Coroners Amendment Bill

Government Bill

As reported from the Justice and Electoral Committee

Commentary

Recommendation

The Justice and Electoral Committee has examined the Coroners Amendment Bill and recommends, by majority, that it be passed with the amendments shown.

Introduction

The bill seeks to improve the timeliness and efficiency of the coronial system by amending the Coroners Act 2006. The amendments aim to 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; and ensure coronial resources are used effectively.

This commentary covers the key amendments that we recommend to be made to the bill. It does not cover minor or technical amendments.

Reasonable health practitioner

The bill, as it stands, sets out the requirements for which a death must be reported to the coroner and includes deaths that occur while a person is undergoing a medical procedure or is affected by anaesthetic, and that a reasonable health practitioner would not have expected. We were concerned that the term "reasonable health practitioner" is open to subjective interpretation of what constitutes "reasonable" in practice. We recommend that clause 9 (which replaces sections 13 and 14) be amended. In section 14(2) we recommend "that … a reasonable health practitioner would not have expected" be replaced by "that was medically unexpected". For the purposes of defining "medically unexpected" we recommend the inclusion in clause 9 that a death is medically unexpected if it would not reasonably have been expected by a health practitioner who was competent to carry out the procedure or administer the anaesthetic in

question, and had knowledge of the dead person's medical condition before the procedure began.

Responsible coroner

A duty coroner is always available somewhere in New Zealand, and is empowered to act on behalf of the coroner who is responsible for the case. We recommend amending clause 11 (which would replace section 16) to allow that the duty coroner, from time to time, carry out the functions of the responsible coroner.

Coroners' relationship with Police

The Coroners Act 2006 allows the coroner to direct the New Zealand Police to perform all investigations that are necessary to meet the purposes of the Act. The bill, as it stands, would provide that coronial requests to Police would need to be both necessary and reasonable.

However, we consider that the word "reasonable" would provide too broad a scope for Police to reject their investigative obligations.

For this reason, we recommend amending clause 12 (which amends section 17(1)) by inserting new clause 12(2), which inserts new section 17(1A), (1B), and (1C) to provide for a dispute resolution mechanism involving the chief coroner and the Commissioner of Police, in the event of a dispute concerning coronial direction of police investigation. The new subsections would require the responsible coroner to consider the principles of the Policing Act 2008 when directing Police, and provides for a dispute resolution process, to be undertaken by the Commissioner and the chief coroner, should a dispute arise.

Contact between families and pathologists

The bill, as introduced, would allow the pathologist, at the request of a member of the dead person's immediate family, to contact the family to explain or answer questions relating to the pathologist's report. Although the National Forensic Pathology Service welcomed this avenue of communication with family members, we considered that contact between the pathologist and family members that circumvents the coroner might impede the coroner's investigation. Because New Zealand coroners operate a 24-hour service, we were satisfied that a coroner could be contacted promptly to facilitate communication between families and pathologists, with little disruption to the family. We recommend clarifying clause 18(3), which would insert section 27(1A), so that any contact between pathologists and families should occur only with the coroner's prior approval.

Dentist attendance at post-mortems

Multiple-death post-mortems

We recommend amending clause 19(1A) (which would amend section 31) to allow the coroner to authorise a dentist to attend post-mortems where multiple deaths have

occurred. In multiple-death situations, the bill would allow a coroner to direct one or more pathologists to perform post-mortems. Allowing the coroner to also authorise a dentist to attend these post-mortems for the purpose of dental examination would assist the coroner in resolving identification issues associated with multiple deaths.

Authorisation of attendance

The bill, as introduced, would allow a dentist to attend a post-mortem if authorised by the pathologist directed to perform the post-mortem. We recommend amending clause 21 (which would amend section 38) to specify that the coroner, not the pathologist, would authorise the dentist's attendance, as the coroner is the responsible investigating authority.

Retention of parts and samples on release of the body

Clause 26 would amend section 48, which provides for the retention of body parts or bodily samples on release of the body. We recommend that clause 26, which inserts new section 48(3), be amended to clarify that the notice of definition of "minute" must be published in the *Gazette*, both the printed and the online versions, so that users are aware that they can find it online.

Consultation on coroners' recommendation

The bill, seeking to ensure that coroners' recommendations are focused and relevant, would require the coroner to consult with interested parties on recommendations before they are finalised. However, given the requirement for the coroner to consult, it is reasonable to expect those targeted for consultation to respond, and in such a way that does not delay the coroner's release of the recommendations. We recommend amending clause 30, which would insert new sections 57A and 57B, to specify a period of 20 working days during which an agency subject to consultation may choose to respond to the coroner. If no response is received, the coroner would be entitled to act on the basis that the agency has no comments and to proceed to finalise the recommendations.

Although responses are expected to be substantive, some of us agreed with submitters who argued that, to give full effect to the coroner's recommendations, it should be mandatory for consulted agencies to respond either by indicating how implementation of the recommendations will occur or by providing any reasons for a refusal to implement.

