Regulatory Impact Statement

Coroners Act 2006: Proposals for Reform Paper 2

Agency Disclosure Statement

1. This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Justice. It provides an analysis of options for stage two of the reform of the Coroners Act 2006 to:
   - improve accountability, transparency and leadership in the coronial system, particularly in regard to coronial appointment processes, management of conflicts of interest and timeliness of cases
   - ensure the management of human tissue samples is more responsive to the needs of families
   - clarify the jurisdiction of coroners to investigate overseas deaths.
2. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Coroners Act 2006 to improve the timeliness and efficiency of the coronial system. A RIS was prepared for the first Cabinet paper which covered proposals to:
   - clarify which deaths are reported to the coroner and when inquests should be held for deaths in official care or custody
   - improve the timeliness of coronial decisions
   - reduce and manage duplication with other agencies
   - formalise the role of Deputy/Acting Chief Coroner
   - improve coroners' recommendations to ensure effective outcomes for families and public safety.
3. The following are constraints in the regulatory impact analysis for the second stage:
   - Anecdotal evidence from submissions and government agencies is used in many areas. It is difficult to collect precise information on each stage of the coronial process. Coroners are independent judicial officers and as such may conduct their cases in different ways. Coroners also deal with a number of cases at the same time which can make it difficult to measure the time allocated to each case. Cases are not always under the direct control of coroners (e.g. coroners may be awaiting the outcome of a criminal trial or another investigation). These variables can make it difficult to analyse the situation and develop options for change.
   - Key stakeholders have been consulted on specific proposals and all stakeholders were given the opportunity to input into areas of reform. Public consultation on the full proposals would have been a preferred approach but we were constrained by timeframes set by the Minister for Courts for the introduction of the Bill.
   - It is difficult to quantify the additional costs or savings of some options because we cannot definitely ascertain how the policy will influence coroners in their exercise of discretion and the extent to which the number of coronial cases are reduced as a result. Some assessment has been undertaken based on the information available.

Dianne Patrick
Project Manager
Courts and Justice Services Policy

16 September 2013

Executive summary

1. This paper considers the second group[1] of proposals for improvements to the coronial system and the Coroners Act 2006 (the Act) following a targeted review. The review focuses on improving efficiency and timeliness, reducing the impact of the coronial process on families, and improving public safety outcomes.

2. Some policy and operational concerns and ideas for improvement have been raised that suggest further improvement to the Act is desirable in order to achieve a coronial system that is clear, timely, efficient and supports families and improved public safety. The main changes subject to this RIS are to:

   - improve accountability, transparency and leadership in the coronial system, particularly regarding the coronial appointment process, management of conflicts of interest and timeliness of cases
   - ensure the management of human tissue samples taken as part of a coronial post-mortem examination is responsive to the needs of families
   - clarify the jurisdiction of coroners to investigate overseas deaths.

Background

3. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Coroners Act 2006 aimed at:

   - better balancing the needs of grieving families, including the cultural needs of Māori whānau, with the public interest in understanding the causes and circumstances of deaths
   - improving the quality, consistency and timeliness of coronial investigations and decision making
   - clarifying the role of coroners and reducing duplication between coroners and other authorities that investigate deaths and accidents
   - clarifying the role coroners have in making recommendations to prevent future deaths and their relationship to agencies that have policy and operational responsibility in those areas, and
   - ensuring resources are used effectively.

Role of the Coroner

4. The role of the coroner is to establish, so far as possible, the causes and circumstances of sudden or unexplained deaths and deaths in other special circumstances. The coroner's role differs from other investigations into accidents and deaths in that the focus is on the particular person who died and the circumstances of their death.

5. The coroner's role includes making recommendations or comments that, if drawn to public attention or the attention of professional organisations, may reduce the likelihood of similar deaths.

---

[1] The first group of proposals was set out in the Regulatory Impact Statement - Coroners Act Review: Proposals for Reform Paper One (5 June 2013)

Legislative framework

6. The Act's purpose is to help prevent further deaths in similar circumstances and to promote justice through investigating and identifying the causes and circumstances of deaths.

