Regulatory Impact Statement

Coroners Act Review: Proposals for Reform Paper 1

Agency Disclosure Statement

1. This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Justice. It analyses options to improve the timeliness and efficiency of the coronial system and the Coroners Act 2006.

2. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Coroners Act to improve these areas.

1.1. The following are constraints in the analysis:

- Evidence of the areas that can be improved is mainly anecdotal from submissions and government agencies. The information collected on the coronial process includes the length of time taken to receive external reports and hold an inquest or produce findings but does not measure how coroners allocate their time on each case. Coroners also deal with a number of cases at the same time. There are reports of considerable variation between coroners in how they carry out their role which makes it difficult to assess where problems such as unnecessary delay occur and how they are best addressed.

- Information is not collected on the volumes of every category of case (eg, the different types of death required to be reported to the coroner under section 13 of the Act) therefore this RIS only includes some evidence on the volume of cases in specific categories.

- Some regulatory options are not available for consideration due to the importance of maintaining the coroners' role as independent judicial officers. For instance, regulations and court rules were not considered appropriate instruments for the ideas under consideration because coroners have considerable freedom in how they carry out their role and rules or regulations may not provide sufficient flexibility.

- Key stakeholders have been consulted on specific proposals. Public consultation on the full proposals would have been a preferred approach but we were constrained by timeframes

- 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 is reduced as a result. Some assessment has been undertaken based on the information available.

- Further proposals for reform will be included in a second Cabinet paper in August, and further analysis will be require on those proposals.

3. The policy options are not likely to:

- impose additional costs on businesses;

- impair private property rights, market competition, or the incentives on businesses to innovate and invest; or

- override fundamental common law principles (as referenced in Chapter 3 of the Legislation Advisory Committee Guidelines).

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Executive summary

1. This paper considers the first tranche of proposals for improvements to the coronial system and the Coroners Act 2006 (the Act) following a targeted review.

2. The main focus of the review is on improving efficiency and timeliness, reducing the impact of the coronial process on families, and improving public safety outcomes.

3. The options considered in the paper address ways to:

   - manage entry into the coronial system to better define which cases need to be reported to the coroner to ensure the system is focussed on cases that warrant investigation by a judicial officer
   - ensure deaths in official care or custody receive an appropriate level of scrutiny consistent with the circumstances of the death
   - improve timeliness and consistency in the coronial system to ensure efficient processes
   - reduce duplication with other investigating agencies
   - address short term absences by the Chief Coroner
   - improve coroners' recommendations to ensure effective outcomes for families and public safety.

4. A second tranche of proposals will be considered in August 2013.

Introduction

5. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Act 2006 aimed at improving the efficiency and timeliness of the coronial process and ensuring the coronial system is responsive to the needs of families.

6. The overall cost to the Ministry of Justice of the New Zealand coronial system is approximately $16.8 million for the year 2011/2012. More than half of the costs ($8.77 million) are for services procured from third parties including coroner directed post-mortem examinations, mortuary services, laboratory tests and human tissue return. The overall cost has remained steady since the implementation of the Act when the coronial services unit was established and excludes the costs to the New Zealand Police and other investigating agencies.

Role of the Coroner

7. The role of the coroner is to establish, so far as possible, the cause 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.

8. 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.

Legislative framework

9. 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. The Act came into effect on 1 July 2007 and made significant changes to the coronial system, including:

   a. establishing the office of the Chief Coroner to provide leadership and co-ordination
   b. moving to a smaller number of mostly full-time, legally qualified coroners
   c. ensuring family members are notified at significant steps of the coronial process

d. introducing a specific regime for retention and release of body parts and bodily samples

e. promoting co-operation between coroners and other agencies.

Aims of the Review

10. The aims of the review are to:

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

Workload

11. In the year ending 30 June 2012, approximately 29,500 people died in New Zealand. There were 3,351 incoming coronial cases and coroners provided advice (but did not accept jurisdiction and open an inquiry) on a further 2,744 cases (6,095 in total). In the same period, 1,280 inquiries were opened, of which 891 were hearings on papers and 288 inquests[1] were held (including joint and special fixtures). The total outcomes issued for this period was 3,105 which is slightly less than the total incoming caseload.

12. The average length of time (in days) to close a case and the total number of cases between 2007/08 and 2011/12 is shown in Appendix 1.[2] The average time to receive the final pathologist's report and close a case where no inquiry was required was 133 days in 2011/12 (these being primarily natural deaths), while the average time when an inquiry was conducted and an outcome issued was 429 days.

13. In 2012, 185 recommendations were made by coroners, of which 89 (48%) were made at inquest.

Problem

14. The areas identified for reform, can be grouped into three areas of the coronial process: managing the cases that enter the system, efficient processes within the system, and effective outcomes for families and public safety, as follows:

Managing entry into the coronial system to ensure it is focused on cases that warrant investigation by judicial officers

15. There is uncertainty about the role of the coroner and when deaths should be reported. The areas of concern noted in submissions and from Ministry analysis include when deaths are linked to medical treatment and procedures or surgical operations; the handling of koiwi tangata (historic human remains such as bones); and deaths from natural causes in official custody or care, which currently require a mandatory inquest to be held as part of the coronial inquiry.

[1] 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.

[2] The average time taken to complete a coronial case is dependent on several factors and can be skewed by particularly long and complex cases. This is especially evident where other investigations or prosecutions are taking place, as the length of time may largely rely on how long the coroner has to wait for an investigation report.

Efficient processes within the coronial system

16. There are concerns that the coronial process is not always completed in a timely manner Reported delays include the length of time coroners can take to accept a case, the time required to release bodies following post-mortem examinations as well as the overall time required to complete coronial inquiries and produce the coroner's findings. There are also concerns about a lack of consistency of practice between coroners and regions which requires a tailored approach to each coroner or region and can reduce efficiency for the people dealing with them.

17. Concerns raised by stakeholders and analysis of timeframes suggest that the improvements made to the coronial system in the Act have not yet achieved the level of consistency and timeliness that was originally envisaged.

18. The current mechanisms for appointing an Acting Chief Coroner create legality and practicality issues when the Coroner is absent for short periods of time.

19. There is potential for duplication of resources and uncertainty about respective roles of different investigating authorities.

Delivering effective outcomes from the coronial service for families and public safety

20. There is debate about the quality of some recommendations made by coroners and the sources of expertise coroners draw on to make their recommendations.

21. There are concerns that recommendations can propose wide-ranging reviews or reform of legislation based on limited evidence and without showing how such reviews or reform would have prevented that particular death.

22. Options in the following areas are:

    Managing entry

    1) Clarification of reportable deaths
    2) Deaths in official care and custody

    Efficient processes

    3) Timeliness of coronial decisions
    4) Duplication with other investigating agencies
    5) Deputy Chief Coroner

    Effective outcomes

    6) Coroners' recommendations

23. Other problems can be addressed through minor changes which fall under the RIA exemptions. The status quo, problem and analysis are set out for each of these areas, following a general overview and overarching objectives.

