

# **Coroners Amendment Bill**

Government Bill

## **Explanatory note**

### **General policy statement**

This Bill makes a number of amendments following a targeted review of the Coroners Act 2006 (the **Act**). Good progress has been made in improving the coronial system since the Act was passed, and the system is working well in many respects. However, there are still opportunities to enhance the current service to ensure it is clear, timely, and efficient, and that it supports families and improves public safety. The focus of the current reforms has been on providing greater certainty for families and the general public, and enhancing the role of coroners as independent judicial officers. The amendments will—

- improve the quality, consistency, and timeliness of coronial investigations and decision making:
- clarify the role of coroners and reduce duplication between coroners and other authorities that investigate deaths and accidents:
- clarify the role coroners have in making recommendations to prevent future deaths and the relationship with agencies that have policy and operational responsibility in those areas:
- ensure resources are used effectively.

Key changes include—

*Strengthening coroners' recommendations*

- requiring a coroner's recommendations or comments to be specific to the case and the evidence before the coroner, and to be clear about how the recommendations will reduce the likelihood of future deaths in similar circumstances. These changes will make it easier for members of the public to understand how recommendations link to the death:
- strengthening the requirement for the coroner to consider which individuals or organisations have an interest in the death and to ensure that those individuals or organisations have the opportunity to give evidence or consider any recommendations that may be directed to them before the coroner finalises his or her decisions.

*Improving processes in the coronial system*

- reprioritising the chief coroner's functions, allowing the chief coroner more flexibility to manage workloads, appointing a deputy chief coroner, and encouraging the use of practice notes to improve consistency between coroners:
- clarifying the role of pathologists and improving the processes for retaining or returning human tissue samples to be more sensitive to the needs of families:
- better protecting the rights of people whose conduct may be called into question in an inquiry by requiring the coroner to notify them of their right to be represented, and to cross-examine witnesses, at the inquest:
- reducing potential duplication with other investigating authorities, for example, by allowing the chief coroner to direct that no further investigation is needed if another authority has already investigated the death.

*Better defining which cases need to be reported to the coroner or go to inquest*

- focusing the requirement to report medical-related deaths on cases where the death was not reasonably expected immediately prior to the treatment, operation, or procedure so that families are not unnecessarily disrupted by the death being reported to the coroner:
- removing the requirement for a mandatory inquest into deaths in official custody or care to provide the coroner with more

flexibility, particularly when the death is from natural causes and there are no suspicious circumstances (however, the coroner would still be required to hold an inquiry):

- clarifying that a person may report a death that occurred overseas if the body is in New Zealand and the person has concerns about how overseas authorities responded to the death, but that there is no requirement to do so:
- providing for the Attorney-General to determine whether a coronial inquiry is required for the deaths of New Zealand Defence Force members on operational service that are directly caused by hostile action and limiting the scope of the coronial inquiry to establishing the person's identity and the causes and circumstances of the death.

### **Suicide reporting**

The Bill also amends the restrictions on reporting self-inflicted deaths set out in sections 71 to 73 of the Act. The Act restricts the information that can be made public about a self-inflicted death without the authorisation of the coroner. During the targeted review, concerns were raised that some aspects of the current restrictions were unclear and did not recognise the growing role of social media.

As there was likely to be a range of views on the scope of restrictions on reporting self-inflicted deaths, the Government invited the Law Commission to undertake a first principles review of the restrictions. The purpose of the review was to examine whether the law struck an appropriate balance between preventing suicide deaths and the principle of freedom of expression.

The Law Commission recommended amending the legislation to—

- restrict the making public of the method of the death (including the place at which the death occurred if the place suggests the method), unless the chief coroner has granted an exemption:
- allow the chief coroner to grant an exemption only if satisfied that the circumstances are such that any risk of copycat suicidal behaviour, is small and is outweighed by other matters in the public interest:
- prevent anyone from describing a death as suicide unless the chief coroner has granted an exemption, or a coroner has made a finding that the death is suicide:

- allow a death to be reported as a suspected suicide where the facts support that conclusion.

These recommendations were accepted by the Government and are reflected in this Bill.

To support the amendments to the current provisions, the Law Commission also recommended that the Minister of Health be required to prepare a set of non-legislative standards for suicide reporting, in consultation with representatives of the media and mental health interests. The Minister of Health would also be required to implement an ongoing programme to promote and support the implementation of the standards, and evaluate their success in achieving the goal of low-risk suicide reporting.

The Government has accepted these recommendations in principle. The implementation of these recommendations does not require any legislative changes and will be considered alongside other Government suicide prevention activity.

### **Departmental disclosure statement**

The Ministry of Justice is required to prepare a disclosure statement to assist with the scrutiny of this Bill. The disclosure statement provides access to information about the policy development of the Bill and identifies any significant or unusual legislative features of the Bill.

A copy of the statement can be found at <http://legislation.govt.nz/disclosure.aspx?type=bill&subtype=government&year=2014&no=239&>.

### **Regulatory impact statement**

The Ministry of Justice produced 3 regulatory impact statements (on 5 June 2013, 17 September 2013, and 7 May 2014) to help inform the main policy decisions taken by the Government relating to the contents of this Bill.

Copies of the regulatory impact statements can be found at—

- <http://www.justice.govt.nz/policy/regulatoryimpactstatements/regulatory-impact-statements>
- <http://www.treasury.govt.nz/publications/informationreleases/ris>

### Clause by clause analysis

*Clause 1* is the Title clause.

*Clause 2* is the commencement clause, which provides that the Bill comes into force on 1 July 2015.

*Clause 3* provides that the Bill amends the Coroners Act 2006 (the **principal Act**).

## Part 1 Amendments to Parts 1 and 2

### Subpart 1—Amendments to Part 1 (general provisions)

*Clauses 4 and 5* make consequential amendments to sections 3 and 4 to reflect *new section 57A* and the repeal of the definition of specified recommendations or comments from section 9.

*Clause 6*, which replaces section 7 with a simplified section, sets out the functions of the chief coroner.

*New section 7(1)* specifies that the main function of the chief coroner is to contribute to the integrity and effectiveness of the coronial system provided for by the principal Act by—

- facilitating the orderly and efficient management of the system; and
- overseeing coroners' investigations; and
- facilitating the provision to coroners of support services and specialist advice.

*New section 7(2)* sets out similar functions to some of those set out in the existing section 7, except for the new function, set out in *section 7(2)(a)*, of establishing and maintaining relationships between coroners and other persons carrying out functions or duties within the coronial system.

*Clause 7* amends section 9, which defines terms used in the principal Act. *Clause 7(1)* replaces the definition of chief coroner with a new definition that refers to the new office of deputy chief coroner. *Clause 7(2)* replaces the definition of designated coroner. *Clause 7(3)* inserts definitions of dentist, expert, expert evidence, health practitioner, interested party, medical procedure, overseas death, pathologist's report, and responsible coroner. *Clause 7(4)* repeals the defini-

tions of death in official custody or care, listed pathologist, and specified recommendations or comments. The substance of the definitions of death in official custody or care and specified recommendations or comments are restated in *new sections 14(3)* and *57A* respectively.

*Clause 8* makes a consequential amendment to section 10 to ensure the correct interpretation of *new section 107*.

### Subpart 2—Amendments to Part 2 (deaths to be reported and post-mortems)

*Clause 9* replaces sections 13 and 14, which relate to deaths that must be reported to the New Zealand Police.

*New section 13* (other than *new section 13(3)*) is similar to the existing section 14. *New section 13(3)* is intended to clarify that a person is not obliged to report an overseas death to the New Zealand Police. It also limits the circumstances in which an overseas death may be reported to the Police to circumstances where the person has concerns about any determination made by overseas authorities, and where the body of the dead person is in New Zealand.

*New section 14* is similar to the existing section 13, but with minor changes, including the following:

- *new subclause (2)(b)(ii) and (c)(ii)* limits the circumstances in which deaths resulting from a medical procedure, or deaths of persons affected by an anaesthetic, must be reported to circumstances where a reasonable health practitioner would not have expected the deaths; and
- *new subclause (3)(c)(i)* includes in the definition of “person in official custody or care” a child or young person who has been placed in custody or care under one of several specified provisions of the Children, Young Persons, and Their Families Act 1989.

*Clause 10* makes consequential amendments to section 15(1)(b) and (2)(a), and inserts *new section 15(4)*. *New section 15(4)* is similar to the existing section 16(1), which *clause 11* replaces.

*Clause 11* replaces section 16. *New section 16* provides that the responsible coroner must carry out the functions of the coroner in relation to a death.

*Clause 12* amends section 17 to clarify that the New Zealand Police is only required to carry out investigations that are reasonably necessary for the purposes of the principal Act.

*Clause 13* replaces section 18, which specifies when the New Zealand Police has an exclusive right to custody of a body. *New section 18* is similar to the existing section 18, but is amended to use new defined terms and to update cross-references.

