Appendix One: Issues raised in submissions

	Issue	Summary of submission	Proposed category
1	Importance of the Inquiry.	All submissions received considered that a public inquest should be held. Factors emphasised included that: the attacks were unprecedented in New Zealand, there has been no criminal trial, families were not able to participate fully in the RCOI process, the RCOI addressed only actions of public sector agencies, much of the RCOI evidence has been supressed, sanitized or excluded, and that this is the last public legal proceeding. Various submissions emphasised that they did not consider the RCOI had satisfactorily covered all issues or engaged at a sufficiently granular level to get specific answers and accountability expected, that the RCOI report itself was hard to engage with for victims (as a result of language, lack of professional support and other accessibility issues) and that they considered further recommendations are necessary to prevent future attacks. There was also a consistent theme that the issues victims and their families have had with prior legal processes have left them feeling unheard, and unempowered, and that a more restorative focussed process is now needed.	N/A

Appendix One: Issues raised in submissions

2	How was the terrorist radicalised and how can this be prevented in the future?	Raised by a number of parties. Specific questions asked included: • When and how did his racist views develop as a child? • Why were his racist views not interrupted early? • Why have his online activity and his devices remained largely uninvestigated? • What influences put him on this path as a teenager and young adult? • What activities did he engage in that enabled radicalisation to such an extent? • What recommendations can be made to prevent future deaths occurring in similar circumstances? • Were there missed opportunities to intervene? • How can path of radicalisation and hate be interrupted from now on? • What regulatory, legislative or other steps can be taken in relation to accessing and controlling websites and online gaming that incite dehumanisation and violence? Concerns raised included that the RCOI did not adequately address the terrorist's online and social media use and whether State agencies could have detected the attack by properly concentrating resources on online extremism.	Outside the scope of the Inquiry (considered by the RCOI).
3	What is known about the terrorist's travel history and is there any evidence of him having trained overseas?	This issue was raised by a number of parties. Specific questions asked include why travel history did not raise red flags when he entered NZ and whether he might have trained and killed overseas (based on the sister's indication that he travelled to Afghanistan). A number of submissions refer, with concern, to the terrorist's apparent experience or competence with firearms and military tactics during the attack.	Outside the scope of the Inquiry (considered by the RCOI).

Appendix One: Issues raised in submissions

4	Were red flags missed by intelligence/Police?	Specific issues raised include: failure of intelligence services to track "Barry Harry Tarry" or follow up – IP122.61.118.145 as well as firearm related issues below.	Outside the scope of the Inquiry (considered by the RCOI)
5	Did defective firearms licensing regime contribute to deaths?	Raised by various parties who disagree with RCOI finding that it could not determine whether issues with firearms process were causative of attack.	Outside the scope of the Inquiry (considered by the RCOI).
6	Why was there no reporting of firearms and ammunition purchases?	Families have expressed concern about the lack of reporting in respect of ammunition purchases and Police ability to trace and map significant purchases of, for example, high powered ammunition.	Outside the scope of the Inquiry (considered by the RCOI).
7	Regulation of gun club memberships.	Some families raised that members at the Otago Shooting Sports Rifle and Pistol Club and the Bruce Rifle Club had expressed concern about the terrorist and queried whether there should be mandatory reporting.	Outside the scope of the Inquiry (considered by the RCOI).
8	Why did the hospital not report the firearm injury the terrorist presented with in July 2018?	As above.	Outside the scope of the Inquiry (considered by the RCOI).

Appendix One: Issues raised in submissions

9	Should property owners have mandatory reporting requirements?	Some families are concerned about the terrorist's landlord failing to report the damage to the property rented by the terrorist, as a result of an accidental discharge of a firearm.	Outside the scope of the Inquiry (considered by the RCOI).
10	Why was the terrorist RCOI interview supressed for 30 years?	Various submissions note unhappiness with the inability of families to access suppressed information and to know if the Coroner has seen it.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
11	Did the terrorist have direct assistance from another person present on 15 March 2019?	Some parties have asserted another shooter or assistant was present. Concerns have been raised that the GoPro footage showed someone walking past the terrorist's car with binoculars in their hand and it was after that moment that the terrorist moved. There are also claims that other witnesses believe there was at least one other person outside Masjid an-Nur wearing black with no explanation. There is a witness who believes this person (and not the terrorist) was shooting at the right hand side of Masjid an-Nur. There are claims that some witnesses in Masjid an-Nur say they heard the terrorist talking to someone and asking for a warning if the Police arrived. Other submissions query whether there has been any analysis of the audio recording from inside the terrorist's car while he was driving to the Linwood Islamic Centre to establish who, if anyone, he was in a two-way conversation with?	This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