Objectives

24. The Ministry is focused on developing a modern, efficient and effective coronial system that balances the needs of families with the public good in understanding the cause 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:

    - Better manages entry into the coronial system by being clear about what deaths are reported to coroners.
    - Works more efficiently by providing clarity about the roles, responsibilities and expectations of the people who work with, and in, the system. This involves ensuring

that uncertainty around boundaries between coroners and other investigating authorities is managed.

- Uses modern, efficient and cost-effective processes, particularly ensuring that the coronial process is completed in a timely manner so that grieving families can move forward, while still maintaining coroners' judicial independence.
- Delivers effective outcomes to families, the general public and government. This includes ensuring coroners' recommendations and findings contribute to improving public safety, are reasoned and draw on expertise.

25. Some objectives are more important than others for particular options and are assessed accordingly.

26. 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.

1 Clarification of reportable deaths

Status quo and problem

27. The Act requires the following types of deaths to be reported to the coroner – deaths:[3]

- without known cause, suicide, or unnatural or violent
- for which no doctor's certificate is given
- during medical, surgical, or dental operation, treatment, etc
- in official custody or care.

28. Ten submitters noted uncertainty about the role of coroners and when deaths should be reported. Specific concerns about reportable deaths include: when deaths linked to medical treatment and procedures or surgical operations should be reported to the coroner; and the handling of koiwi tangata (human remains).

29. There is anecdotal evidence from submitters that these particular reportable deaths need clarification, as they currently lead to unnecessary delays and financial pressure on families.

Deaths linked to medical treatment or surgical operations

30. Currently, all deaths that occur while the person concerned was undergoing a medical, surgical, dental, or similar operation or procedure or appear to be a result of any of those procedures, must be reported to the coroner.[4] Submissions from medical professionals and District Health Boards indicate that the lack of definitions for these procedures result in over reporting of these deaths due to confusion.

31. Of the 6,095 deaths reported to the coroner in 2011/12, 2,744 cases (45%) were "advice" cases. Most of these cases are ones where a doctor has contacted a coroner to discuss whether the death should be reported under the Act. While such cases do not require much of a coroner's time, they can be disruptive for medical staff and families as the doctor may not be able to speak to the coroner immediately (especially outside normal working hours), and the family cannot move the body or make arrangements until it is clear whether or not the coroner will taken jurisdiction.

Koiwi tangata (historic human remains such as bones)

32. Deaths that occurred more than 100 years ago are no longer likely to have relevant lessons that can be learnt from the death and people involved are likely to have died. This means that even if the cause of death is identified, the coronial process will produce outcomes that

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[3] Coroners Act 2006, s 13.
[4] Coroners Act 2006, s 13(1)(c).

are no longer relevant and use up valuable time and resources. The overlap with the Historic Places Act 1993 can also cause confusion about jurisdiction when human bones are found. The Historic Places Act protects archaeological sites, while Police will investigate the site on behalf of the coroner to determine whether the death is a crime scene. Clarifying when the coroner has a role may reduce uncertainty about which jurisdiction should take precedence.

Regulatory Impact Analysis

33. We have considered the status quo (option A) and a further *preferred* (option B), clarifying definitions for reporting deaths to the coroner and clarifying the role of the coroner in these situations.

34. Option B would make the following changes (all of which are independent and can operate individually) to the Act:

- The definitions of medical and surgical related deaths will be clarified so that it is clear which deaths should be reported. This would distinguish cases where death was not reasonably expected as being a consequence of the treatment, procedure or operation from cases where people died as a result of medical misadventure.
- The coroner's jurisdiction will be limited to conducting an inquiry for deaths that occurred less than 100 years ago, rather than a fixed date, in the Act, but still retain the ability to conduct a post mortem examination as that may be required to ascertain the age of the remains.

		Clarification of reportable deaths	
		A **Status quo**	**B** **Clarifying reportable deaths**
Objectives	**Effectiveness** Does the option provide clarity? Does the option provide effective outcomes for families and public safety?	• Confusing for individuals and agencies (particularly hospitals), over when a death should be reported to a coroner. A non-legislative option of a form developed by coroners for hospitals to use when reporting deaths has improved but not resolved the problem. • A coronial inquiry is likely to add little value when a death is due to a medical condition and there are no issues about the level of care received. • Deaths that occurred more than 100 years ago do not lead to effective outcomes when a coroner investigates. Any lessons learnt are usually no longer relevant and those involved with the death are likely to have died.	• Ensures coroners focus their time on cases where an inquiry is desirable and appropriate, rather than giving advice or investigating deaths unnecessarily. • Outcomes are relevant and applicable to current issues. • Minimises confusion for medical professionals about when medical related deaths should be reported.
	Efficiency What are the cost-implications? Will the option improve timeliness of cases?	• Extensive delays for families waiting to find out whether the coroner will take jurisdiction and intrusion into their lives to collect information for the coroner if an inquiry is opened. • Costs are incurred by the system when deaths are reported unnecessarily, and reporting of such deaths may reduce the time and resources to investigate other deaths.	• Will reduce the number of cases required to be reported to the coroner – pathologists informally estimated a reduction of 5% for medical related deaths. • Will free up coroners to spend more time on more complex cases. • Families will receive results faster and not have to go through the rigour of a coronial inquiry and

	Clarification of reportable deaths	
	A **Status quo**	**B** **Clarifying reportable deaths**
	• Cost and time implications for medical staff who must liaise with the coroner to find out whether the coroner wishes to take jurisdiction and complete forms to notify the death. There may also be delays if the coroner is not immediately available.	inquest unless necessary (especially when an investigation has already been done elsewhere). • Will reduce costs due to a reduction in reportable cases, however it is possible that these savings may be absorbed by coroners spending more time on more complex cases and pathologists being required to be on call. • Avoids potential overlap with the Historic Places Act 1993 over responsibility for koiwi tangata pre 1900.
Risks	• Interference and duplication with other investigations. • Confusion and unnecessary burden on grieving families when a death is unnecessarily reported to the coroner. • Confusion and uncertainty for and medical staff. • Inefficient use of resources.	• Some families may lose the opportunity to have their family member's death investigated by a coroner when desired, however this is minimised as the coroner will still have the option to investigate where appropriate. • There may be a perception by some members of the public that this will reduce scrutiny of doctors covering up deaths. However, such deaths would not be seen by the coroner if a death certificate had been signed. The Law Commission is reviewing death certification as part of a review of the Burial and Cremation Act 1964. • There are safeguards in the medical system to minimise any concerns over under reporting, including the Health Quality Safety Commission which requires health services to report adverse incidents and the Health and Disability Commissioner who can investigate complaints from families. • There may be concern that cost of investigating some deaths may be shifted to other areas, however, other investigations are usually completed before a coronial inquiry and so are unlikely to incur additional costs.
Impacts	• Additional time and resources for medical staff liaising with coroner. • Little positive impact on people and circumstances when the death occurred more than 100 years ago.	• Keeps more deaths out of the coronial system and removes burden on grieving families when further investigations are not warranted.
Conclusion	• Does not meet objectives and risks interfering and duplicating other investigations and clogging the	• Meets objectives and some risks are manageable through other

	Clarification of reportable deaths	
	A Status quo	B Clarifying reportable deaths
	system with deaths that are reported unnecessarily.	review processes.

