Speech Notes for Public Lecture NZ Centre for Public Law Wednesday 20 July 12.30 at Victoria University Law School, Government Buildings, 15 Lambton Quay

REFLECTIONS ON THE FIRST FOUR YEARS OF THE CHIEF CORONER UNDER THE CORONERS ACT 2006

This is a useful occasion to reflect on the first four and a half years of my role as Chief Coroner.

I will focus on three main areas

- The background to the Coroners Act 2006, particularly with reference to the Law Commission Report of 2000
- Relevant provisions of the Coroners Act in relation to my role and how things have panned out in practice
- A look at some overseas developments.

BACKGROUND

The Law Commission Report of 2000 remains a seminal document in respect of death investigation in NZ. It followed extensive consultation and discussions from many interest groups including in particular Maori concerns regarding perceived insensitivities in the Coronial system.

The Law Commission talked about the system being "patchy, unsystematic and inadequate", being "the poor relation in the justice system" and "with no centralised recording system which would allow patterns to be responded to or any Chief Coroner suitably resourced to devise and maintain the necessary systems to oversee Coroners and monitor the implementation of Coronial recommendations.

They also identified issues around delay and the lack of uniformity of Coronial Practice, a need for an organised training program and perceptions that the system had little or no regard for cultural values and beliefs.

Some key features of their recommendations were having a transparent appointment process similar to other judicial offices with a reduction from the then present 74 Coroners to a much smaller number through a process of centralisation. Also that remuneration should be taken away from the Ministry of Justice and put in the hands of the (now) Remuneration Authority as with the District Court.

Many, who are unfamiliar with the way in which our judicial system operates in NZ ask me what my job description is and who I report to. They are initially puzzled when I say I signed no job description and I report to nobody. In reality my job description of course comes from the provisions of the Coroners Act particularly Section 7 together with the traditional Judicial Oath of the Office.

What did Parliament do?

The broad vision of the Law Commission was substantially accepted by Parliament albeit with some significant differences.

One of the most significant was that the Law Commission anticipated the transition to a new system being by way of attrition by replacing Coroners as they retired together with full time legally qualified Coroners, but also retaining Justices of the Peace in their long standing role as a supplement to the Coroner system.

Parliament went further and instead adopted what the England and Wales Coroners describe as a "Big Bang" approach. This understandably caused some tensions and to some extent residual aspects of that have continued.

The Ministry and I were somewhat taken aback when it was appreciated when the first ever real national stock take of work in progress was done just prior to the implementation to the Act on July 1, 2007, that there were over 2500 cases in the system. That is now down to under 60, but it has taken a surprisingly long time to have those cases work their way through the system. One of the problems was that I was not the Chief Coroner of the former Coroners except for those who became Coroners under the new system and while most were happy to look to me for guidance some were not.

Parliament by adopting a big bang approach simply abolished the warrants of the existing Coroners and took away all but very residual rights for Justices of the Peace. Instead of 74 Coroners the Act provided for a maximum of 20. At the moment there are 16 plus myself.

Parliament also incorporated and reflected many of the cultural concerns uncovered by the Law Commission and considerably enhanced the spelling out of rights of families in relation to autopsy or post mortem examinations and the right in some circumstances to challenge a Coroner's decision.

It was anticipated, based on experience in places such as Victoria and elsewhere, that there would be a considerable number of objections taken to the High Court under the new fast track provisions of the new Act.

Somewhat to everybody's surprise there has not been one objection gone to the High Court although it has been a close run thing on one or two occasions. I like to think that it is because the Coroners have applied the discretion and powers under the Act in a sensible and pragmatic way, but there may be other explanations.

There has always been, and I suspect always will be, tension between the Pathologists fallback position that the only path to certainty is a full internal autopsy with often quite violently opposed views from next of kin. It is the Coroner's task to try and resolve these issues often in a highly charged and confrontational context. A similar tension which has abated considerably in four years, existed and still exists between a Police view of what is necessary and a Coroner's determination after balancing the relevant considerations.

MY POWERS UNDER THE ACT

These are set out in Section 7 and can be summarised as

- To ensure the integrity and effectiveness of the Coronial system
- To ensure investigations are conducted in an orderly and expeditious way by overseeing them

- Facilitating provision and coordination of support services and other advice
- To assist the Ministry of Justice to make arrangements for information and initial and continuing professional education and training
- To designate Coroners (that is to decide what cases Coroners will handle)
- To maintain a list of approved Pathologists (under the old Act, any Doctor in theory could carry out an autopsy)
- To issue practice notes
- To maintain a public register of summaries of Coroners recommendations or comments
- To act as Head of Bench under the Judicial Conduct Commissioner and Judicial Conduct Panel Act 2004
- To provide information and planning for emergencies and disasters
- To try and avoid unnecessary duplication by liaison with other investigating authorities
- And I will quote this in full, because it is a rather unusual thing for a Judicial Officer to have responsibility for "*to help by education, publicity and liaison with the public, to promote understanding of, and cooperation with, the system"*
- There were about 70 explicit references in the Law Commission Report to tasks which the Chief Coroner might carry out and if one is looking for some guideline to what my role should or could be it is interesting to look not only at Section 7, but also at what the Commission said. There is a considerable overlap between the two, but with some differences and I will just mention a few of those differences.

