Coroner's Role

Coroners are like judges. They are qualified lawyers appointed as judicial officers to investigate unexpected, violent or suspicious deaths to find out what happened, and make recommendations to help prevent similar deaths from occurring.

Their powers are defined under New Zealand law, in the **Coroners Act 2006**.

A coroner may:

- start an inquiry to investigate and ascertain the cause and circumstances of a death
- make recommendations and comments to help prevent similar deaths in the future

A coroner cannot:

- decide on civil, criminal, or disciplinary liability

The Coronial Process

A death occurs

If the death is unexpected, violent or suspicious, it is referred to the coroner by Police or a health professional.

If the death is from natural causes, the coroner can pass back to health professionals.

Coroner begins inquiry

A coroner will gather information for their inquiry to establish the facts about a person's death, including:

- who the person was
- when and where the person died
- how the person died
- the circumstances around the death

If multiple deaths occurred at the same time or in similar circumstances, a joint inquiry can be started.

Information gathering includes:

- directing pathologist to perform a post-mortem
- considering or requesting reports from relevant agencies, e.g. NZ Police, Worksafe
- hearing from family and witnesses

A coroner may adjourn an inquiry until all other investigations/criminal proceedings have been completed.

The inquiry can then be resumed, or not if the coroner is satisfied facts about a death have been established by other investigations/criminal proceedings.

Hearing held

Near the end of an inquiry, a coroner looks at all the evidence gathered and decides on the facts of the death. A coroner can hold a hearing in one of two ways:

- in chambers (known as 'on the papers')
- an inquest, which is held in court if a coroner decides they need to hear from witnesses and experts in person

Process continues on the next page

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Process continued

Coronial inquest

Usually held in a courtroom, an inquest can take between one hour and several weeks to complete. Media are welcome to attend.

A coroner will decide what information and issues will be examined, who they wish to hear from, and will ask questions of witnesses and experts to better understand how a death occurred.

- coronial inquests are usually open to media and the public, but a coroner may exclude people from all or part of an inquest
- media have to apply to record (video, photo, audio) evidence given at an inquest
- media can publish what they see and hear at an inquest, unless the death was a suicide, or the coroner restricts what's allowed to be published
- a coroner makes the final decision on what media can publish through non-publication orders

Coroners' findings

After an inquest, a coroner will release their findings. This is a report about the facts of a death and is usually the final step in the coronial process.

- findings may include recommendations to prevent similar deaths from occurring, but recommendations are not legally binding
- is a public document media and public can request a copy of
- will be sent to families and interested parties by the Coronial Services team
- publication of parts of the findings can be restricted by a coroner, if they have reason (e.g. national security)

Media can attend inquests, request coroners' findings, and data around deaths by demographic, location or profession, for example.

For more information about Coronial Services, coroners' recommendations, or the **Coroners Act 2006** visit **www.coronialservices.justice.govt.nz**

For all enquiries and requests, contact the Ministry of Justice Media Team on media@justice.govt.nz, or call on **027 291 3518**.

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