2 Inquests for deaths in official care or custody

Status quo and problem

35. The Act requires deaths in official care or custody to be reported to the coroner, including deaths of:[5]

- patients detained under the Alcoholism and Drug Addiction Act 1966 or the Mental Health (Compulsory Assessment and Treatment) Act 1992
- children and young persons in care or custody under specified sections of the Children, Young Persons, and Their Families Act 1989
- care recipients or proposed care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- prisoners or persons under the control of a security officer under the Corrections Act 2004
- persons in the custody of the New Zealand Police.

Deaths in official custody or care

36. Currently, the Act requires a coroner to both open an inquiry and conduct an inquest if the death occurred in official custody or care.[6] The Ministry of Justice does not record which section of the Act a death was reported under. Data from the Department of Corrections shows that 78 deaths occurred in official Department of Corrections' custody between 2007/08 and 2011/12. Of these deaths, 45 (58%) were classified by the Department of Corrections as apparent natural causes. Although not quantified, deaths from natural causes also occur for people in other forms of care in the health and disability sector and under the Care of Children, Young Persons, and Their Families Act 1989.

37. Despite being classified as apparent natural causes, and other inquiries being carried out, these deaths must be still scrutinised at a public inquest to ensure the person received appropriate treatment and care in custody. The Act does not give a coroner flexibility to consider the evidence and produce findings in chambers, even if the relevant parties have been contacted and no one wishes to give evidence in person.

Regulatory Impact Analysis

38. We have considered the status quo (option A) and a further *preferred* (option B), to provide the coroner more flexibility in how a coronial inquiry is conducted for deaths in official custody or care.

39. Option B would still require the coroner to open an inquiry into every death in official custody or care, but would remove the requirement for the coroner to hold an inquest. This would provide the coroner with flexibility to hold a hearing on the papers and make a chambers finding in appropriate circumstances. The Act will include criteria for the coroner to consider when deciding when to hold a hearing on the papers (the criteria would be developed in consultation with the relevant agencies.

[5] Coroners Act 2006, s 13.
[6] Coroners Act 2006, ss 60 and 80.

		Clarification of reportable deaths	
		A **Status quo**	**B** **Clarifying reportable deaths**
Objectives	**Effectiveness** Does the option provide clarity? Does the option provide effective outcomes for families and public safety?	• Requiring a coronial inquiry to be opened and a public inquest held into all deaths in official custody or care regardless of the circumstances of the death, is clear but does not produce effective outcomes for families and public safety if the death is known to be from natural causes and there are no concerns about the level of care the person received.	• Ensures coroners focus their time on cases where an inquest is desirable and appropriate as part of the coronial inquiry, rather than having a mandatory inquest for natural deaths when people die in custody or care. • Outcomes are relevant and applicable to current issues. • Minimises confusion for families about why a coroner is investigating the death.
	Efficiency What are the cost-implications? Will the option improve timeliness of cases?	• Extensive delays for families where a death is required to have an inquest under the Act. • Costs are incurred by the system if the coroner is required to hold an inquest unnecessarily. • Likely to duplicate other investigations into the death if there are other official investigations such as by the Health and Disability Commissioner, Children's Commissioner, or Independent Police Conduct Authority. All deaths in prisons are also required to be investigated by prison inspectors and their reports are reviewed by the Ombudsman.	• Will reduce costs and free up coroners to spend more time on more complex cases.
Risks		• May imply there is concern about the level of care the person received or the cause of death. • Confusion and unnecessary burden on grieving families. • Interference and duplication with other investigations.	• Some families may lose the opportunity to have their family member's death investigated by a coroner when desired, however this is minimised as the coroner will still have the option to investigate where appropriate. • May be a perception that deaths may be reported as from natural causes to cover up suspicious circumstances, but the coroner is still required to open an inquiry into the death and coroner will exercise judicial independence when deciding whether to hold a public inquest. • Reduced public scrutiny of deaths in official custody or care as hearings in chambers are likely to attract less media attention, however, such deaths may not normally be reported in the media. • May be seen to interfere with or raise questions about New Zealand's commitment to international obligations such as

	Clarification of reportable deaths	
	A **Status quo**	**B** **Clarifying reportable deaths**
		those recognised in our Crimes of Torture Act 1989 (see below paras 23 – 26).
Impacts	• Incurs unnecessary costs and time of notifying and holding a public inquest, and may cause delays in the timeliness of other cases.	• Limited impact on public scrutiny of deaths in official custody or care as public inquests will continue to be held for cases warranting public scrutiny.
Conclusion	• Does not meet objectives and risks interfering and duplicating other investigations and slowing the system with inquests that are held unnecessarily.	• Meets objectives and some risks are manageable through review processes. The small volume of cases the proposal on deaths in official custody is likely to effect may not warrant the perceived constitutional burden on our international obligations. However, the Ministry understands this option would not interfere with OPCAT obligations as the coroner is still required to open an inquiry and will have judicial independence in deciding whether to hold a public inquest (see paras 40 – 43 below).

The Optional Protocol to the Convention Against Torture

40. The Crimes of Torture Act 1989 gives effect to New Zealand's international obligations under the United Nations Optional Protocol to the Convention Against Torture (OPCAT). The objective of the OPCAT is to establish a system of regular visits by independent international and national bodies to places of detention, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

41. The Ombudsman is responsible for examining and monitoring the treatment of people detained in:

- prisons and court cells
- immigration detention facilities
- health and disability places of detention (e.g. hospitals and secure care facilities)
- child care and protection and youth justice residences.

42. Removing the requirement for a formal inquest for deaths that occur in official custody or care may be perceived as interfering with New Zealand's international obligations under OPCAT, even though the Ombudsman rather than the coroner has primary responsibility under OPCAT. However, the coroner still has the option of opening a formal inquest once an inquiry is opened if it appears the person's death is suspicious or they have been mistreated in any way. Additionally, the option for a coroner to hold a hearing on papers and chambers findings only applies if there is no-one who wishes to give evidence in person. The only implication is that an inquest is now optional, based on the discretion and legal expertise of the coroner.[7]

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[7] Coroners Act 2006, s 23.

43. The role of the Ombudsman is independent from the role of the coroner. The Ombudsman will continue to examine and monitor the treatment of people detained in custody or care. Prison inspectors are required to investigate and report on all deaths in custody, and each report is reviewed by the Ombudsman. Like the coroner, the Ombudsman is independent of the executive branch of government. The Office of the Ombudsman has advised that the proposal does not appear to affect the Ombudsman's role and jurisdiction; however the Office will be consulted on the detail of the legislative changes to ensure this is correct.