12	The Police allegedly reported the involvement of up to 9 other people initially.	Some submissions query whether this indicated multiple shooters.	This issue is proposed to be dealt with by an information request.
13	Were fingerprints or DNA taken from all firearms located at the scene?	Some submissions consider this could identify associates.	This issue is proposed to be dealt with by an information request.
14	Did the terrorist have a hiding place on standby for after the attack?	Some submissions consider this could have been an avenue for identifying associates.	This issue is proposed to be dealt with by an information request.
15	Did the terrorist have indirect support from online associates?	A forensically important evidence source is the hard disc of the terrorist's computer – its whereabouts should be investigated. Another submission raised the possibility of "confirmation bias" as a result of him being classified as a lone actor at the very early stages and noted that his manifesto contained language used in extreme right-wing websites and various in-jokes. Was the log from his router investigated in regard to his searches and browsing? Was all the information from the people he was in communication with followed up?	This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

16	Did gaming friend help with gun modifications?	Families are not aware that this was investigated.	This issue is proposed to be dealt with by an information request.
17	Query where terrorist obtained steroids when preparing for attack.	Some submissions consider this could have been an avenue for identifying associates.	This issue is proposed to be dealt with by an information request.
18	Query where the terrorist stayed overnight on his route back from Christchurch to Dunedin, after his final surveillance mission to Masjid an-Nur.	Some submissions query whether an associate provided accommodation for the terrorist and whether they may have been involved in attack.	This issue is proposed to be dealt with by an information request.
19	What is known about each of the Shaheed's movements and could any deceased have been saved with faster medical treatment?	Raised by a number of parties along with requests for expert opinion on cause of death. Concern that current information is too generic or insufficiently detailed. Submissions have also raised that there is a need for insight into the moments before, during and after the attack for each shaheed and affected person, including (a) their travel to the Mosque, (b) their movements in the Mosque, (c) who they were with, (d) their movements in/around the Mosque, (e) the immediate cause/mechanism of death, and (f) exactly when and where each person died (to the extent that this is possible to ascertain).	This issue is within the scope of the Inquiry.

Appendix One: Issues raised in submissions

20	Were first responders sufficiently equipped with both training and resources?	Raised by a number of parties. Concerns were raised that there has been no public examination of how all the relevant first responders, namely the Police, the ambulance service, and Christchurch Hospital, responded on 15 March 2019. Families understand the extraordinary nature of what occurred and are grateful for the genuine efforts made by the first responders. However, they remain concerned about first responders not being equipped, whether by provision of 'material' or by training (including training with other responders), to deal with what happened. Specific questions include: • Were the members of the Police, Armed Offenders' Squad (AOS) and Special Tactics Group (STG) who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable," all trained as described in the evidential overview? • Were the members of the AOS and STG who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable", either AOS medics or STG medics as described in the evidential overview? • Did the members of the STG who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable" have a current annual certificate; undertaken annual refresher training; and completed 40 hours of ride-along training with St John ambulance certified paramedics? • What is the reason why AOS medics are not trained to the same level as the STG medics? Should they be so trained? • Should 40 hours of ride-along training for the STG with St John ambulance paramedics be mandatory rather than "attempted"?	This issue is within the scope of the Inquiry.
21	Why did Police not arrive faster?	Submissions raise issue of terrorist manifesto being sent to authorities at 1:32pm.	This issue is within the scope of the Inquiry.

Appendix One: Issues raised in submissions

22	How did the terrorist leave, re-load his weapon and re-enter Masjid an-Nur without Police intervening?	Some families are concerned that the terrorist started his attack and had time to go outside, reload his weapon and re-enter Masjid an-Nur. They also raise concerns about how the terrorist was so confident about timings and the lack of Police response that he did not hesitate to go out, reload and come back to shoot more people.	This issue is within the scope of the Inquiry.
23	What caused the delay in the medical response?	Various submissions raise delay in the ambulances arriving on scene and providing medical treatment.	This issue is within the scope of the Inquiry.
24	Why did first responders prevent civilians from re-entering the Mosque to provide assistance?	Raised by various parties. There is concern about the delay in entering Masjid an-Nur when the Police had been told by survivors/witnesses that the terrorist had left. People were trying to get back into the Mosque to save lives of those who were shot but were prevented by the Police from entering.	This issue is within the scope of the Inquiry.
25	Did Police prevent ambulance service from entering Masjid an-Nur and if so why?	Some families are also concerned that the Police 'held back' ambulance staff (and others) from going into Masjid an-Nur to render first aid. Some have asked whether there were any barriers to first medical responders imposed by the Police which may have had adverse impacts on the survival outcomes of some victims.	This issue is within the scope of the Inquiry.