*Clause 14* replaces section 19, which specifies when the designated coroner has exclusive right to custody of a body. *New section 19* is similar to the existing section 19, but is updated to use the new defined term of responsible coroner.

*Clause 15* repeals section 22(1), which is no longer necessary.

*Clause 16* replaces sections 23 and 24. *New section 23* is similar to the existing section 23 but is simplified as a consequence of the new definition of interested party inserted into section 9. One effect of the new definition of interested party is that the coroner must provide notice of significant matters to a person whose conduct is likely to be called into question during the course of an inquiry.

*New section 24* specifies the significant matters referred to in *new section 23(1)*. *New section 24* is similar to the existing section 24, but is updated to reflect changes made to other provisions in the Bill.

*Clause 17* amends section 25, which concerns viewing, touching, or remaining with or near a body in the coroner's custody. The amendment sets out the circumstances in which the section applies.

*Clause 18* amends section 27 to clarify that a pathologist may, at the request of a dead person's immediate family, contact that family in relation to a report by the pathologist about that person's death. This is intended to clarify that a pathologist may discuss the report with the family directly.

*Clause 19* inserts *new section 31(1A)* to provide that a coroner may direct 1 or more pathologists to perform post-mortems on any or all of the bodies of persons whose deaths appear to have occurred as the result of a single event, or a series of related events. *Clause 19* also repeals section 31(3), which requires a pathologist performing a post-mortem to be a pathologist listed by the chief coroner.

*Clause 20* amends section 36 to provide that a pathologist directed by a coroner to carry out a post-mortem may carry out that post-mortem

as the pathologist thinks fit (except that the pathologist must comply with section 36(1)).

*Clause 21* amends section 38 to provide that a dentist may attend a post-mortem if authorised to attend by the pathologist conducting the post-mortem.

*Clause 22* replaces section 40. *New section 40* provides that a coroner may require the doctor of a dead person to provide the person's health information, as well as a written report.

*Clause 23* consequentially amends section 41 to reflect the heading to *new section 40*.

*Clause 24* consequentially amends section 42 to use the term responsible coroner.

*Clause 25* amends section 46 to provide that the costs of transporting a body must be met by the responsible department, rather than the Commissioner of Police.

*Clause 26* amends section 48 to allow a definition of minute to be published by the Secretary in the *Gazette*. The purpose of the definition is to clarify the meaning of the term minute. The definition is likely to be very technical, and will need to be developed in consultation with pathologists, coroners, and medical professionals. As this is a new definition, there may need to be changes in future once it becomes clear how the definition is being applied in practice.

*Clause 27* replaces section 50 to provide that, if a body part or bodily sample has been retained, the coroner must notify the people to whom the body is released on or immediately after releasing the body (rather than on or before releasing the body). However, the coroner must notify family members of the intention to retain the part or sample before the sample is retained if the coroner considers that, due to the size or nature of the part or sample, it is appropriate to give notice before the body is released.

*Clause 28* amends section 55 to require that a body part or bodily sample must be returned when the coroner concludes an inquiry in relation to a death. This is a change from the existing provision, which requires the part or sample to be returned once it is no longer required.



## **Part 2**

### **Amendments to Parts 3 and 4**

#### Subpart 1—Amendments to Part 3 (inquiries into causes and circumstances of deaths)

*Clause 29* makes a consequential amendment to section 57 to reflect *new section 57A* and the repeal from section 9 of the definition of specified recommendations or comments.

*Clause 30* inserts *new sections 57A and 57B*.

*New section 57A* provides that recommendations or comments by coroners may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. *New section 57A(3)* provides that recommendations or comments must—

- be clearly linked to the factors that contributed to the death to which the inquiry relates; and
- be based on evidence considered during the inquiry; and
- be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

*New section 57B* provides that coroners must notify certain persons before making a recommendation or comment, and give those persons a reasonable time to comment on the proposed recommendation or comment. The chief coroner must record any comments received (or a summary of those comments) in a register that is available to the public.

*Clause 31* consequentially amends section 58 to include *new sections 57A and 57B* in a cross-reference.

*Clause 32* replaces section 59 with *new sections 59 and 59A*.

*New section 59* limits the jurisdiction of coroners so that they may only open inquiries into deaths that appear to have occurred within the last 100 years.

*New section 59A(1)* provides that a coroner may open an inquiry into an overseas death only if he or she is satisfied that overseas authorities have not established the cause and circumstances of the death, or there is doubt about the accuracy of any conclusion reached by an overseas authority, and that an inquiry under the principal Act is likely to identify the cause and circumstances of the death.

*New section 59A(2) and (3)* prohibits a coroner from opening an inquiry into the death of a member of the New Zealand Defence Force if the death occurred as a result of hostile action while the person was on operational service, and provides that a coroner who has already opened an inquiry into a death of this kind must adjourn the inquiry. *New section 59A(4) and (5)* provides that the Attorney-General may direct a coroner to open or resume an inquiry into a death of the kind described in *new section 59A(2)*, but the purpose of the inquiry will be limited to establishing certain particulars (the coroner will not be able to make recommendations or comments).

*Clause 33* replaces section 60 to use the term responsible coroner and to make consequential amendments to cross-references.

*Clause 34* repeals section 61, which is redundant as a consequence of *new sections 59 and 59A*.

*Clause 35* repeals section 66, which is redundant as a consequence of amendments to section 15 and of *new sections 16 and 133A*.

*Clauses 36 and 37* consequentially amend sections 68 and 69 to use the term responsible coroner.

*Clause 38* replaces sections 70 and 71 with *new sections 70 to 71A*.

*New section 70* provides that the chief coroner may direct the coroner not to open or resume an inquiry into a death that has already been the subject of criminal proceedings or of another investigation.

*New section 71* establishes new rules about the publication of details of self-inflicted deaths. *New section 71(2)* provides that, if a death is self-inflicted, or if there is reasonable cause to suspect that the death was self-inflicted, no person may make public—

- the method or any suspected method of the death; or
- the place where the death occurred, if the place suggests the method (or any suspected method) of the death; or
- a description of a death as a suicide.

The restrictions specified in *new section 71(2)* do not apply to a person who is granted an exemption (under *new section 71A*) from the restrictions or to certain persons and organisations (for example, the Commissioner of Police) permitted by section 72 to publish particulars of suicide deaths. *New section 71(3)* clarifies that *new section 71(2)* does not prevent a person from making public that a death is a suspected suicide, or from making public that a death is a suicide

after the coroner has completed a certificate of findings stating that the death is a suicide

*New section 71A* provides that the chief coroner may grant an exemption from the restrictions that apply to making public the details of self-inflicted deaths. The chief coroner may grant an exemption only if the chief coroner is satisfied that—

- granting the exemption does not present an undue risk that other people will attempt to copy the behaviour of the dead person concerned; and
- any risk that people will attempt to copy the behaviour of the dead person concerned is outweighed by other considerations that make it desirable, in the public interest, to allow the publication of the details.

*Clause 39* consequentially amends section 75 to reflect *new section 71A*.

*Clause 40* replaces section 77, which concerns hearings on papers and chambers findings. *New section 77* clarifies the intention of the existing section 77.

*Clause 41* replaces section 80, which concerns decisions to hold inquests. Under *new section 80*, the coroner is not required to hold an inquest into every death in official custody or care.

*Clause 42* makes consequential amendments to section 81 to reflect changes to section 23 and the new definition of interested party.

*Clause 43* amends section 89 to simplify section 89(1) in light of amendments made to sections 23 and 81.

*Clause 44* replaces section 92. *New section 92* is similar to the existing section 92 except that it allows a coroner to issue a certificate of findings in relation to a death if the death occurred on or from a New Zealand registered aircraft or ship. This ensures consistency with *new section 59*, so that a coroner is able to conclude an inquiry for all deaths in respect of which the coroner has jurisdiction.

*Clause 45* amends section 94, which relates to the presentation of a coroner's findings. *Clause 45* replaces section 94(1) to require a certificate of findings to be completed and signed as soon as is reasonably practicable, replaces section 94(4)(c) and (d) to reflect *new section 57A* and the repeal from section 9 of the definition of specified recommendations or comments, and inserts *new section 94(5)*, which requires the coroner to provide a copy of his or her certificate

of findings, and any specified recommendations or comments, to the chief coroner and all interested parties.

*Clause 46* inserts *new sections 94A and 94B*. *New section 94A* requires the chief coroner to monitor inquiries that are not completed within 1 year. *New section 94B* requires the chief coroner to publish information about inquiries in relation to which an inquest, or a hearing on the papers, has been held but no certificate of findings has been released.