2 Timeliness of coronial decisions

Status quo and problem

44. The Act includes a requirement for coroners to perform their duties without delay as far as it is consistent with justice and practicable to do so.[8] Despite this provision, the length of time required to complete inquests and hearings on papers has increased from 111 days in 2007/2008 to 429 days in 2011/2012. As shown in Appendix 1, the number of cases has also increased from 513 in 2007/08 to 1,202 in 2011/12. However, the length of time to conclude a case has increased by almost four times that in 2007/08 while the number of cases has only increased by just over two times than in 2007/08.

45. It is not clear why the length of time to conclude a case has increased over time, although there are a number of factors that may have contributed to the increase. When the new coronial system came into effect, the initial workload for coroners was higher than anticipated as result of the number of cases remaining under the old Act, increased reporting of cases under the 2006 Act, and increased demand for access to coroners outside normal working hours. In response to the increased demand, there has been a particular focus on closing cases from the old Act (only about 10 cases remain open) and a National Initial Investigation Office has been established as a first point of contact for coronial referrals.

46. Other factors include the earthquake in Canterbury in February 2011 which caused 185 fatalities and put considerable pressure on the coronial system. One coroner retired in September 2011 and was not replaced until January 2013. This increased the workload for other coroners during the vacancy.

47. Data that was recorded for 3 separate months in 2011 and 2012, for cases where inquiries were required, shows that where no other investigation or report was requested or occurring (16 cases), the average time for a coroner to receive a post-mortem report was 55 days and the average time to receive a toxicology report was 40 days. Despite this, the average time to close these cases was still as high as 532 days. This indicates that significant delays for coronial cases are caused in the period from when a coroner receives the pathologist and other reports and when the case is closed.[9]

48. It is unclear why delays are caused in the stage following the coroner receiving a report and preceding the conclusion of case. There is no detailed information about what happens during this period. Where an inquest is ordered then delays may result from confirming witnesses and venues for the inquests. However, despite the requirement to formalise an inquest, 532 days is a significant period of time, particularly where no other agencies are involved. The Ministry is not aware of any additional evidence of other factors that may contribute to this timeframe.

49. 13 submissions from the Ministry’s initial consultation raised concerns that the delay in producing coronial decisions has a negative impact on grieving families and the public safety

[8] Coroners Act 2006, s 5.

[9] Given the small sample of cases available, this may not be indicative of the overall time to complete coronial cases but can provide some insight into the stages of the process which may cause time delays.

benefits of coroners' findings. Several submitters suggested that these delays made coroners' recommendations less relevant if practices had changed in the intervening period.

50. Timeliness and consistency were common themes in submissions, including the length of time coroners take to accept a case, the time required to release bodies following post-mortem examinations as well as the overall time required to complete coronial inquiries and produce the coroner's findings. There are also concerns that the workload varies across the country and that the Chief Coroner does not have sufficient powers to balance workloads between coroners.

51. The leadership and education role of the Chief Coroner is an opportunity to promote a level of consistency and timeliness that was envisaged when the Act was drafted. The provision of practice notes to guide coroners in their procedures is likely to impact on the current lack of consistency and timeliness.

Regulatory Impact Analysis

52. We have considered the following options in this paper, some of which can occur in tandem, relating to the timeliness of coronial decisions, noting that more will be considered in the second Cabinet paper. None of the options considered provide a complete solution to the problems identified; however, a combination of options B and C is likely to be most effective.

A. Status quo: continue with limited aspects in legislation, coupled with operational changes.

- Retaining the status quo relies on current legislative provisions, such as section 5 of the Act which concerns coroners performing their duties without delay, as well as ongoing operational changes (expanding the National Initial Investigation Office, establishing standard operating procedures and electronic filing). Operational changes have already increased timeliness of cases at an administrative level, but unnecessary delays are still evident throughout the coronial process.

B. Non-regulatory changes such as further education and inviting the Chief Coroner to issue practice notes.

- Inviting the Chief Coroner to issue practice notes setting out standard procedures in certain circumstances.
- Training opportunities, developed in conjunction with the Chief Coroner.

C. Strengthen legislative provisions, including increasing flexibility in case allocation.

- Strengthening the overall emphasis on timeliness in the Act and also the Chief Coroner's role of encouraging timeliness and consistency between coroners.
- An amendment would be made to the Act to ensure that the Chief Coroner keeps the need for practice notes under review. In addition, the Act would be amended to remove the statutory requirement for formal consultation with other coroners on draft practice notes to provide the Chief Coroner more flexibility about how they are developed.
- The Chief Coroner will have more flexibility to designate coroners for particular purposes and specific time periods to better manage workloads between coroners.
- This option could be adopted alongside option B.

D. Increase the number of full time coroners by 4 or less.

- When the Act was passed, 14 permanent coroners, one relief coroner and one Chief Coroner were appointed. As a result of increased demand since 2007, there is now a bench of 16 permanent coroners.
- The current maximum number of coroners specified in section 109 of the Act is 20. This option increases the number of full time coroners by up to 4 to still be within the legislative cap of 20 coroners.

		Timeliness of Coronial Process			
		A **Status quo**	**B** **Non-regulatory changes**	**C** **Strengthen legislative provisions**	**D** **Increase the number of full time coroners (not preferred)**
Objectives	**Effectiveness** Will the options deliver consistency, flexibility and ensure judicial independence?	• Allows coroners to use their discretion to deal with cases in an appropriate time frame. • Reinforces judicial independence of coroners.	• Allows the Chief Coroner to use his or her discretion to issue practice notes or promote education. • Maintains the judicial independence of coroners.	• Better regulation of timeliness and consistency. • Certainty of process for families, but allows flexibility to depart from standards when required. • Effectiveness limited by coroners' behaviour and their judicial independence.	• Greater exposure to coroners for families. • No effect on judicial independence.
	Efficiency Will the options reduce case length and by how much? Are there cost implications?	• Lengthy timeframes for disposal of cases (over 400 days for an inquest or hearing on papers). • Lack of consistency across the country.	• May improve timeliness and consistency across coroners (subject to the Chief Coroner issuing practice notes and promoting education in these areas, and judicially independent coroners following the practice notes and education/training).	• The workload will be spread more widely across coroners. • Strongly emphasises the importance of efficiency in legislation. • Allows coroners to dedicate more time to complex cases. • Legislation has a limited ability to influence coroners' behaviour and maintain judicial independence.	• The workload will be spread more widely across coroners. • Coroners could dedicate more time to complex cases. • Increase costs to the justice sector (up to $455,600[10] per year for each additional coroner). • New Zealand's coronial system already has a better ratio of coroners to cases than comparable overseas countries
Risks		• Options to manage timeliness and consistency (such as practice notes) are available under the current legislation but have not been used to the extent intended, and there is limited ability to encourage their use given the Chief	• The Chief Coroner is not bound to enforce these suggestions and as such, has chosen to produce only one practice note to date. • Coroners must have regard to practice notes but are not required to follow them in all	• Risks reducing flexibility in how coroners conduct an inquisitorial process. • Risks interfering with the judicial independence of coroners. • Limited information available to understand causes of delays means legislative changes may not fully address the underlying	• Increased costs to the justice sector cannot be absorbed within current baselines. More coroners may increase difficulties of consistency between them. • Coroners hold office until age 70 unless they resign or are removed for inability or

[10] This is the current actual cost of a coroner but the addition of extra coroners is not likely to require the same level of funding. Additional support staff costs are not likely to increase in the same proportion due to administrative costs being spread across coroners.