Deaths in hostile action

Currently, the Coroners Act 2006 provides that coroners have jurisdiction to open an inquiry into the death of a member of the armed forces overseas, regardless of the circumstances of their death (provided the bodily remains are in New Zealand). The New Zealand Defence Force also has the ability to carry out formal inquiries into the deaths of members of the armed forces, through their court of inquiry process, which is provided for by the Armed Forces Discipline Act 1971.

Clause 32 of the bill, which replaced section 59 with new sections 59 and 59A, seeks to avoid duplication of investigation and to prevent the coroner from making recommendations that are outside the scope of their jurisdiction and concern national security or non-justiciable issues of military tactics. As introduced, the bill would specify that the coroner must not open an inquiry into the death of a member of the Defence Force while on operational service if the coroner is satisfied that the death occurred as a consequence of hostile action. Coroners would be able to investigate such deaths if directed to do so by the Attorney-General.

The bill's proposed amendments give rise to several considerations, including the meaning of "hostile action", concerns regarding the independence of the Defence Force's court of inquiry into the deaths of Defence Force personnel overseas, and what criteria would compel the Attorney-General to direct a coroner to investigate such cases.

"**Hostile action**"

The term "hostile action" is difficult to define precisely because of the varied and fluid nature of the modern-day battlefield. However, as the bill is worded, we considered the meaning of "consequence of hostile action" to be unclear. We consider it would be beneficial to reword the amendment with a phrase that is more widely understood. We recommend amending clause 32, to replace new section 59A(2), to specify that a coroner must not open an inquiry into a death if the coroner is satisfied that the death arose from hostilities in which the Defence Force or an allied force was engaged.

Independence of Defence Force court of inquiry

Concerning the independence of the Defence Force's court of inquiry, we noted that there is a formal mechanism by which the court can be subjected to external legal review, conducted by one of the external counsel (Queens Counsel) on the External Legal Review Panel, established under the office of the Judge Advocate General. The external legal review can make recommendations such as improvements to systems and processes or that the court re-examine aspects of its investigation.

Some of us were not satisfied by this level of external scrutiny and felt that coronial jurisdiction in the investigation of overseas Defence Force personnel deaths provided a measure of accountability from the force, and from which the public could be assured of the integrity of the investigation. Some of us argued that Option D of the Regulatory Impact Statement would more appropriately provide a balance between protecting national security, and the need for independence and scrutiny. Option D specifies that coroners have jurisdiction but the Attorney-General can prevent investigation, publication of details, or the making of recommendations.

Attorney-General direction of coronial investigation

We recommend amending clause 32, to insert new section 59A(4), to specify matters the Attorney-General must consider before directing a coroner to carry out an investigation or resume an inquiry into the death of a member of the Defence Force, as set out in new section 59A(2). The proposed considerations would assist the Attorney-

General in considering whether coronial investigation might be helpful, redundant, or pertain to issues that are non-justiciable.

Restrictions on suicide reporting

The Coroners Act 2006 prohibits anyone from publishing details relating to a death suspected of being self-inflicted. If the coroner's investigation finds the death to have been self-inflicted, only the deceased person's name, address, and occupation, and the fact of the coroner's finding of suicide, may be published. The restriction aims to prevent copy-cat suicides. The coroner may authorise exemptions from this prohibition if they consider the reporting of such details is unlikely to be detrimental to public safety.

This prohibition does not work well in practice. Although this reporting restriction applies to suspected suicides occurring in New Zealand, it does not cover overseas suicides, which are able to be reported in New Zealand media. The media do not always comply with the prohibition, and have developed terms of innuendo that hint at suicide and are probably understood as such by the public. The rise in the use of social media has also made the restriction difficult to enforce.

Some submitters argued that restrictions on suicide reporting should be abolished entirely. We do not support these submissions, agreeing with the Director of Mental Health, who acknowledged the positive role the media could play in helping people support each other around suicide, but observed that there was a strong body of evidence to support that media reporting of suicide methods can popularise those methods, and give rise to suicide contagion. The bill seeks to narrow reporting restrictions to the details most likely to lead to copy-cat behaviour. As it stands, the bill would prohibit reporting the method of a suicide, or the site if it suggests the method, unless the chief coroner has granted an exemption. Media reports would be permitted to describe a suspected suicide as such ahead of a coroner delivering his or her finding.

However, we consider that publishing information other than the site can also suggest the method of suicide. We recommend amending clause 38, which would replace section 70 and 71 with new sections 70 to 71A, so that the prohibition on publishing (without exemption) applies to any information, including the site, which tends to suggest the method. We consider these amendments would achieve a balance between providing for the freedom and role of the media in suicide-reporting, and the need to prohibit the publication of the more problematic elements of suicide-reporting to protect vulnerable people and reduce New Zealand's high suicide rates.

Inquests into deaths in official custody or care

Clause 41 of the bill stipulates that it would no longer be mandatory for coroners to hold an inquest—a public hearing where evidence is heard and witnesses can be cross-examined—into deaths that occur in official custody or care. The bill as it stands would allow the coroner to exercise discretion concerning whether to conduct an inquest, provided they have taken into account two specified considerations.