#### Subpart 2—Amendments to Part 4 (appointments, administration, powers, offences and penalties, and technical provisions)

*Clauses 47 and 48* amend sections 103 and 104 to provide that former coroners and relief coroners over 70 years of age may be reappointed as a coroner or relief coroner only for 1 term of no more than 2 years.

*Clause 49* inserts *new sections 105A and 105B*. *New section 105A* provides for the appointment of a deputy chief coroner who may perform or exercise the functions, duties, or powers of the chief coroner in the coroner's absence or under delegation. *New section 105B* allows the chief coroner to delegate the chief coroner's functions, duties, and powers to the deputy chief coroner.

*Clause 50* inserts *new section 106A*, which requires the Attorney-General to publish information concerning the coronial appointment process.

*Clause 51* replaces section 107 with *new sections 107 and 107A*. *New section 107* requires the chief coroner to publish a protocol specifying the types of employment that coroners may engage in and the types of offices that may be held concurrently with the office of coroner. *New section 107A* provides that the chief coroner must publish guidelines to assist coroners to decide if they should recuse themselves from an inquiry.

*Clause 52* inserts *new section 116A* to establish a suicide and media expert panel to advise the chief coroner about applications for exemptions from the restrictions applying to the publication of details of self-inflicted deaths.

*Clause 53* amends section 123 to provide that section 110 of the Search and Surveillance Act 2012 applies to a search authorised under section 122.

*Clause 54* amends section 132 to allow the chief coroner to issue practice notes relating to specified recommendations or comments and co-ordination with other organisations investigating deaths, and to remove the provision allowing the chief coroner to issue practice notes regarding the making public of details of self-inflicted deaths.

*Clause 55* replaces section 133 with *new sections 133 and 133A*. *New section 133* is similar to the existing section 133, except that it also allows the chief coroner to designate coroners to receive reports of all deaths that are reported within a specified time period. *New section 133A* requires the chief coroner to appoint a responsible coroner in relation to a death that has been reported to a coroner other than the designated coroner. *New section 133A(2)* provides that the chief coroner may at any time appoint a replacement coroner to be the responsible coroner in relation to a death.

*Clause 56* replaces the offence in section 139 with 2 separate offences. *New section 139* continues the offence for publication of details in contravention of section 71 (which relates to the making public of details of self-inflicted deaths), but with increased penalties. *New section 139A* restates the offence applying to the publication of material in contravention of section 74.

*Clause 57* provides that the enactments specified in the *Schedule* are amended in the manner indicated in that schedule.

The *Schedule* sets out the consequential amendments to other enactments that are necessary as a result of this Bill.

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*Hon Chester Borrows*

## **Coroners Amendment Bill**

Government Bill

### **Contents**

		Page
1	Title	5
2	Commencement	5
3	Principal Act	5
<b>Part 1</b>		
<b>Amendments to Parts 1 and 2</b>		
Subpart 1—Amendments to Part 1 (general provisions)		
4	Section 3 amended (Purpose of this Act)	5
5	Section 4 amended (Coroner’s role)	6
6	Section 7 replaced (Chief coroner’s functions)	6
7	Chief coroner’s functions	6
7	Section 9 amended (Interpretation)	7
8	Section 10 amended (Coroner defined)	9
Subpart 2—Amendments to Part 2 (deaths to be reported and post-mortems)		
9	Sections 13 and 14 replaced	9
13	Duty to report deaths	9
14	Deaths that must be reported under section 13(2)	9
10	Section 15 amended (Reporting of deaths to coroner by police)	11
11	Section 16 replaced (Chief coroner to designate replacement designated coroner or report death to original designated coroner)	11
16	Responsible coroner	12
12	Section 17 amended (Investigations by police)	12

**Coroners Amendment Bill**

---

13	Section 18 replaced (When police have exclusive right to custody of body)	12
	18 When New Zealand Police has exclusive right to custody of body	12
14	Section 19 replaced (When designated coroner has exclusive right to custody of body)	13
	19 When responsible coroner has exclusive right to custody of body	13
15	Section 22 amended (Representative for liaison with immediate family)	13
16	Sections 23 and 24 replaced	13
	23 Coroner must give interested parties notice of significant matters	13
	24 Significant matters referred to in section 23(1)	14
17	Section 25 amended (Viewing, touching, or remaining with or near body in coroner's custody)	14
18	Section 27 amended (Family may request pathologist's report on post-mortem)	15
19	Section 31 amended (Coroner may direct post-mortem)	15
20	Section 36 amended (Nature of post-mortem)	15
21	Section 38 amended (Who may attend post-mortem)	15
22	Section 40 replaced (Coroner may require person's doctor to report)	16
	40 Coroner may require person's doctor to provide report or health information	16
23	Section 41 amended (High Court may order post-mortem in certain circumstances)	16
24	Section 42 amended (Release of bodies)	16
25	Section 46 amended (Costs of transporting body moved for post-mortem, etc)	16
26	Section 48 amended (Retention of parts and samples on release of body)	16
27	Section 50 replaced (Coroner must notify family, etc, of retention, and of right to request return, of retained parts and samples)	17
	50 Coroner must notify immediate family of retention, and of right to request return, of parts and samples	17
28	Section 55 amended (Return on request of retained parts and samples)	18



**Coroners Amendment Bill**

---

**Part 2  
Amendments to Parts 3 and 4**

Subpart 1—Amendments to Part 3 (inquiries into causes  
and circumstances of deaths)

29	Section 57 amended (Purpose of inquiries)	18
30	New sections 57A and 57B inserted	18
	57A Recommendations or comments by coroners	19
	57B Coroner must consult interested parties on recommendations or comments	19
31	Section 58 amended (Adverse comments by coroners)	20
32	Section 59 replaced (Jurisdiction of coroners to open inquiries)	20
	59 Jurisdiction of coroners to open inquiries	20
	59A Limits on coroners' jurisdiction under section 59	21
33	Section 60 replaced (Deaths into which inquiries must be opened)	22
	60 Deaths into which inquiries must be opened	22
34	Section 61 repealed (Deaths where coroner may decide not to open inquiries)	22
35	Section 66 repealed (Which coroner conducts inquiry)	22
36	Section 68 amended (Procedure if person charged with offence)	22
37	Section 69 amended (Procedure if some other investigation to be conducted)	22
38	Sections 70 and 71 replaced	22
	70 Coroner may decide not to open or resume postponed or adjourned inquiry	23
	71 Restrictions on making public details of self-inflicted deaths	23
	71A Chief coroner may grant exemption from restrictions in section 71	24
39	Section 75 amended (Review of coroner's decision as to making public of details, evidence, etc)	25
40	Section 77 replaced (Hearings on papers and chambers findings)	25
	77 Hearings on papers and chambers findings	25
41	Section 80 replaced (Decision to hold inquest)	25
	80 Decision to hold inquest	26
42	Section 81 amended (Date, etc, and notice of inquest)	26
43	Section 89 amended (Others who may cross-examine at inquest)	27

**Coroners Amendment Bill**

---

44	Section 92 replaced (Body must be viewed before certain inquiries concluded)	27
	92 Body must be viewed before certain inquiries concluded	27
45	Section 94 amended (Certificate of and written reasons for findings)	27
46	New sections 94A and 94B inserted	28
	94A Chief coroner to monitor inquiries not completed within 1 year	28
	94B Chief coroner to publish information regarding findings not yet released	28
	Subpart 2—Amendments to Part 4 (appointments, administration, powers, offences and penalties, and technical provisions)	
47	Section 103 amended (Coroners)	29
48	Section 104 amended (Relief coroners)	29
49	New sections 105A and 105B inserted	29
	105A Deputy chief coroner	29
	105B Delegation of functions, duties, or powers of chief coroner	30
50	New section 106A inserted (Attorney-General to publish information concerning coronial appointment process)	30
	106A Attorney-General to publish information concerning coronial appointment process	30
51	Section 107 replaced (Concurrent office or employment)	30
	107 Concurrent office or employment	30
	107A Recusal	31
52	New section 116A inserted (Establishment and constitution of suicide and media expert panel)	31
	116A Establishment and constitution of suicide and media expert panel	31
53	Section 123 amended (Entry and search under warrant under section 122)	31
54	Section 132 amended (Chief coroner may issue practice notes)	31
55	Section 133 replaced (Chief coroner must designate coroners for specified deaths)	32
	133 Chief coroner must designate coroners for specified kinds of deaths	32
	133A Appointment of responsible or replacement coroner	33

56	Section 139 replaced (Publication of information in contravention of section 71 or prohibition under section 74)	33
	139 Publication of information in contravention of section 71	33
	139A Publication of information in contravention of section 74	34
57	Consequential amendments	34
	<b>Schedule</b>	35
	<b>Consequential amendments</b>	

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**The Parliament of New Zealand enacts as follows:**

- 1 Title**  
This Act is the Coroners Amendment Act **2014**.
- 2 Commencement**  
This Act comes into force on **1 July 2015**. 5
- 3 Principal Act**  
This Act amends the Coroners Act 2006 (the **principal Act**).