Workload and cost

7. In the year ending 31 December 2012, 30,099 people died in New Zealand[2]. There were 3,286 incoming coronial cases and coroners provided advice (but did not accept jurisdiction and open an inquiry) on 2,653 cases (5,939 in total). In the same period, 1,289 inquiries were opened, of which 933 were hearings on papers. Inquests[3] were held for 267 deaths (including joint and special fixtures).

8. The average time to close a case where no inquiry was required was 64 days in 2012 (these being primarily natural deaths), while the average time when an inquiry was conducted and an outcome issued was 464 days.

9. The overall cost of the New Zealand coronial system was approximately $16.8 million for the year 2012/2013.

Context and objectives

10. The Government is focussed on developing a modern, efficient and effective coronial system that balances the needs of families with the public good in understanding the causes and circumstances of deaths. To contribute to this overarching goal, objectives have been identified to assess proposals against. The objectives are a coronial system that:

    - uses modern, efficient and cost-effective processes, particularly ensuring that the coronial process is completed in a timely manner
    - delivers effective outcomes to families, the general public and government (including maintaining public confidence in the coronial system, ensuring the system is clear and transparent and the public are assured that the system is independent of government and impartial.)

11. The cost to the justice sector is a constraint within which the outcomes must be considered. The proposals should not unduly add to the existing fiscal pressures faced by the justice sector.

12. The status quo and problem definition for each matter are explained separately under the following sections:

    - improving accountability, transparency and leadership in the coronial system
    - the management of human tissue samples taken as part of a coronial post-mortem examination
    - jurisdiction of coroners to investigate overseas deaths.

2 Deaths registered in New Zealand (Statistics New Zealand).

3 An inquest is a part of an inquiry where experts and witnesses give evidence in court about what happened. An inquest is not required as part of every inquiry.

Improving accountability, transparency and leadership in the coronial system

Status quo and problem

Consistency with best practice procedures for appointments and conflicts of interests

13. As part of the Ministry of Justice's work on the Judicature Modernisation and other Matters Bill, proposals are being considered which will make the processes and criteria for appointing judges more transparent. This will help ensure public acceptance of the independence and impartiality of judicial decisions and to improve public confidence in the justice system over time.

14. Coroners are judicial officers and, similar to judges, there is public interest in maintaining confidence in the independence and impartiality of the coronial process. Similar changes to coronial best practice should be considered where appropriate.

15. Currently the Act provides limited information about the coronial appointment process and processes for managing conflicts of interest. Safeguards are needed to ensure the public has confidence in the expertise of those in coronial system. This will help families engage in the coronial process and take notice of coroners' recommendations directed to the public.

16. The Act also provides that coroners and relief coroners can remain in office until they are 70 years old and can then be reappointed on one year terms. It does not specify how many times they may be reappointed. The Act's intention is to provide for refresh of coroners and the Act needs to be clear for the general public and coroners how this occurs. The current legislation is not sufficiently transparent about appointment process and conflicts of interests and should generally align with proposals in the Judicature Modernisation and other Matters Bill to increase transparency and public acceptance of judicial decisions by limiting reappointment.

Emphasis on Timeliness and Quality

17. During the targeted review of the Act, concerns have been raised about:
    - Quality of findings and coronial recommendations – not many recommendations are implemented and some have been criticised for their nature and scope.
    - Practices and processes – some processes are inconsistent between regions/coroners.
    - Timeliness - some coroners take considerably longer than others to conduct their inquiries and complete their findings, impacting on families and interested parties in affected areas. Evidence shows that the length of time required to complete inquests and hearings on papers has increased from 111 days in 2007/2008 to 464 days in 2012/2013 despite the number of coroners increasing to meet demand. While not all steps in the process are under the direct control of the coroner (e.g. the coroner may be awaiting the results of another investigating authority), coroners do have control over some elements.

18. The Act does not emphasise timeliness and consistency within the system as one of the main functions of the Chief Coroner. While timeliness is specifically mentioned in the purpose of the Act and is important for improving public safety, it is not emphasised as a main function of the Chief. Functions are also not prioritised and this means it can be difficult for the Chief to allocate his time between the different functions.