Some submitters argued that mandatory inquests are an important protective mechanism for people among the most vulnerable in society. Conversely, the chief coroner welcomed increased discretion for coroners in deciding whether an inquest is necessary.

We support the bill's intent to reduce unnecessary inquests by increasing the scope of discretion of the coroner. However, we were concerned that the considerations specified in the bill might appear to introduce threshold considerations—circumstances that must exist before an inquest can be held—and hinder the intent of the bill to provide greater discretion to the coroner. We recommend clarifying clause 41, which would replace section 80, to stipulate that the coroner must take into account the specified considerations, but is not limited by these considerations when deciding whether to undertake an inquest.

The bill, as introduced, specifies that the coroner, in deciding whether to hold an inquest into a death in official custody or care, must consider whether the "negligence or misconduct of a person other than the dead person appears to have contributed to their death." In enhancing the discretionary scope of the coroner, we recommend replacing this consideration in clause 41 to specify in new section 80 that the coroner, in deciding whether to hold an inquest into a death in official custody or care, must consider whether the death of the person would reasonably have been expected by a doctor who had access to the person's health information.

Some submitters were concerned that providing coroners with greater discretion in whether to hold an inquest would produce inconsistencies in practice between coroners, and that some deaths might not get the full investigation they required. We acknowledged that, although the bill would specify that inquests are no longer mandatory, all coroners would still be required to undertake inquiries (investigation through a "hearing on papers"). Additionally, any interested party involved in the inquiry can initiate an inquest on request.

Findings not yet released

The bill would require the chief coroner to publish information regarding findings not yet released; this is intended to ensure speedy and orderly processing of cases and increase public visibility of inquiries still being investigated. One such item the chief coroner is required to report on is the number of inquiries in relation to which, in his or her opinion, a certificate of findings has not been released within a reasonable time.

We agreed with the chief coroner's submission that the phrase "within a reasonable time" was too subjective a measure. We recommend amending clause 46, which would insert new sections 94A and 94B, to require the chief coroner to publish, at regular intervals, a list of coronial inquiries still awaiting a certificate of findings, and the dates on which the inquest or hearing on the papers into each such inquiry was held.

We consider that these amendments would make the coroner's monitoring of inquiries to be easier and more specific, while still providing a measure of public accountability and transparency regarding coronial investigations.

Preliminary inspections

We concurred with many submitters that the bill should provide for the undertaking of preliminary, non-invasive inspections of a body before a decision is made on whether to hold a post-mortem. We considered that this would help the coroner in determining whether, and what kind of, post-mortem should be undertaken, and would help reduce the number of unnecessary post-mortems. In seeking to introduce this provision, we recommend inserting clause 14A, which would insert new section 21A.

New section 21A(1) and (2) would allow the coroner to direct a pathologist to undertake a preliminary inspection of the body for the purpose of advising on whether the coroner should direct a post-mortem.

New section 21A(3) and (5) would provide that a "preliminary inspection" is limited to an external visual inspection of the body and the use of medical imaging technology if such technology is available.

Coroners' obligations to inform family members of their rights, at scenes of death

Mr and Mrs Still, whose daughter died in a balloon crash in the Wairarapa, submitted that the bill should require coroners to advise members at scenes of death of their rights under section 25 (Viewing, touching, or remaining with or near body in coroner's custody).

We heard with compassion the anguish that Mr and Mrs Still experienced as they waited at the scene of the accident, unable to identify or be with the body of their daughter. We are advised that the coroner who investigated this case did not recommend any reform in this area. We consider that the difficulties encountered by Mr and Mrs Still were specific to the individual case, were unlikely to have broader implications, and could not be remedied by changes to the legislation, although we acknowledge the frustration and anguish that Mr and Mrs Still have suffered as a result of this tragic accident, and extend our sincerest sympathies to them and to those other submitters who have lost family members.

Schedules

We recommend inserting new clause 56C, which replaces Schedules 1 and 2 with new Schedule 1 to provide for the transition of the new legislation upon commencement. Schedule 1 would specify that if a death occurs and is reported to the coroner before the commencement date, the current Act largely applies, with a few technical amendments. If the death is reported to the coroner after the commencement date, the amended Act would apply.

New Zealand Labour Party minority view

Labour recognises the need for a well-functioning, efficient, accessible and properly resourced coronial system. This is underpinned by the Coroners Act, which was introduced by Labour in 2006. We also support the principles this bill generally promotes, including improving the quality, consistency and timeliness of coronial investigations, clarifying the role of coroners to remove duplication, and ensuring strong leadership of the coronial bench. However, we remain very concerned that the mechanisms in the bill to achieve these goals go too far, and have the potential to undermine and weaken the critical role of our coronial system.