**Part 1**

**Amendments to Parts 1 and 2**

- Subpart 1—Amendments to Part 1 (general provisions) 10
- 4 Section 3 amended (Purpose of this Act)**  
Replace section 3(1)(b) with:
  - “(b) the making of recommendations or comments that, if drawn to public attention, may reduce the chances of further deaths occurring in circumstances similar to those in which the deaths occurred.” 15

**5 Section 4 amended (Coroner's role)**

In section 4(2)(b), replace “specified recommendations or comments (as defined in section 9)” with “recommendations or comments under **section 57A**”.

**6 Section 7 replaced (Chief coroner's functions)**

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Replace section 7 with:

**“7 Chief coroner's functions**

“(1) The chief coroner's main function is to contribute to the integrity and effectiveness of the coronial system provided for by this Act by—

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“(a) facilitating the orderly and efficient operation of the system; and

“(b) overseeing coroners' investigations by—

“(i) managing the workloads of coroners; and

“(ii) issuing practice notes; and

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“(iii) monitoring the operation of the system; and

“(c) facilitating the provision to coroners of support services and cultural, legal, medical, or other specialist advice.

“(2) The chief coroner has the following additional functions (which support the chief coroner's main function):

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“(a) to establish, and to help maintain, relationships between coroners and other persons carrying out functions or duties within the coronial system:

“(b) to help to inform, and to achieve consistency in, coronial decision making and other coronial conduct (for example, by issuing practice notes):

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“(c) to perform the functions of a Head of Bench under the Judicial Conduct Commissioner and Judicial Conduct Panel Act 2004 in relation to the exercise by coroners (except for those who are District Court Judges) of the judicial authority conferred on them by this Act:

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“(d) to help to avoid unnecessary duplication in investigations into deaths by liaising, and encouraging co-ordination (for example, through issuing practice notes or developing protocols), with other investigating authorities, official bodies, and statutory officers:

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“(e) to set up and maintain a register, which must be publicly available, of coroners' recommendations and com-

ments (or summaries of those recommendations and comments):

- “(f) to carry out any other function or task conferred or imposed by this Act or any other enactment.”

- 7 Section 9 amended (Interpretation)** 5
- (1) In section 9, replace the definition of **chief coroner** with:  
 “**chief coroner** means the person appointed under section 105, and includes either of the following people while he or she is authorised to act for the chief coroner under **section 105A(1)** or 106: 10  
 “(a) the deputy chief coroner:  
 “(b) the acting chief coroner”.
- (2) In section 9, replace the definition of **designated coroner** with:  
 “**designated coroner**, in relation to a death, means the coroner designated by the chief coroner under **section 133** to receive reports of all deaths of a specified kind” 15
- (3) In section 9, insert in their appropriate alphabetical order:  
 “**dentist** means a health practitioner who is, or is deemed to be, registered with the Dental Council established by section 114(2) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of dentistry 20  
 “**expert** has the same meaning as in section 4(1) of the Evidence Act 2006  
 “**expert evidence** has the same meaning as in section 4(1) of the Evidence Act 2006 25  
 “**health practitioner** means a person who is or is deemed to be registered with an authority as a practitioner of a particular health profession under the Health Practitioners Competence Assurance Act 2003 30  
 “**interested party**, in relation to the death, or suspected death, of a person means—  
 “(a) a person who is recognised under section 22 as a representative of the immediate family of the person who is, or is suspected to be, dead; and 35  
 “(b) a member of the immediate family of the person who is, or is suspected to be, dead who has asked to be no-

tified of matters, and has given the responsible coroner contact details for that purpose, because his or her interests are not represented by a representative recognised under section 22; and

“(c) a person whose conduct is, in the view of the responsible coroner, likely to be called into question during the course of any inquiry in relation to the death or suspected death; and 5

“(d) any other person or organisation that the responsible coroner considers has an interest in the death or suspected death (apart from any interest in common with the public) 10

“**medical procedure**—

“(a) means a medical, surgical, or dental treatment or operation, or any procedure of a similar kind; and 15

“(b) includes the administration of a medicine (as defined in section 3 of the Medicines Act 1981) or an anaesthetic

“**overseas death** means a death that occurs outside New Zealand other than a death on or from—

“(a) a New Zealand registered aircraft (as defined in section 2(1) of the Civil Aviation Act 1990); or 20

“(b) a New Zealand ship (as defined in section 2(1) of the Maritime Transport Act 1994); or

“(c) an aircraft or a ship of the Armed Forces (as defined in section 2(1) of the Defence Act 1990) 25

“**pathologist’s report** means a report given by a pathologist to a coroner under section 31(6)

“**responsible coroner**, in relation to a death, means,—

“(a) until a replacement coroner is appointed under **section 133A(2)**, the coroner who is— 30

“(i) the designated coroner to whom the death is reported under **section 15(2)(a)**; or

“(ii) if the death is reported to another coroner under section 15(2)(b), the responsible coroner appointed by the chief coroner under **section 133A(1)**; and 35

“(b) on and after the date on which the chief coroner appoints a replacement coroner under **section 133A(2)**, the coroner who is the replacement coroner”.

- (4) In section 9, repeal the definitions of **death in official custody or care, listed pathologist, and specified recommendations or comments**.

**8 Section 10 amended (Coroner defined)** 5  
Repeal section 10(2)(c) and (4)(c).

Subpart 2—Amendments to Part 2 (deaths  
to be reported and post-mortems)

- 9 Sections 13 and 14 replaced**  
Replace sections 13 and 14 with:
- “13 Duty to report deaths** 10
- “(1) A person who finds a body in New Zealand must report the finding to a Police employee as soon as practicable unless the person believes that the finding is already known to the New Zealand Police, or will be reported to a Police employee by another person. 15
- “(2) A person who learns of a death of a kind described in **section 14** must report that death to a Police employee as soon as practicable unless the person believes that the death is already known to the New Zealand Police, or will be reported to a Police employee by another person. 20
- “(3) Any person may, but is not required to, report an overseas death to a Police employee if—
- “(a) the person is concerned that overseas authorities have not established the cause and circumstances of the death, or there is doubt about the accuracy of any conclusion reached by an overseas authority; and 25
- “(b) the body of the dead person is in New Zealand.
- “14 Deaths that must be reported under section 13(2)**
- “(1) A death of a kind described in **subsection (2)** must be reported under **section 13(2)** if the death occurred in New Zealand or on or from— 30
- “(a) a New Zealand registered aircraft (as defined in section 2(1) of the Civil Aviation Act 1990); or
- “(b) a New Zealand ship (as defined in section 2(1) of the Maritime Transport Act 1994); or 35

- “(c) an aircraft or a ship of the Armed Forces (as defined in section 2(1) of the Defence Act 1990).
- “(2) The kinds of deaths referred to in **subsection (1)** are—
- “(a) a death that appears to have been without known cause, or self-inflicted, unnatural, or violent: 5
- “(b) a death—
- “(i) that occurred during, or appears to have been the result of, a medical procedure; and
- “(ii) that, immediately before the procedure was undertaken, a reasonable health practitioner 10 would not have expected:
- “(c) a death—
- “(i) that occurred while the person concerned was affected by an anaesthetic; and
- “(ii) that, immediately before the anaesthetic was 15 administered, a reasonable health practitioner would not have expected:
- “(d) the death of a woman that occurred while the woman was giving birth, or that appears to have been a result of the woman being pregnant or giving birth: 20
- “(e) the death of a person in official custody or care:
- “(f) a death in relation to which no doctor has given a doctor’s certificate (as defined in section 2(1) of the Burial and Cremation Act 1964).
- “(3) In **subsection (2)(e)**, a **person in official custody or care** 25 means any of the following:
- “(a) a patient who is required to be detained in an institution pursuant to an order under section 9 of the Alcoholism and Drug Addiction Act 1966 (whether or not the death occurred in the institution): 30
- “(b) a child or young person whom the chief executive has, under section 365 of the Children, Young Persons, and Their Families Act 1989, placed in a residence established under section 364 of that Act (whether or not the death occurred in the residence): 35
- “(c) a child or young person who—
- “(i) is in the custody or care of an iwi social service, a cultural social service, a residential disability care operator, or the director of a child and family



support service, pursuant to section 43, 78, 101, 102, 110, 139, 140, 141, 142, 234, 238, or 345 of the Children, Young Persons, and Their Families Act 1989:

- “(ii) is in the charge of any person or organisation pursuant to section 362 of that Act: 5
- “(d) a patient within the meaning of section 2(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (whether or not the death occurred in the hospital concerned): 10
- “(e) a proposed care recipient or care recipient within the meaning of section 5(1) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (whether or not the death occurred in the facility concerned): 15
- “(f) a prisoner within the meaning of section 3(1) of the Corrections Act 2004 (whether or not the death occurred in the prison concerned):
- “(g) a person in the custody of the New Zealand Police:
- “(h) a person under the control of a security officer (as defined in section 3(1) of the Corrections Act 2004).” 20

**10 Section 15 amended (Reporting of deaths to coroner by police)**

- (1) In section 15(1)(b), replace “section 14” with “**section 13**”.
- (2) Replace section 15(2)(a) with: 25
  - “(a) to the appropriate designated coroner; or”.
- (3) After section 15(3), insert:
- “(4) A coroner (other than the chief coroner) to whom a finding or death is reported under section 15(2)(b) must report it to the chief coroner as soon as practicable.” 30

**11 Section 16 replaced (Chief coroner to designate replacement designated coroner or report death to original designated coroner)**

Replace section 16 with:

**“16 Responsible coroner**

The responsible coroner must perform every part of the coroner’s role in relation to a death.”