	Timeliness of Coronial Process			
	A **Status quo**	**B** **Non-regulatory changes**	**C** **Strengthen legislative provisions**	**D** **Increase the number of full time coroners (not preferred)**
	Coroner's independence. • Will continue to raise concerns with families and the public about the delays and uncertainty in the coronial system.	circumstances.	problems. • Further changes would require legislative amendment which reduces flexibility to respond to changing circumstances.	misbehaviour. If coroners' workload significantly reduces, may result in inefficiency if there are more coroners than needed for the current workload.
Impacts	• Significant impacts on timeliness or consistency of coronial processes are unlikely.	• The use of discretion will mean a lack of clarity of process for families and other agencies. • Some improvement in timeliness and consistency possible, but the extent of changes is uncertain.	• Increased clarity of process for families and other agencies. • Some improvement in timeliness and consistency possible, but the extent of changes is uncertain given the need to protect judicial independence. • Timelier disposal of cases is less of a burden on families.	• Increased exposure to coroners for families. • Timelier disposal of cases.
Conclusion	• Fails to sufficiently meet objectives but maintains judicial independence.	• Flexible and meets objectives, but only if the Chief Coroner implements suggested changes, and they are followed by coroners. These options are available under the current legislation but have not been fully utilised to improve consistency and timeliness.	• Best meets objectives, cost restrictions and improves spread of workload, but risks judicial independence, may require further legislative amendment in the future and may not provide a complete solution.	• Partially meets objectives, but the least cost-effective option and not attainable in the current baseline.

4 Duplication with other Agencies

Status quo and problem

53. The coroner's role in relation to a death is currently defined in section 4 of the Act. This role includes determining whether the public interest would be served by the death being investigated by one of the investigating authorities listed in section 14. Section 119 of the Act provides that the coroner's powers and functions in respect of a death are not limited or affected if the coroner refers the death to an investigative authority.

54. The conclusion of coronial cases has been extended by the involvement of other investigating agencies in 4 cases in 2008/09 rising to 21 in 2011/12. The delays faced by grieving families in these cases are evident in the increased length of time taken to close a coronial case where another agency is also investigating (244 days in 2008/09 to 738 days in 2011/12). The coroner's role has the potential to duplicate the outcomes of other investigations in some circumstances.

55. Evidence recorded in three months in 2011 and 2012 shows that the coroner receives a report from the other investigating agency after approximately 319 days (13 cases). The coroner then spends another 288 days on the case before it is closed. It is likely that the complexity of these cases results in the coroner spending time consulting other experts, however, given the coroner has already received a report from an investigating agency it is likely that at least some of this time may be unnecessary.

56. Submissions from other agencies that investigate deaths disclosed this apparent jurisdictional issue between coroners and agencies with similar functions. The Transport Accident Investigation Commission (TAIC) particularly noted the overlap of investigations due to the similar nature of coronial investigations and TAIC investigations. TAIC is concerned that coronial proceedings are beginning to inappropriately challenge and review the Commission's inquiries and reports, which risks undermining the role of the Commission and its findings.

57. The problem would be best addressed by an independent review of the roles of all the statutory investigations into the causes and circumstances of deaths. This would enable identification of the appropriate level of investigation in each death, the level of public scrutiny required, and who should carry out the investigation. Such a review is outside the scope of the current targeted review. Therefore the analysis of the problem assumes that coroners do however have a role in investigating deaths. In particular, to provide a public forum for families should there be further or different issues to investigate. The issue is how best to delineate roles and ensure that due consideration is given to whether another inquiry would add value.

Regulatory Impact Analysis

58. We considered the following options relating to duplication with other agencies:

A. Status quo.

- Retaining the status quo would rely on coroners continuing to operate within the current definitions in the Act. The status quo allows coroners to refer deaths to these authorities without limiting their own powers and functions and this is likely to be where jurisdictional concerns arise.

B. Legislative changes to improve cooperation and reduce duplication between coroners and other investigating authorities.

- The Chief Coroner will be required to consider developing memoranda of understanding with other investigating authorities and relevant organisations, to clarify respective roles and how authorities will work together.

- If an inquiry has already been conducted by an investigating authority[11], the Chief Coroner can direct that no further investigation is needed.

C. *Non-legislative changes to improve cooperation between coroners and other investigating authorities.*

- The Chief Coroner will be encouraged to issue practice notes that provide coroners with opportunities and ways to promote information sharing with other authorities and boundaries for when other authorities are involved in the investigation of a death.
- The Chief Coroner will also be encouraged to use the existing power to develop protocols with other investigating authorities and relevant organisations, to clarify how authorities will work together and minimise duplication between authorities.

D. *Legislative changes to prioritise investigations by other agencies over coronial investigations.*

Where another agency is investigating a death or has completed an investigation into a death, then the coroner may not open an inquiry into the same death.

[11] As defined in s 9 of the Coroners Act 2006.

		Duplication with other Agencies			
		A **Status quo**	**B** **Legislative changes**	**C** **Non-legislative changes**	**D** **Prioritising other agencies**
Objectives	**Effectiveness** Will the options deliver expertise, reduce duplication and ensure judicial independence?	• Coroner continues to have discretion to refer deaths to other investigating authorities.	• Reduces duplication between agencies due to sharing of information. • Increased use of expert knowledge. • Easier to develop memoranda of understanding (MOUs) with clearer legislation.	• If processes are adopted then it will reduce duplication between agencies. • Relying on the Chief Coroner's powers and discretion to facilitate may not result in desired outcomes for other agencies.	• Expertise in particular areas will be delivered through the investigating agencies. • Duplication of investigations will be significantly reduced, with only one agency investigating (affects on average 306 cases each year).
	Efficiency Will the options reduce case length where other investigating agencies are involved and by how much? Are there cost implications?	• Inefficient use of resources (in both the coronial system and in other investigating agencies). • Negative impact on timeliness of coronial investigations when additional agencies are involved (extra 370 days).	• Increased resource efficiency. • Increased timeliness of investigations. • Some costs may occur as a result of creating agreements between the coroners and other agencies.	• Some costs may occur if the Chief Coroner does decide to develop agreements between agencies. • An informal process may result in long periods of time to develop any agreements or practice notes.	• Case length will be significantly reduced (by about 288 days). • Reduced costs to the Justice sector as a result of less coronial cases - approx 306 (5.3%) less cases a year.
Risks		• Continues to impact on the timeliness of coronial investigations so risks lie with ongoing complaints from those involved in the system (families and other agencies). • There are also risks with agencies developing alternative ways of investigating and reporting in order to reduce interaction with coroners. • May undermine the public reputation of both investigating authorities if inquiries produce different outcomes.	• Relies on Chief Coroner to make decisions on whether to stop a coronial investigation and to initiate MOUs. • May have no effect if MOUs are not completed. • May prevent coroners from being involved in some investigations.	• The Chief Coroner is not bound to comply with the non-legislative changes. • Unlikely that grieving families will receive any clarity of role between the agencies if the changes are not formally implemented.	• There is not necessarily public accountability for the decisions made by other investigating agencies. • Families do not have the option to request a judicial review of a decision. • May prevents coroners from involvement in matters that would warrant coronial investigation.
Impacts		• Current levels of potential duplication and inefficiency likely to continue.	• Greater clarity for families and other agencies about the role of each agency in their family member's death. • Will have some impact in reducing potential duplication and inefficiency.	• Likely to have some impact in reducing potential duplication and inefficiency.	• Clarity for families about the role of each agency.