Relationship Management

19. The coronial system relies on the combined effort of a number of key professional groups and coroners working together in the best interests of families. The Act gives the Chief Coroner a role in liaising with the public, other investigating authorities, official bodies and statutory officers. However, it does not include responsibility for relationship management with other stakeholders who are involved with the coronial process. It is useful for families if there is a clear mechanism for stakeholders to work together effectively and resolve any differences of opinion that may arise from time to time.

Regulatory Impact Analysis

20. We have considered three options to increase public confidence in coronial appointments, the management of conflicts of interest and the leadership of the coronial system:

    A. Status quo: No change to the current legislation.

    B. Strengthen provisions in the Act to:

    - provide clarity and transparency in appointment processes (publicising appointment processes and limiting reappointment terms by specifying how many times a coroner can be reappointed and for how long).
    - assist in the management of conflicts of interest by producing and disseminating online guidance on the compatibility of holding other office as well as judicial office, and on determining when it is inappropriate for a coroner to hear a case (recusal)
    - prioritise the functions of the Chief Coroner to reflect the need for orderly and efficient processes
    - include responsibility for relationship management as a function of the Chief Coroner.

    C. Issue guidance for voluntary publication of appointment processes and management of conflicts of interest. Work with the Chief Coroner to prioritise the functions of the Chief Coroner within the limits of the current Act.

21. The preferred option is to strengthen provisions in primary legislation (Option B). Within this, the Ministry does not have a view as to how many times a coroner can be reappointed and for how long. The aim of limiting reappointment is to provide clarity and transparency in appointment processes and to provide for the refresh of coroners. At this stage we have insufficient information to determine which length of term is preferable.

Accountability, transparency and leadership				
		A **Status quo**	B **Strengthen primary legislation**	C **Guidance to assist with voluntary change to processes**
Objectives	Effectiveness Does the option provide transparency and clarity? Does the option provide the public with assurance that the system is independent of government and impartial? Does the option provide effective outcomes for families and public safety? Is this option consistent with relevant provisions in the Judicature and Other Matters Bill?	• Public availability of information about coronial appointments, appointment criteria and managing conflicts of interests is limited. • The functions of the Chief Coroner listed in the Act are not prioritised to reflect the needs of grieving families and the public for an orderly and efficient process. • The Act does not provide the Chief with a role in managing relationships with key stakeholders. • Inconsistent with Judicature and Other Matters Bill proposals.	• Legislative requirement to publish information on key accountability processes. • Public and families have access to information and clearly understand processes. • Functions of the Chief Coroner are prioritised to support the public's interest in a clear, timely and supportive coronial system. • Chief Coroner actively promotes key professional groups and coroners working together in the best interests of families. • Consistent with the Judicature and Other Matters Bill.	• Public and families clearly understand processes and may have access to information if it is available (voluntary). • It may take time for information to be published or updated. • Chief Coroner determines own priorities, although this is not likely to change significantly from the status quo. • No formal role for the Chief Coroner to encourage coroners and stakeholders to work together effectively. • Partially consistent with the Judicature and Other Matters Bill.
	Efficiency Will the option improve timeliness of cases? What are the cost-implications?	• Responsibility for timeliness is not emphasised in the Act as one of the Chief Coroner's main functions. • No change in costs.	• Easy for families to find information about appointments and processes for managing conflicts of interest. • Efficiency and timeliness are prioritised in the Chief Coroner's functions. • Change in administrative procedures may create minor initial costs (covered within baseline).	• Voluntary processes will not guarantee significant improvements to the timeliness of cases. • A change in administrative procedures will create minor initial costs (to be covered within baseline).
Risks		• Lack of transparency to maintain public confidence in the independence and impartiality of the coronial system. • Some opportunities to improve the timeliness and efficiency of the coronial	• Less flexibility if changes are needed to matters covered by legislation.	• Guidelines are not binding. Trust in the coronial system may reduce if members of the public have concerns about the appointment process. • If Chief Coroner determines priorities,