**12 Section 17 amended (Investigations by police)**

Replace section 17(1) with:

5

“(1) If a death has been reported to a coroner under section 15, the Commissioner of Police must cause to be made all investigations that are reasonable and necessary to help to achieve the purpose of this Act in relation to the death, including any investigation directed by the responsible coroner.”

10

**13 Section 18 replaced (When police have exclusive right to custody of body)**

Replace section 18 with:

**“18 When New Zealand Police has exclusive right to custody of body**

15

“(1) The New Zealand Police has an exclusive right to custody of the body of a person—

“(a) from the time when a Police employee first suspects on reasonable grounds that a death to which **section 13(2)** applies may have occurred; and

20

“(b) until—

“(i) the death is reported to the designated coroner under **section 15(2)(a)**; or

“(ii) if the death is reported to another coroner under section 15(2)(b), a responsible coroner has been appointed by the chief coroner under **section 133A(1)**.

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“(2) Despite **subsection (1)(b)**, the New Zealand Police must ensure that the death is reported to the designated coroner, or another coroner, as soon as practicable.

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“(3) Nothing in this section affects when the exclusive right can be and is exercised by or on behalf of the New Zealand Police, or prevents the New Zealand Police from exercising on behalf of the responsible coroner his or her right under **section 19**.”

- 14 Section 19 replaced (When designated coroner has exclusive right to custody of body)**  
Replace section 19 with:
- “19 When responsible coroner has exclusive right to custody of body** 5  
The responsible coroner has an exclusive right to custody of the body of a person—
- “(a) from the time when—
- “(i) the death of the person is reported to him or her (as the designated coroner) under **section 15(2)(a)**; or 10
- “(ii) he or she is appointed as the responsible coroner in relation to the death under **section 133A(1) or (2)**; and
- “(b) until— 15
- “(i) he or she authorises the release of the body under section 42; or
- “(ii) another coroner is appointed as the responsible coroner in relation to the death under **section 133A(2)**.” 20
- 15 Section 22 amended (Representative for liaison with immediate family)**  
Repeal section 22(1).
- 16 Sections 23 and 24 replaced**  
Replace section 23 with: 25
- “23 Coroner must give interested parties notice of significant matters**
- “(1) The responsible coroner must take all reasonable steps to give interested parties notice, as soon as practicable, of significant matters that relate to the carrying out of the duties and processes required by law to be performed or followed in relation to a death. 30
- “(2) A failure to comply with this section does not affect the validity of any action taken by or on behalf of the coroner. 35  
“Compare: 1988 No 111 s 11(1), (3)

- “24 Significant matters referred to in section 23(1)**
- “(1) The significant matters referred to in **section 23(1)** include, without limitation,—
- “(a) a direction by the coroner that a post-mortem of the body concerned be performed; and 5
  - “(b) the coroner’s reasons for directing that a post-mortem be performed; and
  - “(c) the fact that a copy of the pathologist’s report on a post-mortem can be obtained under section 27; and
  - “(d) the opening of an inquiry; and 10
  - “(e) the date, time, and place fixed for an inquest; and
  - “(f) the completion of an inquiry.
- “(2) For representatives recognised under section 22, and any member of the dead person’s immediate family who has asked to be notified of matters and has provided contact details to 15 the coroner, the significant matters also include—
- “(a) the right to object to a proposed post-mortem if, under section 33, specified family members have that right; and
  - “(b) the receipt or removal of a body part, or the taking of a 20 bodily sample, under section 47; and
  - “(c) the retention of a body part or bodily sample under section 48(2)(a) or (b) (and, in particular, the matters in **section 50(4)**).”
- 17 Section 25 amended (Viewing, touching, or remaining with or near body in coroner’s custody) 25**
- Replace section 25(1) with:
- “(1) This section applies to a body if—
- “(a) the responsible coroner’s exclusive right to custody of the body, under **section 19**, is being exercised by the 30 responsible coroner or on the responsible coroner’s behalf; and
  - “(b) 1 or more people to whom **subsection (2)** applies wish to view, touch, or remain with or near the body.”

**18 Section 27 amended (Family may request pathologist's report on post-mortem)**

- (1) In section 27(1), replace “the member of the person’s family a copy of the report” with “a member of a dead person’s immediate family a copy of the pathologist’s report”. 5
- (2) Replace section 27(1)(c) with:  
“(c) that family member has asked for a copy of the report; and”.
- (3) After section 27(1), insert:  
“(1A) A pathologist may, at the request of a member of the dead person’s immediate family, contact the family to explain, or answer questions in relation to, the pathologist’s report.” 10

**19 Section 31 amended (Coroner may direct post-mortem)**

- (1) After section 31(1), insert:  
“(1A) Where more than 1 death appears to have occurred as a result of a single event or a series of related events, a coroner may direct 1 or more pathologists to perform post-mortems of any or all of the bodies (whether discovered before or after the direction is made) of people whose deaths appear to be a result of that event or series of events.” 15
- (2) Repeal section 31(3). 20

**20 Section 36 amended (Nature of post-mortem)**

- Before section 36(1), insert:  
“(1AA) A pathologist who is directed under section 31 to carry out a post-mortem may carry out that post-mortem as he or she thinks fit. 25
- “(1AB) **Subsection (1AA)** is subject to section (1).”

**21 Section 38 amended (Who may attend post-mortem)**

- After section 38(1)(f), insert:  
“(fa) a dentist, if authorised to attend by the pathologist who is directed to perform the post-mortem.” 30

- 22 Section 40 replaced (Coroner may require person’s doctor to report)**  
 Replace section 40 with:
- “40 Coroner may require person’s doctor to provide report or health information** 5  
 Despite anything in the Privacy Act 1993 (or any code issued under that Act), a coroner may, by written notice to a doctor who attended a person before the person’s death, require the doctor to give the coroner either or both of the following:
- “(a) the person’s health information (as defined in section 10  
 22B of the Health Act 1956):
- “(b) a written report (containing information specified in the notice) relating to the person.”
- 23 Section 41 amended (High Court may order post-mortem in certain circumstances)** 15  
 Replace section 41(6)(d) with:
- “(d) **section 40** (coroner may require person’s doctor to provide report and medical records):”.
- 24 Section 42 amended (Release of bodies)**  
 In section 42(1), replace “A coroner to whom a death has been 20  
 reported under section 15(2)(a) or section 16(2)(b)” with “The responsible coroner”.
- 25 Section 46 amended (Costs of transporting body moved for post-mortem, etc)**  
 In section 46(2) and (3), replace “Commissioner of Police” 25  
 with “responsible department”.
- 26 Section 48 amended (Retention of parts and samples on release of body)**  
 After section 48(2), insert:
- “(3) In this section, **minute**, in relation to a body part or bodily 30  
 sample, has the meaning given by the Secretary by notice in the *Gazette*.
- “(4) A notice under **subsection (3)** is a disallowable instrument, but not a legislative instrument, for the purposes of the Legis-

lation Act 2012 and must be presented to the House of Representatives under section 41 of that Act.”

