Regulatory Impact Statement

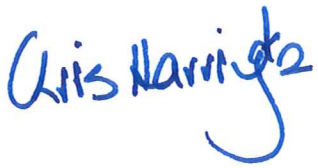
Coroners Act 2006: Proposals for Reform Paper 3

Agency Disclosure Statement

1. This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Justice. It provides an analysis of options for stage three of the reform of the Coroners Act 2006 to:
    - review the statutory restrictions in the Act regarding suicide reporting and examine ways to guide and monitor suicide reporting by the media (including social media)
    - clarify the jurisdiction of coroners to investigate deaths of members of the armed forces directly caused by enemy action while on operational service.
2. The following are constraints in the regulatory impact analysis for the third stage:
    - Regulatory options with a significant cost were not considered due to competing priorities for funding in the justice and health sectors.

    Suicide reporting provisions

    - It is difficult to quantify the risks to public health of reporting details of self-inflicted deaths and the size of the potential 'copycat' effect. This is because suicide reporting has already been restricted to some degree in New Zealand. Examples from other jurisdictions are used to provide some indication of possible impacts.
    - It is unclear why the current restrictions are not always complied with. Submissions raised concerns that the legislative restriction is too broad and is unclear in its application. This uncertainty has not been tested by the courts. There have been no prosecutions to date, possibly because the law is considered unclear.
    - There have been very few studies that suggest a link between social media reporting of suicide and copycat suicides. However, the Law Commission states in its report that it is likely that the potential for harm extends to reporting of suicide on the internet by social media.
    - The suicide reporting provisions in legislation specifically relate to cases being considered before the Coroner. The broader question of suicide prevention is a question for the public health sector and falls outside the scope of this review.



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Purpose

1. This paper considers the third tranche of proposals for improvements to the coronial system and the Coroners Act 2006 (the Act).

2. The options considered in the paper address the suicide reporting restrictions in the Act and the jurisdiction of coroners to investigate deaths of members of the armed forces directly caused by enemy action while on operational service.

Introduction

3. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Coroners Act 2006 aimed at:

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

Role of the Coroner

4. 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.

5. 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

6. 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.

Context and objectives

7. A series of reforms to the Coroners Act 2006 were confirmed by Cabinet on 17 June 2013 (SOC Min (13) 11/6, CAB Min (13) 20/8). An overarching goal of the reforms was to achieve a coronial system that:

    - delivers effective outcomes for families, the general public and government, and
    - uses modern, efficient and cost-effective processes.

8. In July 2012, the Minister for Courts announced a targeted review of the coronial system and the Coroners Act 2006 to improve the timeliness and efficiency of the coronial system. Two Cabinet papers and associated regulatory impact statements have been produced to date.

9. This paper considers a third group[1] of proposals for improvements to the coronial system and the Coroners Act 2006 (the Act). The key proposals address:

   - the suicide reporting restrictions in the Act, and
   - the coroner's jurisdiction in investigating deaths of members of the armed forces directly caused by enemy action while on operational service.

10. For suicide reporting, a key objective against which proposals are assessed, is to protect public health by encouraging responsible reporting of suicide in the media to reduce the risk of copycat behaviour. Copycat behaviour is identified as one of the causes of suicide clusters. NZ has a high rate of suicide deaths compared to other countries and suicide prevention is a general public concern.

11. Any restrictions on media reporting need to be considered for consistency with the right to freedom of expression. Freedom of expression is a fundamental value of a free and democratic society.

12. As explained below, this RIS considers how proposals will work in both the mainstream media and in social media. As reported by the Law Commission, social media and other internet-based modes of communication are likely to have an impact on suicide. While there is limited research investigating the link between social media reporting of suicide and copycat suicides, social media is still likely to have an impact because its growing use has meant it is becoming as influential as mainstream media.

13. Options for coronial investigations into deaths in combat of New Zealand Defence Force members on operational service will be assessed to ensure the system:

   - does not compromise national security
   - ensures an independent and transparent investigation
   - does not duplicate roles and resources, and
   - is consistent with similar legislation regarding investigation into deaths in combat.