Accountability, transparency and leadership			
	A **Status quo**	**B** **Strengthen primary legislation**	**C** **Guidance to assist with voluntary change to processes**
	system may not be recognised.		they may not reflect public or government priorities.
Impacts	• May reduce public confidence if concerns are raised about any appointments or conflicts of interest. • Delays in completing cases and timeliness of recommendations may occur if timeliness and efficiency are not prioritised. • If stakeholders do not work together effectively, it may lead to delays, miscommunication and frustration.	• Clear signal to members of the public about expectations of coronial appointments and management of conflicts of interest. • Will initially require some time and resource (funded within baseline) to prepare material for the public. Minimal ongoing cost. • Cases are completed faster and the release of coroners' findings and recommendations will be on a timelier basis. • Consistent with other legislation concerning judicial officers. • Clarity for coroners and greater operational efficiencies. • Limiting reappointment will not impact on the ability of coroners to respond in a mass fatality disaster. The Act provides for relief coroners and states all District Court Judges are ex-officio coroners under the District Courts Act 1947.	• Does not ensure transparency or provide public with assurance of independence or impartiality, but some improvements may occur. • Would initially require some resource (funded within baseline) to prepare material for the public. Minimal ongoing cost. • Some improvements in timeliness may result.
Conclusion	• Does not ensure transparency. • Risk of continued and increasing delays if timeliness is not a priority. • Inconsistency with other comparable provisions on transparency, accountability and leadership.	• Meets objectives to provide greater transparency and provide assurance to public about independence and impartiality. • Faster completion of cases may result from increased focus on timeliness.	• Partially meets objectives. • Voluntary nature of option does not guarantee achievement of objectives. Delays may continue. • Does not address relationship management issues.

The management of human tissue samples taken as part of a coronial post-mortem

Status quo and problem

22. The Act allows pathologists to take human tissue samples if they are required for coronial post-mortem examinations.

23. Submissions and analysis have highlighted areas where the Act is not clear or could be more responsive to the needs of families:

Status quo	Problem
• "Minute" samples can be retained temporarily for post-mortem purposes. • "Minute" is not defined in the Act.	• The lack of definition in the Act has caused some confusion for coroners and pathologists and can negatively impact on case management and the operation of the system.
• Families only have a short timeframe (5 days) to request that any tissue taken be returned. • This timeframe is generally not observed in practice.	• This timeframe is not sensitive to grieving families, who are often not in a position to make decisions about the return of tissue. • The short timeframe may cause families to feel pressured into making a decision which they may later regret or wish to change.
• Families are provided with detailed description of samples.	• This can cause distress to families who find the information too graphic.
• Current practice is to notify the family before the body is released about what tissue can be retained.	• This can delay the release of the body to the family or funeral director if the family cannot be readily contacted.
• The form for requesting return of tissue samples does not allow families to request return of some samples and not others (eg, allowing minute samples in glass slides, wax blocks and blood spots to be retained for further analysis, research and quality assurance).	• This means that families may have tissue samples returned that they may not expect or may not know what to do with. • There is an increasing trend of families returning the samples they receive. • Currently there is no real opportunity for pathologists to explain to families the benefits of retaining minute samples.

Regulatory Impact Analysis

24. We have considered the following options to improve processes for taking and retaining human tissue samples:

    A. Status quo: Families must be given detailed information about the specific body parts and bodily samples that have been retained for the purposes of the post-

mortem examination. Families have 5 days to decide if they would like samples returned once they are no longer required.

B. Preferred option: Remove requirements which place unnecessary distress on families whereby:

- families are only provided with general information about the nature of human tissue samples that have been retained and are advised that more detailed information is available if they request it
- clarify that families do not need to be contacted about taking tissue samples before the body is returned unless coroners think the size or nature of the sample is such that the family should be notified in advance
- the timeframe for families to request return of samples is not prescribed in legislation but set administratively so that the time families have to request that samples be returned will be extended in some cases to better reflect how long the case is likely to take overall
- minute samples are defined in consultation with relevant health sector professionals and pathologists which will make the size of samples taken clearer to families who wish to have this information and when pathologists must seek coroner's authorisation to retain samples
- allow families to discuss the implications of retention or return of samples with a pathologist if they wish.