**27 Section 50 replaced (Coroner must notify family, etc, of retention, and of right to request return, of retained parts and samples)** 5

Replace section 50 with:

**“50 Coroner must notify immediate family of retention, and of right to request return, of parts and samples**

- “**(1)** This section applies if, under section 48(2)(a) or (b), a pathologist intends to retain, or has retained, a body part or bodily sample from a dead person’s body. 10
- “**(2)** A responsible coroner must, before the release of the body, give notice of the intention to retain a part or sample if, due to the nature of the part or sample, the coroner considers that it is appropriate to give notice before the body is released. 15
- “**(3)** Unless the coroner has given notice under **subsection (2)**, the coroner must, on or immediately after the release of the body, give notice that a part or sample has been retained.
- “**(4)** A notice under this section must be given to the dead person’s immediate family (and any representative of the immediate family recognised under **section 22**) and must— 20
- “**(a)** identify in general terms the part or sample that the pathologist intends to retain, or has retained; and
- “**(b)** advise that detailed information about the part or sample is available on request; and 25
- “**(c)** explain the authority and reasons for the intention to retain, or for the retention of, the part or sample; and
- “**(d)** indicate how long the pathologist expects the part or sample will need to be retained for those reasons; and
- “**(e)** indicate (if known by the coroner) whether, and, if so, to what extent, the part or sample is likely to be destroyed in the course of being used for the purpose for which it is retained; and 30
- “**(f)** advise that members of the immediate family have the right to request the return of the part or sample (to the extent that the part or sample has not been destroyed); and 35
- and

- “(g) indicate the date by which the return of any part or sample that has not been destroyed must be requested.
- “(5) In considering whether to request the return of a part or sample, members of the dead person’s immediate family may, with the coroner’s approval, contact the pathologist for further information about the part or sample (including information about how the part or sample has been dealt with and how it may be dealt with if it is not returned). 5
- “(6) A failure to comply with this section does not affect the validity of any action taken by or on behalf of the coroner.” 10

**28 Section 55 amended (Return on request of retained parts and samples)**

Replace section 55(2) with:

- “(2) The part or sample must, to the extent that it has not been destroyed in the course of analysis conducted for the purpose for which it was retained, be returned to the makers of the request when— 15
- “(a) the coroner, having conducted and completed an inquiry into the death, completes and signs a certificate of findings in accordance with section 94; or 20
- “(b) the coroner notifies the Secretary, under section 64, of the coroner’s decision not to open an inquiry.”

**Part 2**

**Amendments to Parts 3 and 4**

Subpart 1—Amendments to Part 3 (inquiries into causes and circumstances of deaths) 25

**29 Section 57 amended (Purpose of inquiries)**

Replace section 57(3) with:

- “(3) The second purpose is to make recommendations or comments (*see section 57A*).” 30

**30 New sections 57A and 57B inserted**

After section 57, insert:



**“57A Recommendations or comments by coroners**

- “(1) A responsible coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death.
- “(2) Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. 5
- “(3) Recommendations or comments must—
- “(a) be clearly linked to the factors that contributed to the death to which the inquiry relates; and 10
  - “(b) be based on evidence considered during the inquiry; and
  - “(c) be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances. 15

**“57B Coroner must consult interested parties on recommendations or comments**

- “(1) Before making a recommendation or comment under **section 57A**, a coroner must—
- “(a) notify the following persons or organisations of the proposed recommendation or comment: 20
    - “(i) any experts from whom the coroner has received evidence under section 76; and
    - “(ii) any other expert who the coroner considers has an interest in the inquiry; and 25
    - “(iii) any persons or organisations to whom the recommendation or comment is directed; and
  - “(b) give those persons or organisations a reasonable time to comment on the proposed recommendation or comment. 30
- “(2) The chief coroner must record any comments (or summaries of those comments) made by persons or organisations notified under **subsection (1)** in the register of recommendations and comments maintained under **section 7(2)(e)**.
- “(3) To avoid doubt, the chief coroner may make the comments made by a person or organisation publicly available, via the register or otherwise, without the approval of that person or organisation.” 35

- 31 Section 58 amended (Adverse comments by coroners)**  
 In section 58(5), replace “section 57 (purposes of inquiries)” with “sections 57 to **57B**”.
- 32 Section 59 replaced (Jurisdiction of coroners to open inquiries)** 5  
 Replace section 59 with:
- “59 Jurisdiction of coroners to open inquiries**
- “(1) The responsible coroner in relation to a death may open an inquiry into the death if the death occurred, or is likely to have occurred, within the last 100 years and— 10
- “(a) the body of the person concerned is in New Zealand; or
- “(b) the coroner is satisfied that it is likely that the person concerned is dead and that—
- “(i) the person’s body is destroyed, irrecoverable, or lost; and 15
- “(ii) the person was in New Zealand immediately before the person’s death; or
- “(c) the body of the person concerned is not in New Zealand, or is destroyed, irrecoverable, or lost, but—
- “(i) the death occurred on or from— 20
- “(A) a New Zealand registered aircraft (as defined in section 2(1) of the Civil Aviation Act 1990); or
- “(B) a New Zealand ship (as defined in section 2(1) of the Maritime Transport Act 1994); 25
- or
- “(C) an aircraft or a ship of the Armed Forces (as defined in section 2(1) of the Defence Act 1990); or
- “(ii) the death occurred outside New Zealand on or 30
- from an aircraft or a ship (other than an aircraft or ship referred to in **paragraph (i)**) and the Solicitor-General has authorised the coroner to open an inquiry into the death.
- “(2) This section is subject to **section 59A**. 35

**“59A Limits on coroners’ jurisdiction under section 59**

- “(1) A coroner must not open an inquiry into an overseas death unless the coroner is reasonably satisfied that—
- “(a) overseas authorities have not established the cause and circumstances of the death, or there is doubt about the accuracy of any conclusion reached by an overseas authority; and 5
  - “(b) an inquiry under the Act is likely to identify the cause and circumstances of the death.
- “(2) A coroner must not open an inquiry into the death of a person if the coroner is satisfied that the death occurred— 10
- “(a) while the person was a member of the Defence Force on operational service; and
  - “(b) as a consequence of hostile action.
- “(3) A coroner must adjourn an inquiry if, during the course of an inquiry into a death, the coroner determines that the death to which the inquiry relates is likely to have occurred in the circumstances described in **subsection (2)**. 15
- “(4) **Subsections (2) and (3)** apply unless the Attorney-General directs the coroner to carry out an investigation, or to resume an inquiry, into the cause and circumstances of the death. 20
- “(5) If the Attorney-General directs a coroner to carry out an investigation, or to resume an inquiry, the coroner may open or resume an inquiry into the death, but the only purpose of the inquiry is to establish, so far as possible, the particulars specified in section 4(2)(a). 25
- “(6) In this section,—
- “**Defence Force** has the meaning given in section 2(1) of the Defence Act 1990
  - “**operational service** means service as a member of the Defence Force— 30
    - “(a) in a war or other armed conflict; or
    - “(b) in a peacekeeping force; or
    - “(c) in any other type of service declared by the Chief of Defence Force to be operational service for the purposes of this section.” 35

- 33 Section 60 replaced (Deaths into which inquiries must be opened)**  
Replace section 60 with:
- “60 Deaths into which inquiries must be opened**
- “(1) A responsible coroner must open and conduct an inquiry into a death if—
- “(a) the death appears to have been self-inflicted; or
  - “(b) the dead person appears to have been a person in official custody or care; or
  - “(c) the coroner is not satisfied that the matters required by this Act to be established by an inquiry are already adequately disclosed in respect of the death by information arising from investigations or examinations the coroner has made or caused to be made.
- “(2) This section is subject to **sections 59 and 59A.**”
- 34 Section 61 repealed (Deaths where coroner may decide not to open inquiries)**  
Repeal section 61.
- 35 Section 66 repealed (Which coroner conducts inquiry)**  
Repeal section 66.
- 36 Section 68 amended (Procedure if person charged with offence)**  
In section 68(1), replace “coroner to whom a death has been reported under section 15(2)(a) or section 16(2)(b) and” with “responsible coroner in relation to a death”.
- 37 Section 69 amended (Procedure if some other investigation to be conducted)**  
In section 69(1), replace “coroner to whom a death has been reported under section 15(2)(a) or section 16(2)(b) and” with “responsible coroner in relation to a death”.
- 38 Sections 70 and 71 replaced**  
Replace sections 70 and 71 with:

- “**70** **Coroner may decide not to open or resume postponed or adjourned inquiry**
- “(1) This subsection applies to an inquiry that is postponed or adjourned under either of the following sections:
- “(a) section 68 (procedure if person charged with offence): 5
- “(b) section 69 (procedure if some other investigation to be conducted).
- “(2) A coroner may decide, or the chief coroner may direct the coroner, not to open or resume an inquiry to which **subsection (1)** applies. 10
- “(3) Before making a decision or a direction under **subsection (2)**, the coroner or the chief coroner (as applicable) must be satisfied that the matters specified in section 57(2)(a) to (e) have, in respect of the death concerned, been adequately established in the course of the relevant criminal proceedings or investigation. 15
- “(4) A coroner who decides, or who is directed, under **subsection (2)** not to open or resume an inquiry must give the Secretary written notice that the inquiry will not be opened or resumed.
- “**71** **Restrictions on making public details of self-inflicted deaths** 20
- “(1) This section applies in respect of a death if—
- “(a) the death occurred in New Zealand after the commencement of **section 39** of the Coroners Amendment Act **2014**; and 25
- “(b) the death was self-inflicted, or there is reasonable cause to suspect that the death was self-inflicted.
- “(2) No person may, unless the person is granted an exemption under **section 71A** or has permission under section 72, make public— 30
- “(a) the method or any suspected method of the self-inflicted death; or
- “(b) the place where the death occurred, if the place suggests the method (or any suspected method) of the self-inflicted death; or 35
- “(c) a description of the death as a suicide.
- “(3) Despite **subsection (2)(c)**,—

- “(a) a person may make public that the death is a suspected suicide; and
- “(b) a person may describe the death as a suicide if the coroner has completed a certificate of findings under section 94 stating that the death was a suicide.