Appendix One: Issues raised in submissions

26	Who triaged injured and deceased persons and how was this done?	Issue raised by a large number of families. Questions about this issue included: • How did first responders determine the person was not alive in each case? • Who determined if someone was alive and to be taken to hospital? • What steps were taken to ensure those of the shaheed who were later determined to have died in-situ, were not in reality still alive and could possibly have had emergency aid administered? • Could living victims have been mistaken for dead and not received medical treatment because of this? • Were determinations made about those that were alive and could survive and those who had organ function and movement but could not survive? If so how? • Were any victims showing signs of life but were left at the scene because first responders assessed they could not be saved? • What time were each of the deceased checked and by whom? • Are there any records of these triaging assessments? If not could/should such records have been kept? • Was there any system of picking up and collecting of victims or any other such systems of joint work to get victims out of the Mosque to treatment? • Were doctors from the local medical centre involved in triage at Linwood Islamic Centre? • What was the operational response of Police and paramedic services and any of the services providing first aid?	This issue is within the scope of the Inquiry.

Appendix One: Issues raised in submissions

27	Is there any evidence of assistance given to bullet injured at scene who survived?		This issue is proposed to be dealt with by an information request.
28	Did problems with radio contribute in any way to loss of life?	Various families want to know if the problems with radio protocol and real time tracking technology identified in the formal Police debrief, in any way contributed to the loss of life. The same questions apply to the ambulance service's triage process.	This issue is within the scope of the Inquiry.
29	Was there sufficient control and direction during the triage/medical assistance phase?	Concern raised that there are no records of who triaged which individuals and that various bullet injured were transported by members of the public or found their own way to hospital.	This issue is within the scope of the Inquiry.
30	Should Police have deployed a team to Linwood Islamic Centre when reports of shooting at Masjid an-Nur were made?	Some families are concerned that the Police did not deploy a team to the Linwood Islamic Centre once the shooting at the Masjid an-Nur was notified. Others have asked why other Islamic sites in the city were not secured?	This issue is within the scope of the Inquiry.

Appendix One: Issues raised in submissions

31	Could traffic CCTV have assisted in apprehending the terrorist before he reached Linwood Islamic Centre?	Issues raised as to the extent of CCTV footage which recorded the events of that day, including the terrorist's drive from Masjid an-Nur to the Linwood Islamic Centre, and whether any of this CCTV was Police monitored CCTV. If so, what was done in response to the terrorist's speed and erratic driving?	This issue is proposed to be dealt with by an information request.
32	Were first responders from Police confrontational or aggressive in approach to some survivors?	Concerns raised that some survivors have reported aggressive conduct by Police on 15 March 2019 towards those shot, stating "it is understood from survivors that the terrorist was not the only one to point a gun at those shot that day. This raises the question of additional trauma and shock from such behaviour contributing to any of the deaths."	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
33	Whether Police "allowed" the terrorist to escape.	Survivor asserts that he saw the Police were there at the same time as the terrorist and that they allowed him to leave.	This issue is proposed to be dealt with by an information request.
34	Could Police have stopped the terrorist on the way to the Linwood Islamic Centre?	Submissions raise that Police did not stop the terrorist despite him shooting at people as he left, speeding and driving the wrong way.	This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