Restrictions on suicide reporting

Status quo and problem

14. During the Ministry's review of the Coroners Act 2006, concerns were raised in submissions that the current suicide reporting provisions were unclear, too restrictive and not being complied with or enforced.

Current legislative provisions

15. The legislative provisions restricting the reporting of self-inflicted deaths are set out in sections 71 to 73 of the Coroners Act 2006. The reporting restrictions apply to both media and the general public (who make information public through, for example, newsletters or websites).

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1 The first group of proposals was set out in the Regulatory Impact Statement - Coroners Act Review: Proposals for Reform Paper One (5 June 2013). The second group of proposals was set out in the Regulatory Impact Statement – Coroners Act Review: Proposals for Reform Paper Two (17 September 2013).

16. If a death appears to have been self-inflicted the Coroners Act 2006 states that, unless the coroner agrees, no one can make public any information about the manner in which a death occurred until the inquiry into the death has been completed. If a coroner has found the death was self-inflicted, the only information that can be made public without the coroner's authority is the person's name, address, occupation and the fact that the coroner has found the death to be self-inflicted.

Non-compliance

17. In practice, the current restrictions do not always appear to be complied with or enforced. Furthermore, the Law Commission found in its view that, of the news items it reviewed, nearly a third (24/83) did not appear to comply with section 71 of the Coroners Act or with the coroner's rulings in respect of publication. There have been no prosecutions to date under the current provisions.

18. This situation may be because there are different views on how some of the wording should be interpreted. Although section 71 appears to provide clarity about the limits on suicide reporting, the Law Commission's analysis suggests that section 71's limits are not so readily understood by the media or coroners.

19. Although this uncertainty has not been tested by the courts, given the evidence about the implications of inappropriate publishing, there should be attention devoted to ensuring the limits of inappropriate publication are clearly set out.

20. Transparency is a fundamental concept in the rule of law. People should be able to find out what the law is without difficulty, know their rights and understand the responsibilities of the parties involved.

21. Achieving compliance amongst social media users is also a key challenge. The growth in social media use has meant it is just as influential as mainstream media.

Details of self-inflicted deaths which are likely to cause harm

22. Evidence does not support the breadth of the current restriction. Submitters raised concerns that the provisions were too restrictive. In the interests of ensuring as few limitations as possible are placed on freedom of expression, it is important to ensure that restrictions are evidence based and proportionate.

23. Evidence in other jurisdictions shows that media reporting of specific details of suicide deaths can lead to an increase in 'copycat' or imitative suicides. In particular, there is evidence demonstrating a link between reporting of the method and site of suicide death and subsequent suicidal behaviour.

24. There is limited evidence to suggest that reporting details other than method and site will lead to subsequent suicidal behaviour. Restricting the reporting of details beyond method and site may lead to unjustified limitations on freedom of expression.

25. Submitters also raised concerns that restrictive provisions remove opportunities to assist public understanding of the causes and consequences of suicide.

Regulatory Impact Analysis

26. We have considered the following options to encourage informative and educative reporting of suicide while minimising the risk to public health of 'copycat' suicides.

    A. Status quo: No change to the current legislation.

    B. Dual approach: Explicit statutory restriction on the publication of suicide method and site (where the site is suggestive of method), supported by reporting guidelines.

    The Chief Coroner would be able to grant exemptions if satisfied the risks of making

public the method of death are small and outweighed by other matters in the public interest.

Existing guidelines would supplement the legislative restrictions initially. The need for new standards/guidelines would be considered as part of the *New Zealand Suicide Prevention Action Plan 2013-2016.*

Imposition of a greater fine for breaches: a maximum of $20,000 for a body corporate and $5,000 for other cases. The current fines are $5,000 and $1,000 respectively.

C. Non legislative approach: Remove legislative restrictions on reporting from the Coroners Act and rely on and promote existing suicide reporting guidelines.