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**“71A Chief coroner may grant exemption from restrictions in section 71**

“(1) A person may apply to the chief coroner to grant an exemption from the restrictions specified in **section 71**.

“(2) On receiving an application under **subsection (1)**, the chief coroner—

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“(a) must, so far as practicable, give priority to the consideration of the application; and

“(b) may request advice from the suicide and media expert panel established under **section 116A**; and

15

“(c) may request further information from the applicant.

“(3) The chief coroner may grant a person an exemption from all or any of the restrictions (specified in **section 71(2)**) applying to the publication of details of self-inflicted deaths only if the chief coroner is satisfied that—

20

“(a) granting the exemption does not present an undue risk that other people will attempt to copy the behaviour of the dead person concerned; and

“(b) any risk that people will attempt to copy the behaviour of the dead person concerned is outweighed by other considerations that make it desirable, in the public interest, to allow the publication of the details.

25

“(4) To ensure an application is dealt with promptly, the chief coroner may carry out any communications necessary for processing the application in person or by way of remote access (such as by telephone, video, or Internet link).

30

“(5) The chief coroner must keep a written record of—

“(a) every application received under **subsection (1)**; and

“(b) whether the chief coroner granted an exemption to the applicant under **subsection (3)**; and

35

“(c) the reasons in each case for granting, or declining to grant, the exemption.”

- 39 Section 75 amended (Review of coroner’s decision as to making public of details, evidence, etc)**
- (1) Replace the heading to section 75 with “**Review of decisions relating to publication of details, evidence, etc**”.
- (2) Replace section 75(1)(a) with: 5  
 “(a) a refusal by the chief coroner to grant an exemption under **section 71A** from a restriction applying to the publication of details of self-inflicted deaths:”.
- 40 Section 77 replaced (Hearings on papers and chambers findings)** 10  
 Replace section 77 with:
- “**77 Hearings on papers and chambers findings**
- “(1) A coroner may, instead of holding an inquest, hold a hearing on the papers and make chambers findings if the coroner—
- “(a) gives notice to the persons specified in **subsection (2)** 15  
 of the coroner’s proposal to hold a hearing on the papers and make chambers findings; and
- “(b) has, at the end of the period stated in the notice (which must be a period that the coroner considers reasonable in the circumstances), received no notification of an in- 20  
 tention to give evidence, or cross-examine witnesses, in person.
- “(2) The persons to whom the coroner must give notice under **sub-  
 section 1(a)** are—
- “(a) those persons who, under section 76, are persons from 25  
 whom evidence is generally to be heard for the purposes of an inquiry; and
- “(b) those persons who, under section 89, are entitled to cross-examine witnesses at an inquest.
- “(3) A coroner who has given notice under **subsection (1)(a)** must 30  
 hold an inquest instead of holding a hearing on the papers and making chambers findings if he or she receives a notification of the kind referred to in **subsection (1)(b)**.”
- 41 Section 80 replaced (Decision to hold inquest)**
- Replace section 80 with: 35

**“80 Decision to hold inquest**

“(1) A coroner conducting an inquiry into a death must decide whether to hold an inquest for the purposes of the inquiry.

“(2) In deciding whether to hold an inquest, a coroner must consider whether either, or both, of the following applies in relation to the death: 5

“(a) the dead person was, at the time of death, a person in official custody or care (as defined in **section 14(3)**) and the negligence or misconduct of a person other than the dead person appears to have contributed to the dead person’s death: 10

“(b) an inquest would assist the inquiry into the death by providing an opportunity for persons who have not been involved in the inquiry to—

“(i) scrutinise evidence considered by the coroner as part of the inquiry; or 15

“(ii) offer new evidence in respect of the death.

“(3) A coroner who decides under this section not to hold an inquest must comply with **section 77**.”

**42 Section 81 amended (Date, etc, and notice of inquest) 20**

(1) Replace section 81(1) with:

“(1) A coroner who decides to hold an inquest for the purposes of an inquiry must—

“(a) fix a date, time, and place for the inquest; and

“(b) comply with **section 23** (coroner must give interested parties notice of significant matters) in relation to the date, time, and place fixed for the inquest at least 10 working days before that date.” 25

(2) In section 81(2), replace “the people who have a sufficient interest in the inquiry concerned include a person who” with “an interested party”. 30

(3) After section 81(3)(a), insert:

“(ab) are likely to have their conduct called into question if an inquiry is opened in relation to the death; or”.



- 43 Section 89 amended (Others who may cross-examine at inquest)**  
 Replace section 89(1) with:  
 “(1) Any interested party may, personally or by counsel, cross-examine witnesses at an inquest.” 5
- 44 Section 92 replaced (Body must be viewed before certain inquiries concluded)**  
 Replace section 92 with:  
**“92 Body must be viewed before certain inquiries concluded** 10  
 No coroner may issue a certificate of interim findings, or conclude an inquiry, unless satisfied that the body of the person concerned—  
 “(a) has been viewed in New Zealand; or  
 “(b) is destroyed, irrecoverable, or lost, and—  
     “(i) the person was in New Zealand immediately before the body was destroyed or became irrecoverable or lost; or  
     “(ii) the death occurred on or from—  
         “(A) a New Zealand registered aircraft (as defined in section 2(1) of the Civil Aviation Act 1990); or  
         “(B) a New Zealand ship (as defined in section 2(1) of the Maritime Transport Act 1994); or  
         “(C) an aircraft or a ship of the Armed Forces (as defined in section 2(1) of the Defence Act 1990).” 20 25
- 45 Section 94 amended (Certificate of and written reasons for findings)**  
 (1) Replace section 94(1) with: 30  
 “(1) The coroner conducting and completing an inquiry must—  
     “(a) consider all the evidence admitted for the purposes of the inquiry; and  
     “(b) as soon as is reasonably practicable, and in light of the purposes stated in section 57, complete and sign a certificate of findings in relation to the death concerned.” 35

- (2) Replace section 94(4)(c) and (d) with:  
“(c) any recommendations or comments made under **section 57A.**”
- (3) After section 94(4), insert:
- “(5) The coroner must provide a copy of the completed and signed certificate of findings, together with any recommendations or comments, to—  
“(a) the chief coroner; and  
“(b) all interested parties.”
- 46 New sections 94A and 94B inserted** 10  
After section 94, insert:
- “94A Chief coroner to monitor inquiries not completed within 1 year**  
If a coroner conducting an inquiry into a death has not, in respect of the death, completed and signed a certificate of findings under section 94 within 1 year of the date on which the death was reported to the coroner, the chief coroner—  
“(a) must monitor the progress of the inquiry; and  
“(b) may require the coroner conducting the inquiry to explain why he or she has not concluded the inquiry.” 20
- “94B Chief coroner to publish information regarding findings not yet released**  
The chief coroner must, at regular intervals, publish the following information:  
“(a) the process by which a person may find out the status of an inquiry in relation to which an inquest (or a hearing on the papers) has been held but a certificate of findings has not yet been released; and  
“(b) the number of inquiries in relation to which—  
“(i) an inquest, or a hearing on the papers, has been held; but  
“(ii) in the opinion of the chief coroner, a certificate of findings has not been released within a reasonable time.” 25 30

Subpart 2—Amendments to Part 4  
(appointments, administration, powers,  
offences and penalties, and technical  
provisions)

- 47 Section 103 amended (Coroners)** 5  
Replace section 103(5) with:
- “(5) However, a former coroner of or over the age of 70 years may be reappointed for 1 term that—
- “(a) is specified in a warrant of reappointment; and
- “(b) does not exceed 2 years.” 10
- 48 Section 104 amended (Relief coroners)**  
Replace section 104(6) with:
- “(6) However, a former coroner or a former relief coroner of or over the age of 70 years may be appointed or reappointed as a relief coroner for 1 term that— 15
- “(a) is specified in a warrant of appointment or reappointment; and
- “(b) does not exceed 2 years.”
- 49 New sections 105A and 105B inserted** 20  
After section 105, insert:
- “105A Deputy chief coroner**
- “(1) The Governor-General may, on the advice of the Attorney-General, appoint a coroner as deputy chief coroner for a term that does not exceed 5 years.
- “(2) Where there is a vacancy in the role of chief coroner or the chief coroner is for any other reason absent from duty, the deputy chief coroner may, unless an acting chief coroner has been appointed, perform or exercise all or any of the functions, duties, and powers of the chief coroner. 25
- “(3) Without limiting **subsection (2)**, the deputy chief coroner may at any time perform or exercise any function, duty, or power of the chief coroner that has been delegated by the chief coroner to the deputy chief coroner. 30
- “(4) The fact that a deputy chief coroner purports to perform or exercise, or to have performed or exercised, any function, duty, 35

or power under this section is, in the absence of proof to the contrary, sufficient evidence of the deputy chief coroner's authority to do so.