C. Non-regulatory, operational changes: Provide more information to families about processes and what to expect.

		Human tissue		
		A **Status quo**	**B** **Amend requirements which cause distress to families or are unclear**	**C** **Provide information to families to help set expectations**
Objectives	**Effectiveness** Does the option provide effective outcomes for families?	• Families are provided graphic information at a vulnerable and distressing time. • Families are given short timeframes (5 days) for decisions about the return of tissue. • No specific opportunities for families to request a pathologist explains the benefits of tissue retention.	• Families make better informed decisions due to the availability of appropriate information and timeframes.	• Families can make better informed decisions due to the availability of more information. • The current requirements to provide detailed descriptions of samples and the limited timeframe are set in legislation and can only be changed by legislation.

		Human tissue		
		A **Status quo**	**B** **Amend requirements which cause distress to families or are unclear**	**C** **Provide information to families to help set expectations**
	Efficiency What are the cost-implications?	• Administration costs involved with liaising with families (decisions about returning tissue and providing detailed information). • Delays in release of body if family not able to be contacted. • Inefficient if families return tissue samples after receiving them.	• Some minor possible costs associated with publication and dissemination of information (met within baseline – approximately $7,000).	• Some minor possible costs associated with publication and dissemination of information (met within baseline – approximately $7,000).
Risks		• Negative public perception that the Act and coronial system are not supportive of families.	• People may be concerned that information is being withheld from them or the return of tissue will be delayed if timeframes are not specified in legislation.	• Perception that information provision does not go far enough to support families involved in the coronial system.
Impacts		• Unnecessary distress and burden to families.	• Families supported in decision making process. • More flexible process. • May require additional time from pathologists.	• Families and public have clearer expectations about what to expect but concerns about graphic detail and short time frames are not addressed.
Conclusion		• Does not meet objectives.	• Meets objectives.	• Only partially addresses the expectations of families – does not address timeframes for requesting return of tissue and the provision of very detailed information.

Jurisdiction of coroners to investigate overseas deaths

Status quo

25. There is uncertainty about a coroner's jurisdiction to investigate deaths where the body is returned to New Zealand for burial or cremation.

26. The Chief Coroner has requested that all such deaths be reported, whereas the Ministry and other stakeholders consider the Act provides discretion to report such deaths.

Problem

27. While the number of cases is relatively small (31 cases over an 18 month period[4]), the approach used by coroners has the potential to adversely impact on case throughput and creates delays in releasing the body and costs for families. There is also potential for repeat post-mortem examinations and investigations of deaths already examined abroad. This may unnecessarily raise concerns for families about investigations conducted overseas and could interrupt families' grieving.

28. Coroners have limited ability to gather information from overseas authorities and in some cases little new information can be learnt that would be of benefit to the family or New Zealand.

29. The uncertainty over the Act's provisions is causing concern for stakeholders about their role, particularly in relation to the additional work that is being required of the Police and funeral directors.

Regulatory Impact Analysis

30. The following options have been considered:

    A. Status quo: No change to the current legislation and processes (legislation remains unclear and Chief Coroner continues to require all deaths to be routinely reported).

    B. Preferred option: Clarify in the Act when or if coroners have jurisdiction to investigate where the death occurred overseas and the body is returned to New Zealand for burial or cremation, or is in transit to another country for burial or cremation. People can still make an application for a case to be investigated – see options below:

        a. Coroners can decide to investigate overseas deaths if they are satisfied that there has been no or insufficient previous investigation, and, on application by a family member or another person with sufficient interest, the coroner is satisfied it is in the public interest or interests of justice to open an inquiry

        b. The decision about overseas death investigations is shifted from the coroner to the Attorney-General who can initiate a coronial investigation on application by a family member or another person with sufficient interest, if the Attorney-General is satisfied it is in the public interest or interests of justice to open an inquiry.

---

[4] The Chief Coroner was advised of 275 overseas deaths from Jan 2011 until Jun 2013. 31 were accepted as coronial cases.

C. Non-regulatory option: The Chief Coroner to issue practice guidelines that limit a coroners jurisdiction to investigate overseas deaths when (based on the criteria above):

- they are satisfied there has been no or insufficient previous investigation, and,
- on application by a family member or another person with sufficient interest, the coroner is satisfied it is in the public interest or interests of justice to open an inquiry.