27. These options are analysed in the table (below) against the following questions:

- does the option protect against 'copycat' suicides
- is the option consistent with freedom of expression
- does the option allow sufficient opportunities for the media to assist the public understanding of the causes and consequences of suicide
- will the option improve compliance with restrictions, and
- is the option enforceable and are the penalties reasonable.

Restrictions on suicide reporting				
		A **Status quo: Broad legislative restriction on reporting suicide and voluntary guidelines**	**B** **Dual approach: Explicit statutory restriction on reporting method and site of suicide, supported by voluntary guidelines. A greater fine for breaches will also be imposed**	**C** **Voluntary guidelines: No legislative restriction in the Coroners Act**
Objectives	**Minimising the risk to public health of 'copycat' suicides** Does the option protect against 'copycat' suicides?	× Section 71's limits do not appear to be suitably defined and therefore not easily understood and also potentially leading to adverse public health outcomes. × Existing voluntary guidelines in New Zealand have not been effective to date in encouraging responsible reporting of suicide.	✓ Statutory restrictions are focussed on the areas with the most potential for harm. This protects public health by minimising the risk of 'copycat' suicides, while permitting reporting of information which can assist in raising public awareness of suicide. ✓ A clearer and more targeted legislative prohibition will assist in working collaboratively with the media to encourage responsible reporting. × Lack of awareness of legislative restrictions may be a barrier to compliance. ✓ Voluntary guidelines outside legislation and the Ministry of Health's role in promoting them help guide other aspects of reporting of suicide.	× Guidelines alone may reduce harmful reporting of suicide over time with a strong emphasis on working collaboratively with media[2], but significant risk to public health caused by reporting method and site still exists. × Unlikely to be effective amongst social media users. Unlike mainstream media, it is difficult for a regulatory body to act as a single mechanism for generating awareness.

[2] International case studies provide successful examples of where standards encourage responsible, accurate and sensitive media representation. Successful examples are where guidelines have been developed and promoted collaboratively with the media.

Restrictions on suicide reporting			
	A **Status quo: Broad legislative restriction on reporting suicide and voluntary guidelines**	**B** **Dual approach: Explicit statutory restriction on reporting method and site of suicide, supported by voluntary guidelines. A greater fine for breaches will also be imposed**	**C** **Voluntary guidelines: No legislative restriction in the Coroners Act**
Consistency with freedom of expression To what extent does the option impact on freedom of expression? Can the limitation be justified?	✓ Restricts freedom of expression. However, statutory limitations on freedom of expression can be justified given the purpose of the provision to protect public health. × Coroner's power to grant exemption to reporting restrictions may lead to inconsistencies amongst coroners, leading to uncertainty for those who have to comply.	✓✓ A clearly defined restriction on reporting site and method of suicide provides least restrictive option on freedom of expression. ✓ Chief Coroner's (rather than all coroners) power to grant an exemption to publish method of death provides consistency and certainty.	✓✓✓ No statutory restriction on freedom of expression.
Encouraging informative and educative reporting of suicide Does this option allow sufficient opportunities for the media to assist the public and private understanding of the causes and consequences of suicide?	× Because the provisions regarding reporting are unclear, there is no strong signal to media that they have a role to play in assisting the public and private understanding of the causes and consequences of suicide.	✓ Narrowing restrictions signals to media the value of their role in assisting the public and private understanding of the causes and consequences of suicide.	× Risk that some media are unlikely to self-regulate appropriately without clear legislative parameters meaning continuation of reporting on aspects which may cause harm.