**“105B Delegation of functions, duties, or powers of chief coroner**

The chief coroner may delegate any of the chief coroner's functions, duties, or powers to the deputy chief coroner.” 5

**50 New section 106A inserted (Attorney-General to publish information concerning coronial appointment process)**

After section 106, insert:

**“106A Attorney-General to publish information concerning coronial appointment process** 10

The Attorney-General must publish information explaining his or her processes for—

“(a) seeking expressions of interest for the appointment of coroners; and 15

“(b) nominating people for appointment as a coroner.”

**51 Section 107 replaced (Concurrent office or employment)**

Replace section 107 with:

**“107 Concurrent office or employment**

“(1) The chief coroner must, after consulting the Attorney-General, develop and publish a protocol specifying— 20

“(a) the employment, or types of employment, that the Attorney-General considers to be compatible with being a coroner; and

“(b) the offices, or types of offices, that the Attorney-General considers to be compatible with being a coroner. 25

“(2) The protocol may specify different employment or offices, or types of employment or types of offices, for relief coroners and other coroners.

“(3) A coroner may hold another judicial office but must not undertake any other paid employment or hold any non-judicial office (whether paid or not) unless that employment or office is of a type specified in the protocol as compatible with being a coroner. 30

**“107A Recusal**

The chief coroner must, after consulting the Attorney-General, develop and publish guidelines to assist coroners to decide if they should recuse themselves from an inquiry.”

**52 New section 116A inserted (Establishment and constitution of suicide and media expert panel) 5**

After section 116, insert:

**“116A Establishment and constitution of suicide and media expert panel**

- “**(1)** A suicide and media expert panel is established. 10
- “**(2)** The panel consists of up to 4 members appointed by the Director-General of Health by written notice.
- “**(3)** The Director-General of Health must be satisfied that the panel includes—
- “**(a)** at least 1 member with expertise in suicide prevention; 15
- and
- “**(b)** at least 1 member with expertise in media; and
- “**(c)** at least 1 member with expertise in tikanga Māori; and
- “**(d)** at least 1 member with expertise in Māori youth suicide.
- “**(4)** The panel or any member of the panel must advise the chief coroner, if the chief coroner requests the panel or the member to do so, about applications, made under **section 71A(1)**, for exemptions from the restrictions applying to the publication of details of self-inflicted deaths.” 20

**53 Section 123 amended (Entry and search under warrant under section 122) 25**

Replace section 123(1) with:

- “**(1)** Section 110 of the Search and Surveillance Act 2012 applies to a search authorised by a warrant issued under section 122.”

**54 Section 132 amended (Chief coroner may issue practice notes) 30**

- (1)** Replace section 132(3) with:

- “**(3)** Practice notes under this section may specify matters to which coroners must have regard in—

- “(a) making recommendations or comments (*see section 57A*):
- “(b) recommending to the chief coroner that a specialist adviser be appointed to sit with and help the coroner at an inquest (*see section 83(2)*): 5
- “(c) holding joint inquests (*see section 84(3)*):
- “(d) calling for investigations or examinations, or commissioning reports (*see section 118(2)*):
- “(e) managing the disclosure of evidence to witnesses appearing at a hearing: 10
- “(f) determining whether to hold a pre-hearing:
- “(g) determining whether a person is appropriately regarded as an expert in a particular area:
- “(h) determining the format of the coroner’s written findings: 15
- “(i) co-ordinating with other investigating authorities, official bodies, and statutory officers who investigate deaths.”
- (2) After section 132(5), insert:
- “(6) The chief coroner must regularly review any practice notes issued under this section.” 20
- 55 Section 133 replaced (Chief coroner must designate coroners for specified deaths)**
- Replace section 133 with:
- “133 Chief coroner must designate coroners for specified kinds of deaths” 25**
- “(1) The chief coroner must from time to time, by notice in writing to the coroners concerned and to the New Zealand Police, designate coroners to receive, under **section 15(2)(a)**, reports of all deaths of a specified kind. 30
- “(2) Deaths of a specified kind may be deaths that—
- “(a) are reported to the coroner within a specified time period; or
- “(b) occur in a specified area; or
- “(c) fall into another specified class. 35
- “(3) The chief coroner may at any time in the same way amend, revoke, or revoke and replace a designation under this section.

**“133A Appointment of responsible or replacement coroner**

- “(1) If the chief coroner receives a report of a death under **section 15(4)**, the chief coroner must appoint a responsible coroner in relation to the death (who may, but need not, be the designated coroner for deaths of that kind). 5
- “(2) The chief coroner may appoint a replacement coroner to take over as the responsible coroner in relation to a death if the chief coroner is satisfied that—
- “(a) the responsible coroner has a personal interest in the inquiry; or 10
- “(b) it is necessary or desirable that the responsible coroner not conduct the inquiry—
- “(i) because of his or her workload; or
- “(ii) because of his or her expertise or lack of expertise in particular areas; or 15
- “(c) there is some other good reason why the responsible coroner should not conduct the inquiry.
- “(3) The chief coroner must appoint a replacement coroner to take over as the responsible coroner in relation to a death if the responsible coroner has recused himself or herself from the inquiry.” 20

**56 Section 139 replaced (Publication of information in contravention of section 71 or prohibition under section 74)**

Replace section 139 with: 25

**“139 Publication of information in contravention of section 71**

- “(1) A person commits an offence if the person publishes or permits to be published any information in contravention of **section 71** (which relates to restrictions on the making public of details of self-inflicted deaths). 30
- “(2) A person who commits an offence against **subsection (1)** is liable on conviction,—
- “(a) in the case of a body corporate, to a fine not exceeding \$20,000;
- “(b) in any other case, to a fine not exceeding \$5,000. 35
- “(3) **Subsection (1)** does not apply to a person who hosts material on Internet sites or other electronic retrieval systems that can

be accessed by a user, unless the specific information has been placed or entered on the site or system by that person.

**“139A Publication of information in contravention of section 74**

“(1) A person commits an offence if the person publishes or permits to be published any information in contravention of a prohibition under section 74 (which empowers the coroner to prohibit the making public of evidence given at any part of inquiry proceedings). 5

“(2) A person who commits an offence against **subsection (1)** is liable on conviction,— 10

“(a) in the case of a body corporate, to a fine not exceeding \$5,000:

“(b) in any other case, to a fine not exceeding \$1,000.

“(3) **Subsection (1)** does not apply to a person who hosts material on Internet sites or other electronic retrieval systems that can be accessed by a user, unless the specific information has been placed or entered on the site or system by that person.” 15

**57 Consequential amendments**

The enactments specified in the **Schedule** are amended in the manner indicated in that schedule. 20

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## Schedule

s 57

### Consequential amendments

#### Part 1

#### Consequential amendments to other Acts

##### **Burial and Cremation Act 1964 (1964 No 75)**

In section 46B(5)(a), replace “section 13 (except subsection (1)(b))” 5  
with “**section 14** (except **subsection (2)(f)**)”.

In section 46C, replace “section 14” with “**section 13**”.

##### **Judicial Conduct Commissioner and Judicial Conduct Panel Act 2004 (2004 No 38)**

In section 5, definition of **coroner**, after “chief coroner”, insert “, 10  
deputy chief coroner,”.

##### **Search and Surveillance Act 2012 (2012 No 24)**

In the Schedule, insert in its appropriate alphabetical order:

<b>Coroners Act</b> <b>2006</b>	section 122	Members of the Police may search specified place, craft, or vehicle if warrant issued	section 110
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##### **Visiting Forces Act 2004 (2004 No 59)**

In section 19(1), replace “If a death has been reported to a coroner 15  
under section 15(2)(a) or section 16(2)(b) of the Coroners Act 2006  
and the coroner is satisfied that the person” with “If a responsible  
coroner in relation to a death is satisfied that the dead person”.

In section 19(6), replace “If a death has been reported to a coroner  
under section 15(2)(a) or section 16(2)(b) of the Coroners Act 2006 20  
and the coroner” with “If a responsible coroner in relation to a death”.

After section 19(7), insert:

“(8) In this section, **responsible coroner** has the meaning given in  
section 9 of the Coroners Act 2006.”

Part 2

Consequential amendment to regulations

**Cremation Regulations 1973 (SR 1973/154)**

In regulation 2, definition of **coroner**, after “acting chief coroner,”, insert “a deputy chief coroner,”.

5