	Duplication with other Agencies			
	A **Status quo**	**B** **Legislative changes**	**C** **Non-legislative changes**	**D** **Prioritising other agencies**
Conclusion	• Inconsistent with the objectives and has a negative impact on grieving families.	• Meets objectives with minimal costs. The risks are minimal if implemented appropriately.	• Flexible, but does not achieve the objectives and relies on the Chief Coroner to action	• Removes the public accountability and purposes of coronial system

5 Deputy/Acting Chief Coroner

Status quo and problem

59. Currently the Act allows for the appointment of an Acting Chief Coroner to carry out the duties of the Chief Coroner if he or she is unable to perform the functions, powers and duties of the role due to illness, absence from New Zealand or some other cause12. However this appointment is made by the Governor-General, and therefore is not available or suitable for short term absences by the Chief Coroner (eg, due to illness).

60. This may lead to informal arrangements being made. This can lead to confusion or dissent if the person tries to exercise the functions, powers or duties of the Chief Coroner without the legal authority.

61. If the Governor-General appoints an Acting Chief Coroner in the Chief Coroner's absence, then the Acting Chief Coroner takes on the full salary of the Chief Coroner ($300,500 as a District Court Judge, plus a $10,000 Chief Coroner allowance) for that period.

Regulatory Impact Analysis

62. We considered the following options in relation to appointing an Acting Chief Coroner:

A. Status quo.

B. Allowing a permanent Deputy Chief Coroner without additional functions (preferred).

- This option would allow the appointment of a permanent Deputy Chief Coroner who would continue in their role as a coroner with no additional functions, unless the Chief Coroner is absent. When the Chief Coroner is absent, the Deputy would step in and act as Chief Coroner for the period of absence.
- The Deputy Chief Coroner would be appointed for a term of five years and would not require the Governor-General's appointment each time the Chief Coroner is absent.
- The Deputy Chief Coroner would be paid an allowance set by the Remuneration Authority (eg, similar to the $10,000 Chief Coroner allowance) when acting for the Chief Coroner, but would be paid their current salary ($240,000) at all other times.

C. Allowing a permanent Deputy Chief Coroner with additional functions.

- This option would allow the appointment of a permanent Deputy Chief Coroner who would continue in their role as a coroner, but with additional functions. These additional functions may include any of the Chief Coroner's functions under section 7 of the Act which he or she has delegated to the Deputy Chief Coroner, however, the primary function would be to act as Chief Coroner in the absence of the Chief Coroner.
- The Deputy Chief Coroner would be appointed for a term and would not require the Governor-General's appointment each time the Chief Coroner is absent.
- The Deputy Chief Coroner would be paid a higher salary than an ordinary coroner (currently $240,000) to account for permanent additional functions. The salary would be set by the Remuneration Authority and would not be as high as the Chief Coroner's salary given the level of additional functions and the Chief Coroner's status as a District Court Judge.

[12] Coroners Act 2006, s 106.

		Deputy/Acting Chief Coroner		
		A **Status quo**	**B** **Deputy without additional functions (preferred)**	**C** **Deputy with additional functions**
Objectives	**Effectiveness** Does the option improve clarity of role when the Chief Coroner is absent?	• Uncertainty when Chief Coroner is absent for periods but clear when he or she is absent for a longer term.	• Clarity of role when the Chief Coroner is absent for long and short periods of time. • No need to receive the Governor-General's permission each time the Chief Coroner is absent. • Seamless transitions for unplanned absences.	• Clarity of role when the Chief Coroner is absent for long and short periods of time. • No need for Governor-General's appointment each time the Chief Coroner is absent. • Seamless transitions for unplanned absences. • Not clear that additional duties are required as there are only 16 coroners in total.
	Efficiency What are the cost-implications?	• Costs are increased when a coroner is Acting Chief Coroner – The Acting Chief Coroner takes on the Chief Coroner's salary for that period.	• Likely to be cost-neutral as the Deputy would not have any additional functions when not acting as Chief Coroner. • The Deputy would be paid an additional allowance when acting as Chief Coroner.	• Will increase the costs of the coronial service due to the increase in duties of a Deputy Chief Coroner and therefore a need to increase the salary. • May result in inefficiencies if much of the Chief Coroner's role is delegated to a deputy. • No need to anticipate need for a Deputy and approach the Governor-General each time the Chief Coroner is absent.
Risks		• Uncertainty of role when the Chief Coroner is absent, especially for short or unplanned periods.	• Acting up function may be used more often with a permanent structure and therefore increase costs.	• Deputy Chief Coroner's additional functions may duplicate or interfere with the Chief Coroner's functions.
Impacts		• There is a need to anticipate and plan in advance when the Chief Coroner will be absent and requires the Attorney-General to ask the Governor-General to appoint an Acting Chief Coroner.	• No need to anticipate the need for a Deputy and approach the Attorney-General and Governor-General each time the Chief Coroner is absent.	• Taking on additional duties may reduce the availability of a Deputy Chief Coroner to carry out ordinary duties of coroner and will require higher levels of co-ordination with coroners and the Chief Coroner.
Conclusion		• Fails to meet the objectives.	• Meets the objectives and likely to be cost neutral.	• Meets the objectives but increases costs and may create issues of potential duplication of functions.

6 Nature of coroners' recommendations

Status quo and problem

63. The coroner's role includes making specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chance of the occurrence of other deaths in circumstances similar to those in which the death occurred.[13] The Chief Coroner's functions include setting up and maintaining a register of summaries of coroners' recommendations and comments.[14]

64. The number of recommendations has fallen over the last 3 years. In 2009/10, coroners made recommendations in 230 cases (6.8% of coronial cases), while in 2011/12, coroners made recommendations in 178 cases (5.3% of coronial cases). Coroners' recommendations attract widespread interest and are frequently reported in the media.