Jurisdiction – overseas deaths					
		A **Status quo**	**B** **Clarify Act's intent to limit jurisdiction**		**C** **Practice guidelines**
			a **Coroners can decide to investigate deaths under some circumstances**	**b** **Shift decision making to the Attorney-General**	
Objectives	**Effectiveness** Does the option provide clarity? Will the option improve consistency? Does the option provide effective outcomes for families? Will the option improve public safety in New Zealand? Will the option provide effective outcomes for the State?	• Confusion for agencies, families and funeral directors over when a death must be reported to a coroner because Act is unclear. • May be inconsistency of approach between regions. • Inconvenience to families when non-suspicious deaths are investigated. • Only applies where body is returned to New Zealand for burial or cremation. Does not apply to cremated remains. • Conducting investigations into overseas deaths does not significantly contribute to the Act's purpose to help prevent further deaths or influence the public safety of New Zealanders overseas.	• Legislation will provide greater clarity for coroners, funeral directors and families. • Some variation in practice between coroners is likely to continue as coroners have discretion to determine whether investigation is appropriate. • Families will not have to go through the rigour of an investigation unless there is good reason. • Coroners will consider public safety interests when deciding whether to investigate an overseas death. • Reducing the number of investigations into overseas deaths will ensure coroners can focus their time on cases that warrant a coronial inquiry.	• Legislation will provide clarity for coroners, funeral directors and families about how decisions are made. • Improved consistency – all decisions made out of a single office will ensure consistency and therefore provide clarity for funeral directors and families. • Families will not have to go through the rigour of an unnecessary investigation, however there may be delays before families find out whether the case will be investigated. • Would ensure there is good reason for any investigations of overseas deaths, including public safety interests. • Reducing the number of investigations into overseas deaths will ensure coroners focus their time on cases that warrant a coronial inquiry.	• Guidelines will help provide clarity for coroners, funeral directors and families. • Families will not have to go through the rigour of an investigation unless necessary. • Reducing the number of investigations into overseas deaths will ensure coroners focus their time on cases that warrant a coronial inquiry. • Some discretion and flexibility remains to investigate overseas deaths which are suspicious or where there are concerns (if they are not reported). • May not fully address inconsistencies between regions - guidelines are not binding and are subject to interpretation.

Jurisdiction – overseas deaths					
	A **Status quo**	**B** **Clarify Act's intent to limit jurisdiction**		**C** **Practice guidelines**
		a **Coroners can decide to investigate deaths under some circumstances**	**b** **Shift decision making to the Attorney-General**	
			• Would address concerns about unnecessary duplication or potential for the risk of criticism of overseas investigations which may offend the country concerned.	
Efficiency Will the option improve timeliness of cases? What are the cost-implications?	• While only a small number of cases are accepted, time is taken analysing whether to accept the case at the detriment of other coronial cases (impacting on families). • Costs are incurred by the system when deaths are reported and the coroner holds an inquiry or inquest. May also delay timeliness of other cases. • May duplicate overseas post-mortem examinations and investigations unnecessarily. • Creates additional work for Police and funeral directors.	• Reduction in cases required to be reported to the coroner, freeing up coroners for cases that fit more appropriately in the coroner's jurisdiction (potentially improving timeliness of other cases in the system and providing families with results faster). • Some duplication with overseas investigations is possible. • No additional costs – any savings of time and resources would be absorbed by other coronial investigations.	• Reduction in cases required to be reported to the coroner, freeing up coroners for cases that fit more appropriately in the coroner's jurisdiction. • Additional step in process may lead to delays in completing investigations and releasing the body to family (no current processes for deciding on cases in weekends and outside of hours). • No duplication with overseas investigations unless there is good reason. • May slightly reduce time and resources required for coronial investigations into overseas deaths (but this would be	• Reduction in cases required to be reported to the coroner, freeing up coroners for cases that fit more appropriately in the coroner's jurisdiction (to a lesser degree than Option B due to flexibility in practice guidelines). • May help to reduce duplication with overseas investigations but is not guaranteed. • May be delays in issuing guidance.