More specifically, we continue to have concerns about the following amendments:

- Clause 30, new sections 57A and 57B, require coroners to considerably narrow the recommendations that they make as part of an inquest or inquiry. The test for these recommendations is very high, and according to Ministry of Justice advice, "in making a recommendation, a coroner would be required to show how the recommendation, if implemented, would have prevented the death in question." In our minds this unnecessarily limits a coroner. For example, a coroner may conduct an inquiry into a road accident where the main cause of the incident is the significant blood alcohol level of the driver. However, the accident may have also occurred on a stretch of road where there were several other incidents that year. Under this test, a coroner would not be able to make a recommendation that related to the dangerous stretch of road in question. The Chief Coroner went so far as to call this new provision too restrictive, and we agree.
- Clause 41 and the replacement of section 80 means that it will no longer be mandatory for coroners to hold an inquest into deaths that occur in official custody or care. While it was argued in committee that all deaths in care would still be the subject of an inquiry, and inquests would become discretionary, we remain uncomfortable with this change. There are relatively few deaths in custody each year, with only about 60 in the last five years. We are concerned that greater discretion could mean that the transparency that comes with a process conducted via open hearings rather than on papers (as an inquiry is) will be lost. For example, during the select committee process some of us were advised by an ex coroner of a case involving a young person in CYFs care who committed suicide. The changes in the Act lean towards an inquiry being held in this case, but the coroner in question conducted an inquest. As a result of the hearings that took place, the coroner identified a series of suicides in the small community and the local DHB was alerted. This would never have happened if an inquiry was chosen over an inquest. We are equally concerned by the loss of more critical examination of deaths in corrections. The proper and full oversight of coroners in these cases is incredibly important.
- Another major source of our opposition is the bill's amendment to the way deaths in the New Zealand Defence Force as a result of hostile action will be dealt with. The bill proposes that coroners will no longer conduct inquiries into

these deaths unless directed to by the Attorney-General. We understand that the New Zealand Defence Force sought this change in the bill as a result of the inquiry by Coroner J. P. Ryan into the deaths of Private Richard Harris, Corporal Luke Tamatea and Lance Corporal Jacinda Baker in Bamyan in 2012. The Defence Force submitted that such inquires potentially expose sensitive information relating to tactics and national security. In our view, the need for independence and scrutiny needs to be balanced against concerns around protecting national security.

We know, however, from the Regulatory Impact Statement (RIS) for this bill that this was not the only option that the Government considered. We strongly support the alternative option in the RIS, that coroners have jurisdiction over deaths in hostile action, but that the Attorney General can prevent investigation or the publication of details, or making of recommendations. We believe this option provides the right balance, and are disappointed it has not been adopted by the Government.

Finally, we also believe that this bill represents a missed opportunity. As past chief coroners have raised, there is no requirement for those who are referenced in a coroner's recommendations (such as Government agencies) to respond. Responding to coroners' recommendations is mandatory for agencies in comparable countries, and it is our belief that it should be in New Zealand too.

Labour will not be supporting this bill at this stage, but remain hopeful that some of the changes we have raised will be implemented at committee stages.

Appendix

Committee process

The Coroners Amendment Bill was referred to the committee on 19 February 2015. The closing date for submissions was 26 March 2015. We received and considered 39 submissions from interested groups and individuals. We heard 18 submissions.

We received advice from the Ministry of Justice and the New Zealand Defence Force. The Regulations Review Committee reported to the committee on the powers contained in clause 26.

Committee membership

Jacqui Dean (Chairperson)

Jacinda Ardern

Chris Bishop

Marama Fox

Peeni Henare

Jono Naylor

Alfred Ngaro

Denis O'Rourke

James Shaw

Hon Louise Upston

David Clendon replaced James Shaw for this bill.

Key to symbols used in reprinted bill

As reported from a select committee

text inserted by a majority

~~text deleted by a majority~~

Hon Amy Adams

Coroners Amendment Bill

Government Bill

Contents

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~~ 2016**.

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)

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.

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)

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—

(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

(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):

(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):

(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:

(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:

(e) to set up and maintain a register, which must be publicly available, of coroners' recommendations and comments (or summaries of those recommendations and comments) made after 1 July 2016:

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

7 Section 9 amended (Interpretation)

(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)**~~ **section 105A** or 106:

(a) the deputy chief coroner:

(b) the acting chief coroner

(1A) In section 9, definition of **death**, replace "member of the police" with "Police employee".

(1B) In section 9, replace the definition of **death in official custody or care** with:

death in official custody or care means the death of 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):

(b) a child or young person who has been placed in a residence within the meaning of section 2(1) or 364 of the Children, Young Persons, and Their Families Act 1989 (whether or not the death occurred in the residence):

(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; or

(ii) is in the charge of any person or organisation pursuant to section 362 of that Act:

(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):

(e) a care recipient or proposed 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):

(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):

(i) a resident within the meaning of section 3 of the Public Safety (Public Protection Orders) Act 2014

(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~~ that kind

(2A) In section 9, definition of **other investigating authority**, paragraph (c), replace "Injury Prevention, Rehabilitation, and Compensation Act 2001" with "Accident Compensation Act 2001".