65. Submitters raised concerns about the quality of some recommendations, the sources of expertise coroners draw on and the lack of involvement of key parties before recommendations are released. The New Zealand College of Midwives, particularly, noted that they are unable to adopt many recommendations made by coroners because they usually reflect a lack of understanding of the maternity sector and its workforce roles. Evidence from other submitters' shows that recommendations can propose wide-ranging reviews or reform of legislation based on little evidence and without showing how such reviews or reform would have prevented that particular death.

Regulatory Impact Analysis

66. We considered the following options in relation to coroners' recommendations:

A. Status quo.

B. Mandatory responses to coroners' recommendations.

- This option, used in some overseas jurisdictions, would require organisations and government agencies to provide responses to recommendations made by coroners. These responses could be positive or negative and do not require agencies and organisations to positively act on the recommendations.
- All responses would be published alongside recommendations on the public database.

C. Legislative changes to better focus the coroner's role in making recommendations and improve the quality of the recommendations (preferred).

- The Act could be amended to:
  - ensure recommendations and comments are specific to the case and evidence before the coroner, the factors that contributed to that death, and are clear as to how they will reduce the likelihood of future deaths in similar circumstances.
  - strengthen the requirement for the coroner to consider which individuals, or organisations have an interest in the death and should be notified of the inquiry or inquest so that they can contribute to the evidence on which the specified recommendations or comments are based.
  - require that organisations or individuals to whom specified recommendations or comments are directed are notified of the potential to make a specified recommendation or comment and given the opportunity to be heard in relation to the proposed recommendation and/or comment prior to it being made.

[13] Coroners Act 2006, s 4(2)(b).
[14] Coroners Act 2006, s 7(i).

- require that any response to a specified recommendation or comment is recorded in the register of recommendations that the Chief Coroner is required to maintain under s 7(i) of the Act.
- list recommendations as a matter for practice notes covering best practice to be actively considered.
- require coroners, in determining whether to hold an inquest, to take into account whether evidence used to support specified recommendations or comments being made would benefit from that evidence being publicly tested.
- insert a definition of interested parties in the Act to refer to persons required to be notified under sections 23 and 81 of the Act.
- that the requirement for coroners to provide a copy of the final findings to the Chief Coroner, families and interested parties be added to the list of "significant matters" set out in section 24 of the Act that families and interested parties must be given notice of.

D. Non-legislative changes to limit the recommendation making power of coroners.

- Additional research resources could be provided to assist coroners to produce more informed recommendations.
- Coroners could be encouraged to share draft findings, with an opportunity to comment, with relevant agencies before they are finalised and published.

E. Remove coroners' recommendation-making power.

- The Act would be amended to remove the provisions that allow and direct a coroner to make recommendations in coronial cases.

		Nature of Coroners' Recommendations				
		A Status quo	B Mandatory responses	C Legislative changes (preferred)	D Non-legislative changes	E Remove recommendations
Objectives	**Effectiveness** Does the option clarify the role of the coroner? Do they produce effective, credible, implementable and feasible outcomes for families and public safety?	• Criticism of recommendations may take the focus away from understanding the cause and circumstances of a particular death and lessons to be learnt from it. • Coroners may not have expertise on specific subject matter. • Evidence that some recommendations are not effective, feasible or credible.	• Ensures agencies consider coroners' recommendations. • Coroners may not have expertise on specific subject matter. • Criticism of recommendations may take the focus away from understanding the cause and circumstances of a particular death and lessons to be learnt from it. (Inappropriate for government and judiciary to be publicly debating). • Does not improve the effectiveness, credibility or feasibility of recommendations. However, would encourage coroners over time to adapt to agency feedback received prior to the release of recommendations.	• Other agencies with the subject matter expertise can comment on the effectiveness and feasibility of proposed recommendations. This will improve credibility. • Ensures due weight is given to how a person died and the factors that contributed to that death by moving the focus back to the death in question. • Clarifies the coroner's role in relation to recommendations.	• Increased support and resources for coroners means their recommendations will be more informed. • Difficult to provide and fund the full range of expertise coroners may require to produce well informed recommendations.	• Avoids unhelpful recommendations but may limit coroners' ability to identify measures that could prevent deaths in the future – one of the key objectives of the coronial system is the prevention of similar deaths. • Does not create effective outcomes for families as families will see coroners' lack of ability to make recommendations as a barrier to the information they need or want publicised.
	Efficiency Would recommendations be cost-effective? Do they impact on timeliness?	• Coroners' recommendations can have significant cost implications for government when suggesting law reform. • Government agencies are often required to spend time responding to the coroner and/or the media about recommendations that are not practical or not cost-effective.	• Would be time consuming and resource intensive for all agencies that must respond. It would take resources away from higher priority work.	• Ensures coroners' recommendations are focused on highlighting issues that contributed to the death which will likely reduce case time (although this would be a minimal reduction). • Ensures coroners receive good evidence on which to base recommendations.	• Cost to provide additional resources. • Coroners' recommendations can have significant cost implications for government departments when suggesting law reform. • Unlikely to reduce the time taken to complete a case.	• Likely to reduce the time taken to complete a case when no research or input required into creating recommendations. • Likely to reduce costs as less support needed to research and develop recommendations. • Likely to reduce potential duplication with other investigating authorities.
	Clarity Is the role of the coroner clarified?	• Lack of clarity of role of coroner in making recommendations and agencies receiving them.	• Improved clarity for families and agencies about expectations for coroners' recommendations.	• Improved clarity for families and agencies about expectations for coroners' recommendations.	• No clarity of role of coroner in making recommendations due to discretion.	• No clarity about what coroners should and should not say in their findings – coroners can still make comments on anything relevant to the case in their findings.

	Nature of Coroners' Recommendations				
	A Status quo	B Mandatory responses	C Legislative changes (preferred)	D Non-legislative changes	E Remove recommendations
Risks	• Continued criticism of recommendations may damage the reputation of coroners and government over time. • Recommendations can give families unrealistic expectations about what changes will be made.	• Continued criticism of recommendations may damage the reputation of coroners and government over time. This is likely to be heightened if mandatory responses are required. • May take the focus away from learning lessons from the death and instead debating practicality of recommendations.	• May impact on coroners' judicial independence and moves away from models used overseas, such as in England and some Australian states. • Does not prevent coroners recommending changes to government policy or legislation but recommendations will be required to be specific.	• Coroners may not implement changes and take up offers of education to improve the relevance of their recommendations. • May increase costs through providing additional support and resources to coroners.	• The public and media will likely see this as the government interfering with judicial independence. • Coroners are likely to still make comments in their findings that amount to recommendations. • May receive criticism internationally as it is out of step with what happens overseas.
Impacts	• Continued uncertainty about the role of coroners in making recommendations • May give families and the general public unrealistic ideas about what changes may be made as a result of the recommendations.	• Significant resource impact on government agencies if they are required to respond to every recommendation and will delay other government priorities if responses to coroners' recommendations are prioritised over other work. • May give families unrealistic expectations if recommendations are not acted on.	• Coroners' recommendations will be more specific and more practical. • Clarity for families and agencies about expectations for coroners' recommendations. • Members of the public will understand the different views on recommendations.	• Impact dependent on the extent to which coroners use the resources available to them and change the nature of their recommendations.	• May improve timeliness of coroners' findings. • More difficult for coroners to highlight changes necessary to prevent deaths and improve public safety.
Conclusion	• Fails to meet objectives.	• Fails to meet objectives.	• Meets objectives, but may limit judicial independence.	• Partially meets objectives but relies on coroners taking up initiatives.	• Partially meets objectives but risks interfering with judicial independence and may not be viewed favourably by public and coroners.