Jurisdiction – overseas deaths				
	A **Status quo**	**B** **Clarify Act's intent to limit jurisdiction**		**C** **Practice guidelines**
		a **Coroners can decide to investigate deaths under some circumstances**	**b** **Shift decision making to the Attorney-General**	
			absorbed by other coronial investigations). Additional resources may be required to enable Attorney-General's decisions to be made in a timely way.	
Risks	• Potential delays for families collecting bodies from the airport. • Unnecessary duplication (and cost) if post-mortem examination and other investigations have been carried out overseas. • Investigation by a New Zealand coroner may be seen as criticising the quality of another country's investigation. • May reduce public confidence generally in overseas authorities' investigations. • Limited information available for coroners investigating deaths overseas as coroners' powers do not apply overseas and obtaining information relies on co-operation of overseas authorities. • Lack of clarity in law may lead to a judicial review.	• Some families may lose the opportunity to have their family member's death investigated if concerns about the death are not immediately evident. • Inconsistent treatment of deaths overseas as coronial jurisdiction is only exercised if the body is returned and has not been cremated.	• Some families may lose the opportunity to have their family member's death investigated by a coroner when desirable. • Creates further delays for families. • Inconsistent treatment of deaths overseas as coronial jurisdiction is only exercised if the body is returned and has not been cremated.	• Some families may lose the opportunity to have their family member's death investigated by a coroner if concerns about the death are not immediately evident. • No certainty that coroners will adhere to guidelines. • Guidelines may not reflect preferred government approach. • Inconsistent treatment of deaths overseas as coronial jurisdiction is only exercised if the body is returned and has not been cremated.

Jurisdiction – overseas deaths				
	A **Status quo**	**B** **Clarify Act's intent to limit jurisdiction**		**C** **Practice guidelines**
		a **Coroners can decide to investigate deaths under some circumstances**	**b** **Shift decision making to the Attorney-General**	
	• Inconsistent treatment of deaths overseas as coronial jurisdiction is only exercised if the body is returned and has not been cremated.			
Impacts	• Screening of all deaths where body is returned to New Zealand. • Confusion and unnecessary burden on grieving families when a death has already been investigated overseas. May delay investigations of other cases.	• Clarifies the law. Removes burden on grieving families when further investigations are not warranted.	• Time and resource implications for the Attorney-General's office.	• Likely that current approach will continue. • Clarifies processes. Removes burden on grieving families when further investigations are not warranted. • Time and resource implications for the Chief Coroner's office.
Conclusion	• Does not meet objectives.	• Reduces cases reported to the coroner. • Some fiscal savings are possible due to the reduction in reported deaths, post-mortem examinations and coronial inquiries. However, it is likely much of these savings will be absorbed by coroners spending more time on complex cases.	• Does not meet efficiency and timeliness objectives due to the addition of another step in the process.	• Guidelines are not binding and are subject to interpretation – may not address objectives for consistency.

Consultation

Targeted consultation

31. As this was a targeted review, submissions were sought from stakeholders rather than conducting formal public consultation. There will be an opportunity for the public to comment when the Bill is considered by select committee.

32. The following agencies have been consulted on the proposals in this RIS: New Zealand Police, Ministries of Health, Transport, Social Development, Business Innovation and Employment, Foreign Affairs and Trade, Pacific Island Affairs and Primary Industries; Department of Corrections, the Treasury, New Zealand Transport Agency, Te Puni Kōkiri, Crown Law Office, Accident Compensation Corporation, New Zealand Defence Force, Law Commission, Transport Accident Investigation Commission, Civil Aviation Authority, Maritime New Zealand, Remuneration Authority, Senior Citizens, Customs, Office of the Health and Disability Commissioner, and the Health Quality and Safety Commission. The Department of Prime Minister and Cabinet has been informed.

33. The Ministry wrote to approximately 168 key stakeholders seeking feedback on the current system. Information about the review was available on the Ministry of Justice website. Key stakeholders included relevant government agencies, investigating authorities, District Health Boards, pathologists, funeral directors, Iwi Authorities and other organisations with an interest in coronial matters.

34. The Ministry received 49 submissions, including some from interested individuals. Feedback from submissions was varied and covered each of the main areas of concern for the targeted review.