(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

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

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

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

(b) a member of the immediate family of the person who is, or is suspected to be, dead who has asked to be notified of matters, and has given the responsible coroner contact details for that purpose, because ~~his or her~~ the member considers that the member's 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

(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)

Justice has the same meaning as in section 2 of the Justices of the Peace Act 1957

medical procedure—

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

(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

(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)

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—

(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

(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)

Repeal section 10(2)(c) and (4)(c).

8A New section 12A inserted (Transitional and savings provisions relating to amendments to this Act)

After section 12, insert:

12A Transitional and savings provisions relating to amendments to this Act

Schedule 1 contains transitional and savings provisions relating to amendments made to this Act that affect this Act's other provisions (*see* **section 143A**).

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

(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.

(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.

(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

(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—

(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).

(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:

(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 would not have expected:~~

(ii) that was medically unexpected:

(c) a death—

(i) that occurred while the person concerned was affected by an anaesthetic; and

~~(ii) that, immediately before the anaesthetic was administered, a reasonable health practitioner would not have expected:~~

(ii) that was medically unexpected:

(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:

(e) ~~the death of a person~~ a death 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) For the purposes of **subsection (2)(b) and (c)**, a death is **medically unexpected** if it would not reasonably have been expected by a health practitioner who—

(a) was competent to carry out the procedure, or administer the anaesthetic, in question; and

(b) had knowledge of the dead person's medical condition before the procedure began.

~~(3) In **subsection (2)(e)**, a **person in official custody or care** 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):~~

~~(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):~~

~~(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:~~

~~(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):~~

~~(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):~~

~~(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).~~

~~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:~~

~~(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.~~

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

Replace section 15 with:

15 Reporting of deaths to coroner by police

(1) This subsection applies to a Police employee—

(a) who finds a body in New Zealand; or

(b) to whom a report of a death is made under **section 13**.

(2) A Police employee to whom **subsection (1)** applies must, unless excused from doing so by **subsection (3)**, cause the death concerned to be reported immediately—

(a) to the appropriate designated coroner; or

(b) if there is no designated coroner, or if that coroner is unavailable, to another coroner.

(3) A Police employee is not required by **subsection (2)** to cause a death to be reported if he or she believes that the death is already known to, or will be reported by another Police employee to, a coroner.

(4) A coroner (other than the chief coroner) to whom a finding or death is reported under **subsection (2)(b)** must report it to the chief coroner as soon as practicable.

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

(1) The responsible coroner must perform every part of the coroner's role in relation to a death.

(2) However, a duty coroner may from time to time perform or exercise a function, duty, or power on behalf of the responsible coroner.

(3) In this section, **duty coroner** means a coroner who is, for the time being, authorised by the chief coroner to perform or exercise any function, duty, or power that—

(a) would ordinarily be performed or exercised by a responsible coroner; but

(b) in the circumstances, is more appropriately performed or exercised by a coroner who is immediately available.

12 Section 17 amended (Investigations by police)

~~Replace section 17(1) with:~~

~~(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.~~

(1) In section 17(1)(b), replace "designated" with "responsible".

(2) After section 17(1), insert:

(1A) In making a direction under subsection (1)(b), the responsible coroner must have regard to the principles set out in section 8 of the Policing Act 2008.

(1B) If the Commissioner considers that a coroner's direction under subsection (1)(b) is unreasonable or unnecessary, the Commissioner may refer the direction to the chief coroner.

(1C) If a referral is made under **subsection (1B)**, the Commissioner and the chief coroner must, by agreement, confirm, revoke, or vary the direction.

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

(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

(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)**.

(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.

(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

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

(ii) he or she is appointed as the responsible coroner in relation to the death under **section 133A~~(1) or (2)~~**; and

(b) until—

(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) or (3)**.

14A New section 21A and cross-heading inserted

After section 21, insert:

Preliminary inspections

21A Coroner may direct preliminary inspection

(1) A coroner may direct a pathologist to perform a preliminary inspection of a body.

(2) The purpose of a preliminary inspection is to enable the pathologist to advise the coroner about whether to direct a post-mortem under section 31.

(3) The pathologist may use medical imaging as part of a preliminary inspection if access to medical imaging technology is readily available.

(4) Nothing in this section limits the coroner's power to direct a post-mortem under section 31.

(5) In this section,—

medical imaging includes, without limitation, X-ray, magnetic resonance imaging, tomography, and ultrasound

preliminary inspection means an inspection of a body consisting of either or both of the following:

(a) an external visual examination:

(b) the use of medical imaging.

15 Section 22 amended (Representative for liaison with immediate family)

Repeal section 22(1).

16 Sections 23 and 24 replaced

Replace sections 23 and 24 with:

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.

(2) A failure to comply with this section does not affect the validity of any action taken by or on behalf of the coroner.

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

(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 or 29; and

(d) the opening of an inquiry; and

(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 the coroner, the significant matters also include—

(a) the right to object to a proposed post-mortem if, under section 33, ~~specified~~ immediate family members have that right; and

(b) the receipt or removal of a body part, or the taking of a 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)

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 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".

(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~~ The coroner may, at the request of a member of the dead person's immediate family, authorise a pathologist to contact the family to explain, or answer questions in relation to, the pathologist's report.