35	Did high activity congestion on the emergency 111 line contribute to early calls from the Linwood Islamic Centre being missed?	Submissions raise that an initial 111 call from Linwood Islamic Centre was made when shots were first fired but was on hold for 6 minutes. Specific questions include: were all calls put through to Police, what capacity did Police have in terms of manpower to answer them, is there a support system available to boost communication and coordination of 111 calls in a mass shooter incident, and did congestion on the 111 line contribute to deaths at the Masjid?	This issue is proposed to be dealt with by an information request.
36	When and how was Christchurch Hospital notified of the attack?	Submissions ask whether it is correct that the Christchurch Hospital's first knowledge of the shootings was two men arriving on foot from Masjid an-Nur? If so, why was the Hospital not notified sooner? Refer to video of two men arriving.	This issue is proposed to be dealt with by an information request.
37	Were there any issues with role and processes of the Christchurch Hospital following attack / during immediate response	Specific questions include: • What information was shared between the CDHB, the Police and the ambulance service after the shootings were notified? • Was there any communication with the Christchurch Hospital in terms of criteria/tests for deciding death or for trying to save lives? • Could any hospital services have been performed at the Mosque to save lives? • What happened on the day? Did people know what they were doing? Could lives have been saved? • Were there any deficiencies in treating survivors that raise questions about how any of the Shaheed were treated?	This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

38	Did CDHB appropriately activate and use emergency policies?	Specific questions included:
		• What is the major incident plan? How does it relate to the Canterbury DHB Health Emergency Plan 2017? Is this best practice from an independent perspective? Was it followed and by whom? What staff training previously had been conducted on such plans? How frequently? At what staff levels?
		• Did the CDHB formulate or use any or all of the following on 15 March 2019?
		  ○ EOC: Emergency Operations Centre. An established facility where the operational response to an incident is controlled and provided.
		  ○ Emergency Coordination Centre: An established facility; the location where the response to any emergency is coordinated, and which operates the EOC.
		  ○ Coordinated Incident Management System. A structure to systematically manage emergency incidents which allows multiple agencies or units involved in an emergency to work together.
		• If any of the above was formulated or used, how did this work?
		• Were the various Centres established and the various systems and plans implemented in the required attempt to bring order into chaos?
			This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

39	Coordination of emergency services.	Submissions ask whether there was any preparation for responding to a terrorist attack and the coordination of emergency services. Specific questions included:
		• Was there any preparation for responding to a terrorist attack and were any policies, systems and practices developed?
		  ○ Did these policies include joint planning and exercises?
		• What was the compliance with these policies, systems and practices?
		• What were the local Mosque or national Islamic organisational protocols?
		  ○ What kinds of security systems had been advised by security agencies to Mosques following steadily increasing risk to them over the preceding years?
		• Did lack of training, preparation, or policy, or a lack of compliance with policies and systems, impact the responders' ability to save lives or in any other way contribute to the extent of the loss of life that occurred?
		• Did CDHB have provisions for:
		  ○ The coordination of hospitals, their adequacy and compliance with relevant planning, preparation, policies, systems and practices.
		  ○ Inter-agency communication and coordination between relevant emergency services, and with civilian services.
		  ○ The adequate utilisation and coordination of resources.
		  ○ the impact of all of the above on preparation for and execution of the emergency response.
			This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

40	Discrepancies raised between time of death and mobile communications?	Some parties were not satisfied with the comment in the General Evidential Overview at paragraph 8.4, which states: "Police investigations have shown that this is explained by an anomaly in the cellular phone and/or connectivity on the day." Some other victims were able to communicate with their families before dying.	This issue is proposed to be dealt with by an information request.
41	Inconsistencies in timeline of shooting.	A number of submissions note that the General Evidential Overview records the first shots being fired at 1:40pm while the reconciliation report records first shots 1:45pm. Other submissions also raise concerns about other inconsistencies that relate to individuals.	This issue is proposed to be dealt with by an information request.
42	Not all families have been given information such as the DVI post mortem report: they did not know this existed and that they could ask for this.	-	This issue is proposed to be dealt with by an information request.
43	Families have made information requests which have been refused or not answered.	-	This issue is proposed to be dealt with by an information request.

Appendix One: Issues raised in submissions

44	Could information dissemination processes have been improved?	A number of families have noted the difficulties they received in obtaining information from Hagley School and the Christchurch Hospital about missing loved ones.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
45	Why were families not allowed unsupervised access to loved ones' bodies?	Submissions highlight that this was distressing to families.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
46	Should families have been consulted on post mortem investigations before they were carried out? And were sufficient procedures in place with NZ Police, SJA and Christchurch Hospital to facilitate culturally appropriate treatment of Shaheed's bodies?	Parties understand the law in this regard but think it should be changed and/or that in the context of Muslim faith consultation should have occurred. They also consider that more cultural competence is required, for example ensuring no women touch bodies of deceased men. Common concerns raised in the submissions were that bodies of women should be washed and handled only by women and bodies of men should be washed and handled only by men. The victim's eyes and lower jaw should be closed and the body covered with a white sheet.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue)
47	Cultural response and coronial inquiry	Concerns have been raised by families regarding the need for the Coroner to be aware of and accommodate cultural and spiritual needs. This includes the correct spelling of the deceased's names and the masjiain.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue)