Restrictions on suicide reporting			
	A **Status quo: Broad legislative restriction on reporting suicide and voluntary guidelines**	**B** **Dual approach: Explicit statutory restriction on reporting method and site of suicide, supported by voluntary guidelines. A greater fine for breaches will also be imposed**	**C** **Voluntary guidelines: No legislative restriction in the Coroners Act**
Provisions are enforceable and compliance is maximised Will the option improve compliance with restrictions? Is the option enforceable? Are penalties reasonable?	× No prosecutions to date under the current provisions. × The current restrictions may not always be complied with and are difficult to enforce[3] because: • there are different views on how some of the wording can be interpreted • legislation is sometimes misunderstood as applying to any public discussion of suicide. × Current penalties are outdated and not aligned with comparable offences.	✓ Explicit legislative provisions prohibiting the reporting of site and method provide greater clarity, enhancing compliance[4]. ✓ Provisions more enforceable due to their clarity. × Unlike mainstream media, it is uncertain if the New Zealand public i.e. social media users and bloggers will have sufficient awareness of restrictions in order to comply. Prosecutions are likely to only be made in cases of substantial breaches. ✓ Proposed fines are better aligned with other comparable offences. ✓ Higher penalties send message that the limits on reporting are important.	✓ May achieve compliance in mainstream media via regulatory bodies such as the Broadcasting Standards Authority. There are successful international examples of guidelines developed and promoted collaboratively with the media. × Guidelines not enforceable meaning achieving compliance amongst bloggers and social media users may be limited. × The lack of penalties and an enforcement regime may not encourage compliance by social media users and bloggers. × Lack of awareness of guidelines may be a barrier in maximising compliance, especially amongst bloggers and social media users. × If guidelines are not successful in achieving widespread compliance, there are no legislative provisions restricting the most harmful reporting.

[3] 'Media Reporting of Suicide' – Law Commission, 2014, p.6, para 1.17.

[4] 'Media Reporting of Suicide' – Law Commission, 2014, p.13.

Restrictions on suicide reporting			
	A **Status quo: Broad legislative restriction on reporting suicide and voluntary guidelines**	**B** **Dual approach: Explicit statutory restriction on reporting method and site of suicide, supported by voluntary guidelines. A greater fine for breaches will also be imposed**	**C** **Voluntary guidelines: No legislative restriction in the Coroners Act**
Impacts	• Potentially already allowing media reporting leading to subsequent copycat suicide deaths. • Greater non-compliance likely, especially as social media commentary becomes more widespread.	• Reduced risk of publishing details that prove harmful to public health due to the clear signal to media and the public about expectations of reporting and public discussion on suicide. • Clarity for media. • Potential for increasing non-compliance, especially as social media commentary becomes more widespread. • Freedom to report exists, with justified limits regarding public health. • Would require ongoing time and resource (Ministry of Health) to promote existing standards.	• Does not ensure that reporting will comply with guidelines aimed at protecting public health. • Would require ongoing time and resource (Ministry of Health) to promote existing standards.

Coronial investigations into deaths in combat

Status quo and problem

28. The jurisdiction of coroners to investigate deaths of members of the armed forces directly caused by enemy action while on operational service has been raised separately to the Coroners Review. There have been eight deaths from enemy action during the last decade (of which three occurred in a single event).

29. The Coroners Act 2006 establishes which deaths are reportable to a coroner. Currently deaths of people on operational service in armed conflict or a peacekeeping role may fall within the categories of deaths that are reportable under the Act.

30. However, investigations into deaths in combat also raise issues that involve national security and military tactics. These are generally a matter for the state and are not subject to legal challenge. There is a well established body of case law that deployment, armament and disposition of the armed forces are decisions for the government of the day (so long as they comply with international and domestic law) and are not open to legal challenge. The ability to conduct a coronial inquiry into a death from enemy action therefore raises the risk that a coroner could examine and comment on decisions of military commanders and hinder commanders from making legitimate battlefield decisions.

Regulatory Impact Analysis

31. The main benefit of a coronial investigation is to provide independent scrutiny of the circumstances in which the death occurred, which is accessible to the public. Proposals aimed at protecting national security should be considered alongside the need for independence and transparency.

32. Other criteria used to evaluate possible options include:

- providing for independent and transparent investigations of deaths
- avoiding unnecessary duplication of roles and resources
- consistency with similar legislation

33. We have considered four options, which are that:

A. Coroners have no jurisdiction in relation to deaths from enemy action.

B. Coroners have no jurisdiction for coroners in relation to deaths from enemy action unless directed by the Attorney-General. Jurisdiction will be limited (i.e. coroners cannot make recommendations).

