injury Prevention Research Unit – Professor John D Langley
Infant Mortality SIDS Study Group – Mrs Caroline Everard,
Dr David Tipene-Leach and Lorna Dyall
Tim Koelmeyer, Alison Cluroe, Jane Vuletic, Simon Stables, and
Meg Clunie (pathologists, Auckland)
Land Transport Safety Authority – Reg Barrett
Lone Parents Generating Solutions – Michelle Pyke
Māori Health, Ministry of Health – Teresa Wall
Gordon Matenga – coroner
Richard McElrea – coroner

Ministry of Justice – Alison Lewes and Alison Stephens
New Zealand Police – Pieri Munro (Police Cultural Affairs
Adviser); and Senior Constable Mike Clark, Senior Constable
Gary Chittenden, Sergeant John Mildenhall, all of Auckland
Police
New Zealand Statistics Limited – Len Cook
New Zealand Health Information Service – Jim Fraser
Occupational Safety and Health Service, Department of Labour –
Mary Adams
Paediatrics Society – Professor Barry Taylor
Regional Māori SIDS Group, Canterbury – Wendy Dallas-Katoa
Royal Federation of Justices Associations – Ken Lyttle
Dr MD Sage – pathologist
Emeritus Professor AJW Taylor
Te Mana Hauora (hui convened by Julena Meroiti)
Dr ABM Tie and Dr KJ Thomson – pathologists
Transport Accident Investigation Commission – Dr Rob Griffiths
Chief Judge RL Young

2 Coroners' Conference at Wellington, September 1999. Papers were
provided by:

Graeme Johnstone – State Coroner, Victoria
Dr John Langley
Caroline Everard
Garry Evans
Sarn Herdson
Richard McElrea
David Crerar

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