RECEIVE AND DETERMINE COMPLAINTS ABOUT CORONERS (AS SUGGESTED BY THE COMMISSION)

The practical reality is that these are part of my daily mail and telephone calls. Many are minor and are often communication issues which can be quickly resolved. Some are more serious and one of the tricks of the trade is to know at what point I should back out and refer a complainant to the Judicial Complaints Commissioner. If every complaint or problem that came to my attention was passed onto the Commissioner he would not thank me for that. By way of interest while there have been a small number looked at by the Judicial Complaints Commissioner to date (touch wood) none have been found to be justified.

TO PRODUCE AN ANNUAL REPORT (Suggested by the Commission)

That possibility became somewhat irrelevant when a previous practice going back a few years, of the Courts making an annual report to Parliament was abandoned. In effect this address today might be classified as my first report to the public. It is not the first address I've given on some of these topics, but probably the most broad ranging other than a presentation I gave at the Asia Pacific Coroners Society Conference in Auckland last year when I had the honour to be President of that organisation. Anybody who was present for that address will recognise some overlap with this address.

HOW THINGS HAVE PANNED OUT IN PRACTICE

A real test of how Coronial reform in NZ has worked has to be our response to the Pike River disaster and the Christchurch Earthquake.

Some of the features of our reformed system including in particular having a Chief Coroner that worked well in the context of these two disasters included.

The flexibility and ability to quickly make decisions as to who would handle matters from a Coronial perspective. Normally the Coroner to handle a matter is determined on a Regional basis ie where the death occurred.

However there comes a point where the response of the Coronial System has to move from the normal proposition that the appropriate regional designated Coroner handle the matter to an escalation point.

For example with Pike River I decided that my urgent attendance was needed and took on the full task myself .This eventuated in early Inquests to establish confirmation of death and likely cause and time of death so that death certificates could be issued with minimal delay, in the absence of any bodies .

One of the benefits of the steep learning curve and development of relationships we went through with Pike River was that when the 22 February earthquake occurred in Christchurch we were better prepared to respond very quickly to events as they transpired.

There has been a fairly major internal debrief of our response to the large number of fatalities in Christchurch, but one of the features emerging was that the Coronial Service was able to very promptly provide the necessary response to the unusual situation that developed there.

On becoming aware of the magnitude of the disaster, I made it clear that I was to be the designated Coroner to whom all reports of death should be made. I quickly established contact with the Police National Headquarters and went to Burnham to help set up our response and coordinate how matters would be dealt with.

Utilising my designation powers, I decided to rotate a small number of Coroners with the aptitude, flexibility and energy to deal with matters on the ground and be an embedded Coroner working in with the ante and post mortem reconciliation team at Burnham Military Camp and also liaising closely with the Pathologists and other specialist working at the temporary Mortuary set up in an impressively short time a few hundred metres away within the safe and secure confines of the camp.

We also utilised the facility of our after hours and weekend facility based at Ellerslie known as NIIO (National Initial Information Office) so that we had in effect a “back office Coroner” on duty at all times to handle the inevitable paper warfare that is required in any death let alone one which involves 181 deaths.

Our ability to handle all this and still cope with the other day to day tasks in the rest of the country has evinced admiration and comment from around the world and I have been asked to do presentations both at the England and Wales Coroners Conference in late September in Bath and at the Asian Pacific Coroners Conference in Queensland in early November about how we managed.

We know from feedback that for the other stake holders involved, such as Funeral Directors, various DVI Specialists, Police, Defence, Health etc it was advantageous to have a clear channel of communication through my office.

It also facilitated the inevitable and necessary liaison with the victims' families including in particular overseas victims, often working though the good offices of MFAT and the various relevant Embassies or Consulates and of course the media. The Police really stepped up to the mark in this area by generous provision of Family Liaison Officers closely working with our staff.

Outside of emergency situations, the balancing of the workload nationally has also been considerably facilitated by use of my designation powers. While I would not pretend our Case Management System is as sophisticated and flexible as I would like it to be, never the less it enables me to keep a fairly close watch on ensuring so far as possible work is divided fairly and equally between the 16 Coroners plus myself.