Consultation

67. The Ministry of Justice wrote to approximately 168 key stakeholders setting out the aims of the review and inviting their comment on how well the current Act and the coronial system are working, and any suggestions for improvement. Key stakeholders included relevant Ministers, government agencies, investigating authorities, District Health Boards, pathologists, funeral directors, iwi authorities and any other organisations with an interest in coronial matters. The information was also made publicly available on the Ministry of Justice website.

68. 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. This RIS assesses many of the proposed options suggested by submitters in the initial consultation phase.

69. The following agencies were consulted on the proposed reforms: New Zealand Police, Ministries of Health, Transport, Social Development, Business Innovation and Employment, Primary Industries, and Culture and Heritage; Department of Corrections, the Treasury, New Zealand Transport Agency, Te Puni Kōkiri, Crown Law Office, Accident Compensation Commission, New Zealand Defence Force, Law Commission, Transport Accident Investigation Commission, Civil Aviation Authority, Maritime New Zealand, the Health Quality and Safety Commission, and the Office of the Ombudsman. The Department of Prime Minister and Cabinet has been informed.

70. Ministry of Justice officials also met with the Chief Coroner, a representative group of coroners, and funeral directors. The Minister of Justice made a presentation to coroners about the proposed reforms.

71. Stakeholders were invited to submit feedback on their views of the system and not on the proposed solutions. The Ministry has consulted relevant government agencies, including The Treasury; New Zealand Police; Department of Corrections; Crown Law; the Law Commission; Ministries of Health; Transport; Defence; Foreign Affairs; Business, Innovation and Employment; Te Puni Kokiri and some Crown Entities on this RIS.

Conclusion

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

Topic		Options	Conclusion
Managing entry	**1. Clarification of reportable deaths**	A. Status quo.	
		B. Clarification of reportable deaths in the Act.	Preferred.
Efficient processes	**2. Timeliness of coronial decisions**	A. Status quo.	
		B. Non-regulatory changes such as inviting the Chief Coroner to issue practice notes.	
		C. Strengthen legislative provisions, including increasing flexibility in case allocation.	
		D. Increase the number of full time coroners.	Not preferred
	3. Duplication with other agencies	A. Status quo.	
		A. Legislative changes to encourage clarification of respective roles with other investigating authorities and allow Chief Coroner to direct that no further coronial investigation is required.	
		B. Non-legislative changes to the role of the coroner when other agencies are involved.	
	4. Deputy/Acting Chief Coroner	A. Status quo.	
		B. Permanent Deputy Chief Coroner with no additional	Preferred.

Topic		Options	Conclusion
		functions.	
		C. Permanent Deputy Chief Coroner with additional functions.	
Effective outcomes	**5. Nature of coroners recommendations**	A. Status quo.	
		B. Mandatory responses to coroners' recommendations.	
		C. Legislative change to require coroners to focus on the particular death and to ensure the coroner has the appropriate information to inform the recommendations.	Preferred.
		D. Non-legislative changes to assist the recommendation making power of coroners.	
		E. Remove coroners' recommendation-making power.	

Implementation

73. Once Cabinet makes policy decisions, the Minister for Courts is likely to issue a press release to publicise the proposals. The Ministry of Justice will provide summaries of the submissions and recommendations on its website www.justice.govt.nz. The Ministry will also write to stakeholder agencies to inform them of proposed changes. A second Cabinet paper in August will include a second suite of proposed changes.

74. If Cabinet agrees to change the coronial system, a Coroners Amendment Bill will be introduced to Parliament in late 2013. The Ministry of Justice will work with other Justice and Health sector agencies to ensure that implementation requirements are identified and given effect in the Bill.

75. 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 coroners' regular training, the Coroners' Bench Book will be updated, and the Chief Coroner will provide guidance. Officials will also work with the Chief Coroner to determine what additional material would be helpful to coroners.

76. Coronial Services staff use Standard Operating Procedures (SOP) to guide them in their work and to provide consistency between regions. The SOP will need to be updated by Ministry of Justice staff, and supported by other training and materials where appropriate.

77. 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. Depending on the nature and extent of the changes, some training may be required for providers of professional services. This will be considered when the detail of the changes is finalised.

Monitoring, evaluation and review

78. The Ministry of Justice will continue to monitor and evaluate the Coroners Act and any changes that may result from an Amendment Bill. Particularly, the Ministry will continue discussions with the Chief Coroner and Coronial Services to ensure that any changes are having the desired effect and continue to be practical.

79. The Ministry of Justice is reviewing its processes to identify gaps in the data collected (such as recording which section of the Act a death is reported under) and to improve the quality of the data entered. The Ministry and the Chief Coroner will also consider what regular reporting of coronial cases, their outcomes and timeliness is appropriate.

Appendix 1: Coronial Caseload

Incoming/Outgoing cases		2007/08	2008/09	2009/10	2010/11	2011/12	Change
Incoming coronial cases		3,331	3,341	3,406	3,392[15]	3,351	**+20**
Outcomes	No inquiry – natural causes	1,156	1,743	1,720	1,541	1,773	**+617**
	Inquiry with inquest or hearing on papers – outcome issued	513	909	1,323	1,299	1,202	**+689**
	Inquiry opened but no inquest following prosecution or investigation by other agency	11	92	112	101	78	**+67**
	Inquiry not opened while police/other agency investigate – closed without inquiry	4	33	47	85	52	**+48**
	Total outcomes	1,684	2,777	3,202	3,026	3,105	**+1,421**
Average time to reach outcome (days)	No inquiry – natural causes	54	101	101	117	133	**+79**
	Inquest or hearing on papers – outcome issued	111	264	341	381	429	**+318**
	Inquiry opened but no inquest following prosecution or investigation by other agency	138	340	458	492	602	**+464**
	Inquiry not opened while police/other agency investigate – closed without inquiry	52	298	509	562	604	**+552**

The significant changes from 2007/08 to 2008/09 are a result of the implementation of the Coroners Act 2006 – approximately 19% of outcomes in 2008/09 were cases opened under the previous Act and this decreased to approximately 5% in 2009/10.

[15] In February 2011, 185 deaths occurred in the Christchurch earthquake which diverted significant coronial resources and created a backlog of cases. These deaths increased the incoming coronial caseload for that period.