35. Feedback was specifically sought from Police, Crown Law, Ministry of Foreign Affairs and Trade, New Zealand Customs Service, Ministry of Defence and Maritime New Zealand on proposals regarding investigations of overseas deaths. No concerns were raised by these agencies during consultation.

Families

36. Families were not specifically consulted. The Ministry does not collect data from families who participate in the coronial system. However, officials are looking at how information can be collected from families in the future.

Coroners

37. Specific recommendations have been discussed with the Chief Coroner. Ministry of Justice officials also met with a representative group of coroners to receive feedback on the proposals.

38. The Minister for Courts has also met with the Chief Coroner to discuss the proposals.

39. All coroners have been informed of the proposals and given the opportunity to provide feedback. Coroners do not support all of the proposals. In particular, they consider that there are good processes in place for receiving advice on all bodies repatriated to New Zealand to allow them to determine whether an investigation is needed. Relying on people to raise concerns will run the risk that some deaths that could have benefited from a coronial investigation are missed.

Funeral directors

40. Officials met with a representative group of funeral directors to clarify the concerns of funeral directors about the coronial system and overseas death investigations. Some funeral directors believe that the Act currently provides only for voluntary reporting and strongly support clarifying a coroner’s jurisdiction to investigate deaths where the body is returned to New Zealand for burial or cremation.

41. The two options regarding decision-making (‘a’ and ‘b’) had not been developed at the time when officials met with the representative group.

Pathologists

42. Officials consulted with pathologists on some of the proposals under consideration regarding the management of human tissue samples. Some proposals have been modified in response to pathologists’ concerns. Some concerns raised by pathologists will be addressed either as part of the coronial pathology procurement project or operationally, once the project is completed.

43. Pathologists strongly advocate for the opportunity to explain the benefit of and seek approval directly from families for the retention of ‘minute’ samples. Retaining ‘minute’ samples is a standard practice internationally, provides valuable health information for other family members and is useful for research, evaluation and audit of the quality of post-mortem examinations.

Conclusion

44. The assessed options are summarised in the table below, with preferred options indicated.

Topic	Options	Conclusion
Improve accountability, transparency and leadership	A. Status quo	
	B. Strengthen Act to provide transparency and assure public of independence and impartiality and prioritise the Chief Coroner’s functions	Preferred
	C. Guidance to assist with voluntary change to processes	
Management of human tissue	A. Status quo	
	A. Remove or amend requirements which cause distress to families	Preferred
	D. Information for families	
Clarification of jurisdiction in respect of overseas deaths	A. Status quo	
	B. Limit jurisdiction (legislative)	Option ‘a.’ preferred
	a. Coroners can decide to investigate in some circumstances b. Decision making shifted to the Attorney-General	
	C. Practice guidelines limiting jurisdiction	

Implementation

45. Once Cabinet makes policy decisions, the Minister for Courts will issue a press release to publicise the proposals. The Ministry of Justice will write to stakeholder agencies to inform them of the proposed changes.

46. The Ministry of Justice will work with other Justice and Health sector agencies to ensure that the Bill gives effect to any changes required for implementation.

47. Coroners will need training and explanatory material to assist them with the implementation of the legislative changes. The new legislative changes will be included as part of the coroners' regular training, the Coroners' Bench Book will be updated, and the Chief Coroner will provide guidance to coroners. Officials will also work with the Chief Coroner to determine what additional material would be helpful for coroners.

48. Forms and information on the Ministry of Justice website for members of the public, service providers and other professional groups involved with the coronial process will be reviewed and updated. This will be considered when the detail of the change is finalised.

Monitoring, evaluation and review

49. The proposed reforms are a combination of both operational and legislative enhancements and will be monitored as a package through the use of key performance indicators. Particularly, the Ministry will continue discussions with the Chief Coroner and Coronial Services to ensure that any changes are having the desired effect. Officials are also considering how best to gather feedback from participants in the coronial system on an ongoing basis.

50. The Ministry of Justice is also reviewing its processes to examine what information needs to be collected, identify gaps in the data and to improve the quality of data entered. The Ministry and the Chief Coroner will also consider what information can be reported publicly on the timeliness of coronial cases.