SOME OTHER MILESTONES OF NOTE

I mentioned earlier one of the requirements for me to make arrangements for professional education and training. One of the major urgent, and very time intensive tasks that I was faced with upon appointment was not only to work closely with the Ministry on the advertising for applications for Coroner positions, interviews and short list selection, but also to arrange an intensive one week orientation course for the new Coroners. I was a little bemused and indeed continued to be that the Institute of Judicial Studies does not consider it part of its mandate to provide this for Coroners, so had to do it myself. Similarly with producing a Bench Book for use by Coroners. All that had been done before my appointment was to produce about 20 very impressive embossed covers for a Bench Book, but with no content. To be fair, with the assistance of people either belonging to IJS or contracted to them, I was able to draw on their expertise albeit having to pay for it to assist with both these projects.

To date I have been able to maintain a twice yearly residential intensive training regime where we get as many of the Coroners as possible together. This is quite expensive and time consuming and I'm not sure that we can continue with it.

With respect to the requirement to maintain a public register of Summaries of Recommendations or Comments, this also has proven to be quite time consuming. The President of the Law Society last year correctly pointed out that the way we were posting these summaries onto the internet was user unfriendly and needed urgent attention. That is something that with the cooperation of the Ministry has been made a priority and we have finalised arrangements to have these posted on a much more sophisticated website starting quite soon.

Plans are also well advanced for full findings to be published on the internet, although this will take a little longer to achieve and involves some work on standardising of template and style formats. I am hoping this will be completed by the end of this year.

A QUICK LOOK AT DEVELOPMENTS OVERSEAS

NZ with its Coroners Act 2006 following the Law Commission Report is admired and regarded internationally as a good model for 21st century Coronial reform.

Other jurisdictions however have not stood still.

You may be aware that England and Wales came very close to appointing a Chief Coroner for their jurisdictions and it was only with the change of Government that at the last minute the proposal was changed.

While a Chief Coroner had been appointed, eventually it was decided not to proceed and instead to transfer the majority of the proposed functions of the Chief Coroner to either The Lord Chancellor or the Lord Chief Justice whilst nevertheless leaving the Office of the Chief Coroner on the Statute Book. It will be interesting to see how that works in practice.

Just last month the Western Australian Law Commission issued a fairly substantial report around the functions of the Office of the State Coroner (the equivalent of a Chief Coroner) in Western Australia. The proposal of the Law Commission at this stage in a discussion paper closely modelled many aspects of the NZ model. In both Victoria which has recently implemented a new Act and Western Australia together with some of the other Australian jurisdictions there is discussion about or actual implementation of the concept requiring that a Chief or State Coroner hold a certain existing status in the judicial hierarchy. In Victoria the Chief Coroner is required to be a County Court Judge (roughly the equivalent of a District Court Judge in NZ). There is discussion in Western Australia as to whether an equivalent provision should apply with perhaps the State or Chief Coroner having District Court status and other Coroner s being Magistrates ie the next level down in the judicial hierarchy.

In NZ there is no specific requirement for any existing judicial rank to be held for a Chief Coroner. It was coincidence that I as the first Chief Coroner was actually an existing District Court Judge. There are some benefits to that, but possibly some detriments as well.

One of the features of my new role has been establishing an excellent relationship with my counter parts in Australia. New Zealand has joined the National Coronial Information System hitherto dealing only with the Australian Coronial cases and shortly New Zealand cases, once completed, will be going on to that site. This will provide a one stop shop with an Australasian catchment area.

THE FUTURE IN NZ

After 4 and a half years it is becoming clear that, bold though it was seen to be at the time, there are areas where the Coronial System could be further streamlined and enhanced to provide a better and more efficient service for New Zealanders.

This is probably not the time to discuss these in detail and some may require legislative change.

These include

- Further consolidation of the Regional structure and possible centralising of some functions.
- Better resourcing of the Office of the Chief Coroner particularly drawing on the example of Victoria and West Australia of legal and medical expertise being attached to it. This obviously in the present economic climate would need to be cost neutral or better
- Restructuring the structure of the Bench of Coroners more akin to the model for other NZ jurisdictions

- A fresh assessment of a better way to provide the counselling and bereavement support for families where major gaps have been identified when we ran a pilot scheme in Greater Auckland and Northland with respect to SUDI deaths (Sudden Unexpected Death in Infants)

All these matters and more are under discussion with the Ministry. While I am largely pleased with what we have achieved there is plenty yet to do. I have just under 3 and a half years on my watch to go, but am hopeful that I will be able to hand over to the next Chief Coroner an even better system than we have now.