Appendix One: Issues raised in submissions

48	Protection of Mosques and Islamic Centres.	Submissions received raise whether, in the context of a rise in hate-inspired vandalism against religious properties in NZ, the government should have arranged for better security. Other submissions noted that the RCOI did not shed any light on the details of how many reports of suspicious activity there were in the years prior to the attacks to give any sense of urgency around safety at Mosques. Requesting the Coroner to investigate why Mosques were not given further protection.	Outside the scope of the Inquiry (considered by the RCOI).
49	Capacity deficiency in tracking lone actor terrorists.	Submissions received request that the Coroner investigate whether NZSIS had any strategies or competencies in place to detect lone actors.	Outside the scope of the Inquiry (considered by the RCOI).
50	Institutional bias against Muslims.	Issue was raised that the failure to follow up on right wing extremism was as a result of institutional bias against Muslims arising out of Islamophobia. Request that the Coroner investigate whether there was institutional bias against Muslims as an attributive factor.	Outside the scope of the Inquiry (considered by the RCOI).
51	Terrorist's family's obligations.	Some families have talked about the moral responsibility of the terrorist's family to let state sector agencies know of their concerns with his political views and their failure to act immediately when the terrorist texted them on 15 March 2019.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
52	Shaheed comments.	What was the action of NZ's intelligence agencies? Was there too much focus on Islamic terrorists so no barrier to this terrorist coming into the country to prepare and do what he did?	Outside the scope of the Inquiry (considered by the RCOI).

Appendix One: Issues raised in submissions

53	Complaints process.	There have been complaints to Police about the treatment of Muslims in NZ – not taken seriously. There was an incident involving the Linwood Islamic Centre, Police promises to be armed and a week later Police still unarmed.	Outside the scope of the Inquiry (no evidence that the event Linwood Islamic centre occurred prior to 15 March 2019).
54	What were the causes of confused/delayed communication with families following the attacks and how can communication be improved after mass casualty events?	Submissions have noted that delays in receiving information or provision of incorrect information caused significant distress and resulted in families resorting to watching GoPro footage of the shooting to try and identify loved ones. Specific questions include: • Was there a review of the Police interviewing and statement-taking processes? o How could these processes have been completed more comprehensively, more promptly and more effectively, in order to get more, higher quality information, from more people? o Could the interview processes have yielded far more information at a much earlier stage when matters were fresh, rather than leaving out important details to emerge months or years later, such as through retraumatising conversations between victims? • How can connections, inferences and analysis be done in order to reconstruct and explain what happened to families in a more comprehensive manner?	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).

Appendix One: Issues raised in submissions

55	Whether there have been any internal reviews of the response to the attack.	Submissions have asked whether CDHB, Police, and St Johns Ambulance have reviewed their procedures following the attack, including interagency coordination and lines of communications, and what changes have been made. Specific questions include:
		• Was there an opportunity to have mutual coordinated awareness of the presence of all kinds of emergency services that day who could have coordinated a response?
		• How can the full spectrum of services in each of these emergency areas be aware of each other's location and ability to respond when needed?
		• Could a local operation command centre like the Justice Precinct if properly informed by the relevant agencies, play a role in maintaining a calendar of all emergency events and services on the ground, and assist with coordination of these services if required?
		  ○ Could such a communication command centre have played a key role in overall coordination?
		• Could some kind of emergency services identification could have alleviated the issue of Police needing to identify who were sworn officers?
		  ○ Could such coordination and identification enhancements have helped the predicament of not only Police identifying other officers but also victims being able to identify Police and emergency responders?
			This issue is proposed to be dealt with by an information request.

56	Documentation deficiencies.	One submission raised whether there is a definitive list of interested parties, and urged a new list from those previously used be created. The submission raised concerns about who is being treated as a victim. Concerns were also raised about the Death Certificate process and how the details for those certificates are settled. Similar concerns were raised about the DVI documentation used. Overall, the submission considered that the information that victims received, such as the Evidential Overviews, needed to be more tailored to their needs.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).