C. Coroners have jurisdiction in relation to deaths from enemy action (status quo).

D. Coroners have jurisdiction in relation to deaths from enemy action, however the Attorney-General has, for the purposes of protecting national security, decision-making powers to:

- prevent an investigation from commencing, or
- direct the coroner to determine the cause of death but not make recommendations, or withhold certain details from publication.

34. After an analysis of options in the attached table, the preferred option is that coroners should not investigate deaths of members of the armed forces on operational service unless directed by the Attorney-General. The coroner's role would be to establish the causes and circumstances of the death, but not to make recommendations (Option B).

		A No jurisdiction	B Limited jurisdiction (none unless directed by the Attorney-General). Jurisdiction with limited scope (i.e. coroners cannot make recommendations)	C Coroners have jurisdiction to investigate deaths from enemy action	D Coroners have jurisdiction but Attorney General has decision making powers to prevent investigation, publication of details or recommendation making
Objectives	**Balancing transparency with the risk of inquiring into matters of the state** Does the option allow for an independent investigation where there is public interest? Is the option consistent with case law that similar military matters are a decision for the government and are not open to legal challenge?	× Limited transparency – no investigation into cases where there is a genuine public interest. A court of inquiry can be convened under the Armed Forces Discipline Act 1971 but it is not open to the public. ✓ No risk that a coroner could comment on matters that are non-justiciable.	✓ Achieves a balance – it ensures that deaths of members of the NZDF can be investigated where there is public interest in doing so, taking potential risks into account. ✓ Coronial investigation will provide independent scrutiny of the circumstances in which the death occurred, which is accessible to the public. ✓ The Attorney-General, as the senior Law Officer of the Crown, is well placed to assess whether a coronial inquiry is desirable taking into account the public interest and the likely impact on the NZDF and New Zealand's security.	× May compromise national security and military tactics: ▪ coroners may comment on matters that are non-justiciable, in particular examining operational decisions of commanders ▪ concerns about how their actions will be interpreted could hinder commanders making legitimate battlefield decisions ▪ often the information will be classified as it may compromise national security (for example deaths of SAS members), therefore all involved in the investigation would need to hold the appropriate government security clearances.	✓ Achieves a balance – it ensures that coroners investigate the deaths of members of the NZDF except where the Attorney General considers there are risks to national security. ✓ A coronial investigation will provide independent scrutiny of the circumstances in which the death occurred, which is accessible to the public.

	A No jurisdiction	B Limited jurisdiction (none unless directed by the Attorney-General). Jurisdiction with limited scope (i.e. coroners cannot make recommendations)	C Coroners have jurisdiction to investigate deaths from enemy action	D Coroners have jurisdiction but Attorney General has decision making powers to prevent investigation, publication of details or recommendation making
			✓ A coronial investigation will provide independent scrutiny of the circumstances in which the death occurred, which is accessible to the public.	
Duplication Does the option duplicate investigations?	✓ Does not duplicate investigations – the NZDF will establish who died and the circumstances of the death and no coronial investigation will be undertaken.	✓ Duplication is justified because of the independence it achieves. Number of coronial inquiries is likely to be minimal and only where there is a public interest.	× Duplicates resources – much of the information provided to the coroner will come from the NZDF. A coronial inquiry will therefore duplicate effort and provide limited benefit to NZDF. × There is also likely to be limited expertise available to assist the coroner to understand what decisions were made and why.	× Duplicates resources – much of the information provided to the coroner will come from NZDF. A coronial inquiry will therefore duplicate effort and provide limited benefit to NZDF. × There is also likely to be limited expertise available to assist the coroner and understand what decisions were made and why.