18A Section 28 amended (Any person may access specified certificates and notices)

In section 28(2), replace "(which relates to restrictions on the making public of details of self-inflicted deaths)" with "or 74".

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.~~

(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—

(a) may direct 1 or more pathologists to perform post-mortems of any or all of the bodies (whether found before or after the direction is made) of people whose deaths appear to be a result of that event or series of events; and

(b) may direct 1 or more dentists to attend any or all those post-mortems.

(2) Repeal section 31(3).

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.~~

~~(1AB) **Subsection (1AA)** is subject to section (1).~~

Replace section 36(1) with:

(1) A pathologist who is directed under section 31 to carry out a post-mortem must carry out a full internal and external examination of the body unless the coroner, in the relevant direction under section 31, requires only a lesser examination (in which case the pathologist must comply with the direction).

(1A) The pathologist may otherwise carry out the post-mortem as he or she thinks fit.

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

(1) After section 38(1)(f), insert:

(fa) a dentist, if authorised to attend by ~~the pathologist who is directed to perform the post-mortem~~ a coroner:

(2) Replace section 38(1)(g) with:

(g) a Police employee:

21A Section 39 amended (Definitions for section 38)

(1) In section 39, replace the definitions of **funeral director**, **national qualification**, and **National Qualifications Framework** with:

funeral director has the meaning given in section 2(1) of the Burial and Cremation Act 1964

(2) In section 39, repeal the definition of **Qualifications Authority**.

~~**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**~~

~~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 22B of the Health Act 1956):~~

~~(b) a written report (containing information specified in the notice) relating to the person.~~

22 Section 40 amended (Coroner may require person's doctor to report)

In section 40, insert as subsection (2):

(2) The information specified in a notice under subsection (1) may include, without limitation, the dead person's health information (as defined in section 22B of the Health Act 1956).

23 Section 41 amended (High Court may order post-mortem in certain circumstances)

In section 41(6)(a), replace "family representative, immediate family, and certain others" with "interested parties".

~~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 reported under section 15(2)(a) or section 16(2)(b)" with "The responsible coroner".

24A Section 43 amended (Restriction on release if no post-mortem directed)

In section 43(1) and (2), replace "member of the police" with "constable".

25 Section 46 amended (Costs of transporting body moved for post-mortem, etc)

In section 46(2) and (3), replace "Commissioner of Police" with "responsible department".

26 Section 48 amended (Retention of parts and samples on release of body)

After section 48(2), insert:

(2A) The pathologist must notify the coroner if the pathologist retains, or intends to retain, a part or sample under subsection (2)(a).

(3) In this section, **minute**, in relation to a body part or bodily sample, has the meaning given by the Secretary by notice in the *Gazette* (both printed and online versions).

(4) A notice under **subsection (3)** is a disallowable instrument, but not a legislative instrument, for the purposes of the Legislation 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)

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.

(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.

(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~~ every representative of the immediate family recognised under section 22~~)~~ and must—

(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

(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

(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

(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).

(6) A failure to comply with this section does not affect the validity of any action taken by or on behalf of the coroner.

27A Section 54 amended (Restrictions on return and disposal)

In section 54(2), replace "section 53 or 55 or section 56" with "section 53, 55, or 56".

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—

(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

(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)

29 Section 57 amended (Purposes of inquiries)

Replace section 57(3) with:

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

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.

(3) Recommendations or comments must—

(a) be clearly linked to the factors that contributed to the death to which the inquiry relates; and

(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.

57B Coroner must consult ~~interested parties~~ certain persons or organisations 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:

(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

(iii) any persons or organisations to whom the recommendation or comment is directed; and

(b) give those persons or organisations ~~a reasonable time~~ 20 working days to comment on the proposed recommendation or comment.

(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.

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)

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—

- (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
  - (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~~ and—
  - (i) 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); or
  - (ii) the death occurred outside New Zealand on or from an aircraft or a ship (other than an aircraft or ship referred to in ~~**paragraph**~~ **subparagraph (i)**) and the Solicitor-General has authorised the coroner to open an inquiry into the death.

(2) This section is subject to **section 59A**, except that **subsection (1)(c)(ii)** overrides **section 59A(1)**.

59A Limits on coroners' jurisdiction ~~under section 59~~ to open inquiries

(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

(b) an inquiry under ~~the~~ this 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~~ a death if the coroner is satisfied that the death ~~occurred —~~

(a) occurred while the dead person was a member of the Defence Force on operational service; and

~~(b) as a consequence of hostile action.~~

(b) arose from hostilities in which the Defence Force or an allied force was engaged.

(3) A coroner must adjourn an inquiry if, during the course of ~~an inquiry into a death~~ the inquiry, the coroner determines that the death to which the inquiry relates is likely to have occurred in the circumstances described in **subsection (2)**.

(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.

