Address to 2007 Regional Air Safety Seminar NZ
James Cook Grand Chancellor, Saturday 9 June 2007

Thank you for inviting me to attend today at your seminar.

From the draft programme I have already seen, you are clearly covering a lot of ground.

My background is that I was the coroner for Christchurch. I was the predecessor to Richard McElrea. For the last 13 or so years I have been a District Court Judge. During that time I maintained a close interest in coronial matters and virtually every year have sat on at least one inquest, usually of a complicated nature some running for some days and in some cases, weeks.

Even more recently I have been acting as the Auckland Coroner whilst Dr Jamieson was taking sabbatical leave so I have had very recent experience working at the coal face and seeing the challenges and difficulties operating under the present system.

Today it is just over 3 weeks until a very significant change to the Coronial systems of NZ takes off.

For the last 4 months I have either been in the Coronial hangar or trundling along in a complicated taxiway initially, on an unfamiliar airfield with no control tower or ground staff.

Over the last 2 months I have gradually accumulated ground staff and we have what might be described as a temporary control tower akin to the sort of arrangements I remember from my territorial artillery days that forward aircontrollers operated from i.e. a sandbagged ditch in the ground with a radio.

The old system has just over 3 weeks to run.

I don't think it would surprise anyone here today if I noted that there has at times been an uneasy relationship between the Transport Accident Investigation Commission, CAA and some Coroners.

My understanding is that similar tensions have arisen in the past in Australia with the Australian Transport Safety Bureau and some coroners.

Relationships between other investigating agencies whose functions often overlap, with the coronial function, have also had their problems in NZ and a significant part of my activities over the last 4 months has been to try and develop dialogue with such agencies.

Section 9 of the new 2006 Act notes these agencies include the Childrens' Commissioner, the Civil Aviation Authority, the Injury Prevention Rehabilitation and Compensation Commission, the Director of the Mental Health or District Inspector, District Inspectors under the Intellectual Disability Act, the Health and Disability Commissioner, Inspectors under the Health and Safety in Employment Act, Land

Transport NZ, Medical Officer of Health under the Health Act, Maritime NZ, Police Complaints Authority, Transport Accident Investigation Commission. There are others.

Today, amongst other things marks for me the first significant step in my process of beginning a fresh dialogue with people involved in the air safety area. I hope to develop matters considerably more in the future and envisage involving other agencies, to training seminars which under the new Act I am enjoined to develop for Coroners.

Up till now, my main focus has been setting up the new Coronial Services Unit - premises – staff – equipment – benchbook (i.e. a best practice manual), forms etc.

One of my most challenging tasks has been my involvement in the selection of the 14 regional Coroners, based at 9 regional sites. Whangarei 1, Auckland 3, Hamilton 2, Rotorua 1, Palmerston North 2, Hastings 1, Wellington 1, Christchurch 2, and Dunedin 1.

At the time of preparation of this address, I was awaiting cabinet confirmation of the appointments, but at the time of preparation, had a good idea of what the likely appointees would be. Today, if you were interested I should be able to confirm the names. Just over half of the Coroners appointed are existing coroners who have been or will be re-sworn under the new act and the balance are people who have never been Coroners before.

What are the significant changes under the new act?

The most significant change is that from a substantially part time operation, we are moving to full time professionals. Recently there were over 70 Coroners – as I speak to you today there are just over 50. All existing coroners are, under the Coroners Act, authorised only to complete matters that have been reported to them prior to midnight on 30 June if they want to.

At the time of preparation of this speech there were approximately 1900 uncompleted coronial files, so it is clear that we will have a dual system running for some time as the existing Coroners finish off their cases with the new Coroners (except where the new Coroners are also old Coroners) only involved in reports of deaths after that time.

The next significant change is the restructuring of the whole coronial system with the object of:

- Much more national consistency of procedure
- National overview through my office of the whole coronial process.

Many of the other changes are of degree rather than substance. By that I mean that under the present 1988 act it has always been made clear that so far as early release of bodies is concerned, and the issue of whether or not there should be a post mortem is concerned, are to be considered against a background of awareness of concerns of the Mäori community and other ethnic groups of abhorrence to the

concept of post mortem and a requirement for early, if not immediate, release of deceased persons to whanau or family.