	A **No jurisdiction**	B **Limited jurisdiction (none unless directed by the Attorney-General). Jurisdiction with limited scope (i.e. coroners cannot make recommendations)**	C **Coroners have jurisdiction to investigate deaths from enemy action**	D **Coroners have jurisdiction but Attorney General has decision making powers to prevent investigation, publication of details or recommendation making**
Consistency with other legislation Will the option be consistent with similar legislation?	× Different approach to similar legislation (i.e. the Visiting Forces Act 2004).	✓ The Attorney-General has a similar power under the Visiting Forces Act 2004 (coroner cannot inquire into a visiting force member's death unless directed by the Attorney-General).	× Different approach to similar legislation (i.e. the Visiting Forces Act 2004).	✓ Some consistency with the Visiting Forces Act 2004 – it provides the Attorney-General with the authority to decide if an investigation should take place.
Conclusion	• Clarifies jurisdiction and reduces duplication. • Does not provide adequate opportunity for an independent investigation. • Inconsistent with other Justice initiatives to make Court processes more transparent and accessible.	• Adequate opportunity for an independent inquiry where there are good reasons. • Limited duplication. • Limited risk to national security and of contravening military tactics.	• Does not guarantee effective outcomes regarding duplication and preserving national security. • Easier for families to seek an independent inquiry. • Provides transparency and independence. • Coronial resources may be stretched if deaths in combat increase as a result of war.	• Adequate opportunity for an independent inquiry. • Does not contravene national security. • Provides transparency. • Duplication. • Coronial resources may be stretched if deaths in combat increase as a result of war.

Consultation

35. The following agencies have been consulted on the proposals in this RIS: New Zealand Defence Force, Crown Law, the Ministry of Health and other agencies represented on the Ministry of Health's Suicide Prevention Action Plan Working Group. No significant concerns were raised.

36. The Law Commission has been informed of the suicide reporting aspect of the paper.

37. We did not consult more widely on the specific proposals covered in this RIS. However, feedback in submissions on the targeted review of the Coroners Act fed into our analysis where possible.

38. During the review of the Coroners Act the Ministry wrote to approximately 168 key stakeholders seeking feedback on the current system. Information about the review was available on the Ministry of Justice website. Key stakeholders included relevant government agencies, investigating authorities, District Health Boards, pathologists, funeral directors, Iwi Authorities and other organisations with an interest in coronial matters.

39. The Ministry received 49 submissions, including some from interested individuals.

Conclusion

40. The assessed options are summarised in the table below.

Options		Preference
Restrictions on suicide reporting	A. Status quo	No preferred option
	B. Dual approach: A well-defined statutory restriction on what can be reported, supported by a set of practice standards.	
	C. Issuing of standards, outside the legislative framework, providing guidance on suicide reporting	
Coronial investigations into deaths in combat	A. Coroners have no jurisdiction in relation to deaths in combat.	
	B. Coroners have no jurisdiction in relation to deaths in combat unless directed by the Attorney-General	Preferred
	C. Coroners have jurisdiction in relation to deaths in combat	
	D. Coroners have jurisdiction in relation to deaths in combat, however the Attorney-General has, for the purposes of protecting national security, decision-making powers to: • prevent an investigation from commencing, or • direct the coroner to determine the cause of death but not make recommendations, or • withhold details from the public.	

Implementation

41. The Ministry of Justice will provide summaries of the recommendations from all three cabinet papers[5] on its website www.justice.govt.nz. Once a Bill has been introduced, the Ministry will also write to stakeholders to advise them they will have the opportunity to make submissions to a select committee.

42. If Cabinet agrees to the changes proposed, a Coroners Amendment Bill will be introduced to Parliament. 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.

43. 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.

44. 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.

45. 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 and evaluation

46. The reforms proposed in the three Cabinet papers are a combination of both operational and legislative enhancements and will be monitored as a package through the use of key performance indicators. The Ministry will continue discussions with the Chief Coroner, Coronial Services and appropriate government departments to ensure that any changes are having their desired effect. Officials are also considering how best to gather feedback from participants in the coronial system on an ongoing basis.

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5 The first group of proposals was set out in the Cabinet Paper: ' Coroners Act Review: Proposals for Reform Paper One'. The second group of proposals was set out in the Cabinet Paper: ' Coroners Act Review: Proposals for Reform Paper Two' available on the Ministry's website.