(4A) Before the Attorney-General directs a coroner to carry out an investigation, or to resume an inquiry, the Attorney-General must, without limitation, consider—

(a) whether the investigation or inquiry is likely to identify the cause and circumstances of the death; and

(b) whether the investigation or inquiry could reveal information that may prejudice the security or defence of New Zealand; and

(c) whether the investigation or inquiry is likely to examine military tactics; and

(d) whether a court of inquiry has been, or will be, assembled under section 200A of the Armed Forces Discipline Act 1971 for the purposes of collecting and recording evidence about the relevant death.

(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~~ its only purpose ~~of the inquiry~~ is to establish, so far as possible, the particulars specified in section 4(2)(a).

(6) In this section,—

allied force and **Defence Force** ~~has~~ have the meanings given in section 2(1) of the Defence Act 1990

operational service means service as a member of the Defence Force—

(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.

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.

34A Section 62 amended (Other deaths)

(1) Replace section 62(1) with:

(1) The responsible coroner must decide whether to open an inquiry into a death.

(2) After section 62(2)(a), insert:

(ab) **section 59A** (limits on coroners' jurisdiction to open inquiries):

34B Section 64 amended (Duties of coroner who decides not to open inquiry)

In section 64(3)(b), replace "member of the police" with "constable" in each place.

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):

(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.

(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.

(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

~~(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~~

~~(b) the death was self-inflicted, or there is reasonable cause to suspect that the death was self-inflicted.~~

(1) This section applies in respect of a death if 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—

(a) the method or any suspected method of the self-inflicted death; or

(b) ~~the place where the death occurred, if the place~~ any detail (for example, the place of death) that suggests the method ~~(~~or any suspected method~~)~~ of the self-inflicted death; or

(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.

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

(1) A person may apply to the chief coroner ~~to grant~~for an exemption from the restrictions (specified in **section 71(2)**) applying to the publication of details of self-inflicted deaths.

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

(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

(c) may request further information from the applicant.

(3) The chief coroner may grant ~~a person~~an applicant 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—

(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.

(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).

(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

(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:

(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~~:~~; or

40 Section 77 replaced (Hearings on papers and chambers findings)

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)** of the coroner's proposal to hold a hearing on the papers and make chambers findings; and

(b) has not, 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~~any notification of an intention to give evidence, or cross-examine witnesses, in person.

(2) The persons to whom the coroner must give notice under **subsection 1(a)** are—

(a) those persons who, under section 76, are persons from 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 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:

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,~~ Without limiting **subsection (1)**, a coroner deciding whether to hold an inquest into a death must consider whether either, or both, of the following applies ~~in relation to the death~~:

~~(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:~~

(a) the death was a death in official custody or care and the death would not reasonably have been expected by a doctor who had access to the person's health information (as defined in section 22B of the Health Act 1956):

(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

(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)

(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.

(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".

(2A) In section 81(3)(a), replace "family" with "immediate family".

(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.

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

(1) 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).

(2) **Subsection (1)** does not apply to an inquiry the opening of which was authorised by the Solicitor-General under **section 59(1)(c)(ii)**.

45 Section 94 amended (Certificate of and written reasons for findings)

(1) Replace section 94(1) with:

(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.

(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

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.

94B Chief coroner to publish information regarding certain inquiries for which findings not ~~yet released~~ completed

~~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.~~

(1) The chief coroner must, at regular intervals, publish—

(a) a list of all inquiries in respect of which an inquest, or a hearing on the papers, has been held but a certificate of findings has not been completed and signed under section 94; and

(b) for each inquiry, the date on which the inquest, or hearing on the papers, was held.

(2) In addition to the information specified in **subsection (1)**, the chief coroner must publish an explanation of the process by which a person can 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 completed and signed.

46A Section 95 amended (Inquiry if coroner has failed or refused to open one)

In section 95(1), replace "coroner by whom the inquiry should be opened" with "responsible coroner".

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

47 Section 103 amended (Coroners)

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.

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—

(a) is specified in a warrant of appointment or reappointment; and

(b) does not exceed 2 years.

49 New sections 105A ~~and 105B~~ inserted (Deutsch chief coroner)

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.

(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.

(4) The fact that a deputy chief coroner purports to perform or exercise, or to have performed or exercised, any function, duty, 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.~~

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

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

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

(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—

(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.

(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 being compatible with being a coroner.

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)

After section 116, insert:

116A Establishment and constitution of suicide and media expert panel

(1) A suicide and media expert panel is established.

(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; 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.

52A Section 122 amended (Warrant for information, document, or other thing)

(1) In section 122, replace "member of the police" with "constable" in each place.

(2) In section 122(3)(a), replace "members of the police" with "constables".

(3) In section 122(3)(b), replace "member or members of the police" with "1 or more constables".

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

(1) 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.

(2) In section 123(2), replace "member of the police" with "constable".

53A Section 124 amended (Duties when executing warrant under section 122)

In section 124, replace "member of the police" with "constable" in each place.

53B Section 128 amended (Warrant for removal of body)

(1) In section 128(1), replace "member of the police" with "constable".

(2) In section 128(2)(a), replace "members of the police" with "constables".

(3) In section 128(2)(b), replace "member or members of the police" with "1 or more constables".