What the new act does is reinforce those concepts and impose a requirement that the interested people who will be identified initially in most cases by the police on initial investigation, are appraised of what is described as “significant matters”. This includes the intention to carry out a post mortem, and/or retain body parts for further examination to name but two of the significant matters.

The challenge will be to make that work without creating delay problems. While there is an ability for a Coroner to issue an override direction for immediate post mortem, after determining that certain factors are present, my expectation is that that will be the exception rather than the rule.

It introduces a whole new dimension of procedural requirement and to make that possible, each Coroner will have his or her own dedicated coronial co-ordinator who will work alongside the Coroner and co-ordinate relationships with police, funeral directors, family etc etc.

The new Coroners will be equipped with PDA wireless laptops, scanners and fax machines so that communication (provided there is cellphone coverage or landline coverage) should be much better and modern technology used to the maximum to ensure that the necessary rapid exchange of information required to make the system work, will actually happen.

There are many in the community including some existing Coroners and police who have expressed understandable reservations about how the new professionalised trimmed down system will work. My task will be to do whatever I can to ensure that such pessimism is not justified.

All the same issues that have arisen in the past with Coroners are alive and well under the new system.

The new act makes it even more clear that the role of the Coroner needs to be looked at in the context of overlapping jurisdictions and that where it is appropriate to either allow another agency to proceed and await developments or go ahead on the information available before the other agency – all those same issues will arise.

There are other changes which I can expand on if necessary including:

- Ability to complete Inquests on the papers
- Suicide inquests are no longer mandatory

The role of the Coroner remains as it has always been, best expressed in the Coroner’s motto of the province of Ontario “*to speak for the dead in order to protect the living”.*

There is a clear expectation on the part of the Ministry and certainly on the part of the Law Commission whose 2000 Law Commission Report is the substantial genesis for the new act, that Coroners in time with proper resourcing can move from being

reactive and progressively move into the twenty first century expectations of society for coronial systems to start to identify trends and to look at issues in a wider context. That could mean more multiple inquests being held together and the possibility that specific coroners could be designated by me not just by geographical area but in relation to particular types of death, such as aviation deaths or deaths of other specific types of people. That will be for the future. My first objective is to get the system up and running and running smoothly before I get too ahead of myself with those sorts of areas.

Next week we are having the first ever coronial orientation course. It will run from the 18 to 22 June. It is my intention as I alluded to earlier, to organise a comprehensive on-going programme of upskilling and informing with the aim of the initial 14 coroners (which could expand up to 20) working in an environment where they are well resourced and supported and not feeling as the Law Commission noted in its report demoralised , working alone and not properly recognised.

One of the speakers at our orientation week will be Baragwanath J who was the chair of the Law Commission who produced the 2000 report. He noted that "aviation experience shows that unrelated events assume a different character when looked at collectively".

I was astonished when I asked our archivist to find out for me the general extent of coronial inquests involving aviation crashes, appendices to this paper, is the schedule that Mr Slade produced.

Clearly investigation of aviation fatalities is and no doubt will remain a major function of the coroners. My hope and expectation is that with now a national structure in place on our part and the ability and powers I have under the act of general overseeing of the system, compilation of a publicly accessible database of recommendations of Coroners and the ability to issue practice notes and amend forms as required that we will be generally "lifting our game".

I am aware of the significant changes that have occurred with Civil Aviation in part arising out of the Coroner's report in relation to the Piper Chieftain crash in Christchurch.

Whatever your views on the outcome and the whole coronial process there you would have to agree I think, that it was a thorough investigation. I anticipate that the well resourced and supported coronial team shortly to come into place will be better equipped than in the past coroners have been to built on this type of experience and to provide a coronial system that is of real value to modern society. Risk identification and prevention is a major theme and expectation of the new coronial system.

Clearly those people involved in aviation safety and the coronial system are and we must always remember this, on the same side. We have the same general objective; we just sometimes go about our investigation differently.

I will encourage to the best of my ability ongoing dialogue between our various organisations to try and remove any feelings of antagonism and suspicion, remembering that the function of all of us is to better serve society.

Thank you for your attentiveness today.