53C Section 129 amended (Entry and search under warrant under section 128)

In section 129, replace "member of the police" with "constable".

53D Section 130 amended (Warrant under section 128 to be produced)

In section 130, replace "member of the police" with "constable" in each place.

53E Section 131 amended (Power to seize evidence relevant to post-mortem)

In section 131, replace "member of the police" with "constable" in each place.

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

(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)):

(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:

(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:

(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.

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

(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.

(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.

(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).

(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

(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

(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.

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

Replace section 139 with:

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).

(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.

(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).

(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 $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.

56A Sections 141 and 142 repealed

Repeal sections 141 and 142.

56B New section 143A inserted (Transitional and savings provisions: arrangements effective on and after 1 July 2016 are in Schedule 1)

After section 143, insert:

143A Transitional and savings provisions: arrangements effective on and after 1 July 2016 are in Schedule 1

The transitional and savings provisions set out in **Schedule 1** have effect on and after the commencement of the Coroners Amendment Act **2014** on 1 July 2016.

56C Schedules 1 and 2 replaced

Replace Schedules 1 and 2 with the **Schedule 1** set out in **Schedule 1** of this Act.

57 Consequential amendments

The enactments specified in ~~the~~ **Schedule 2** are amended in the manner indicated in that schedule.

Schedule 1
Schedules 1 and 2 replaced

s 56C

Schedule 1
Transitional and savings provisions effective on and after 1 July 2016

s 143A

1 Interpretation

In this schedule,—

amendment Act means the Coroners Amendment Act **2014**

date of death means—

(a) the date on which a death occurred; or

(b) if the date on which a death occurred is unknown, the date on which the death is first discovered.

2 Application of Act to deaths occurring before 1 July 2016

(1) This clause applies in respect of a death if the date of death is earlier than 1 July 2016.

(2) Despite the commencement of the amendment Act, the following sections apply in respect of the death as if the amendment Act had not come into force:

(a) section 13:

(b) section 14:

(c) section 15:

(d) section 71:

(e) section 139.

(3) If the death is reported to the coroner on or after 1 July 2016, the rest of this Act applies in respect of the death (except that, in **section 18(1)(a)**, the reference to **section 13(2)** must be treated as a reference to section 13 as it read before 1 July 2016).

(4) If the death is reported to the coroner before 1 July 2016, **clause 3** applies.

3 Application of Act to deaths reported to coroner before 1 July 2016

(1) This clause applies in respect of a death that was reported to a coroner under section 15 before 1 July 2016.

(2) Despite the commencement of the amendment Act, the following sections apply in respect of the death as if the amendment Act had not come into force:

(1) section 16:

(2) section 17:
(3) section 18:
(4) section 19:
(5) section 22:
(6) section 23:
(7) section 24:
(8) section 25:
(9) section 27:
(10) section 31:
(11) section 36:
(12) section 39:
(13) section 41:
(14) section 42:
(15) section 48:
(16) section 50:
(17) section 55:
(18) section 57:
(19) section 58:
(20) section 59:
(21) section 60:
(22) section 61:
(23) section 62:
(24) section 68:
(25) section 69:
(26) section 70:
(27) section 71:
(28) section 75:
(29) section 77:
(30) section 80:
(31) section 81:
(32) section 89:
(33) section 92:
(34) section 94:
(35) section 95:
(36) section 133 (*see* **clause 5**):

(37) section 139.

(3) Despite the commencement of the amendment Act, the following sections do not apply in respect of the death:

(a) **section 21A**:

(b) **section 57A**:

(c) **section 57B**:

(d) **section 59A**:

(e) **section 71A**:

(f) **section 133A**.

4 Practice notes issued by chief coroner saved

A practice note issued by the chief coroner under section 132 before 1 July 2016 continues in force until revoked by the chief coroner.

5 Designated coroners continued

(1) This clause applies to a coroner who, before 1 July 2016, was a designated coroner (within the meaning of section 9 as it read before 1 July 2016).

(2) In respect of deaths where the date of death is earlier than 1 July 2016, the coroner remains the designated coroner (within the meaning of section 9 as it read before 1 July 2016).

(3) In respect of deaths where the date of death is on or after 1 July 2016, the coroner must be treated as a designated coroner (within the meaning of section 9 as amended by the amendment Act).

Schedule 2
Consequential amendments

s 57

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))" with "**section 14** (except **subsection (2)(f)**)".

In section 46C(1), 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 ", deputy chief coroner,".

Search and Surveillance Act 2012 (2012 No 24)

In the Schedule, insert in its appropriate alphabetical order:

Coroners Act 2006	~~section~~ 122	Members of the Police may search specified place, craft, or vehicle if warrant issued	~~s~~Section 110

Visiting Forces Act 2004 (2004 No 59)

In section 19(1), 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 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 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,".

Legislative history

31 July 2014	Introduction (Bill 239–1)
19 February 2015	First reading and referral to Justice and Electoral Committee

Wellington, New Zealand:
Published under the authority of the House of Representatives—2015