IN THE CORONER'S COURT AT AUCKLAND
I TE KOTI KAITIROTIRO MATEWHAWHATI KI TAMAKI MAKAURAU

CSU-2019-CCH-000165 to
CSU-2019-CCH-000214;
CSU-2019-CCH-000326

UNDER	The Coroners Act 2006
AND	
IN THE MATTER OF	An inquiry into the deaths of 51 people in relation to the 15 March 2019 Christchurch Masjid attacks

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SUBMISSIONS OF COUNSEL FOR 37 INTERESTED PARTIES
Dated: 8 February 2022

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MAY IT PLEASE THE CORONER:

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A. INTRODUCTION AND SUMMARY

1. Counsel acts for 37 interested parties. By Minute of 28 October 2021 (the "Minute") the Chief Coroner gave a provisional indication of the matters (termed "issues") that she regarded as being within the scope of this Inquiry. The Chief Coroner invited submissions before a final ruling is made on the scope of hearing. These submissions respond to that invitation.

2. The Chief Coroner's provisional decision was that:

   2.1. Issues 19-26 and 28-30 (as listed in Appendix 1 to the Minute) are **in scope** (**Category A**);

   2.2. Issues 10, 32, 44-47, 51, 53, 54 and 56 are **not in scope on the basis the Coroner has no jurisdiction to inquire into them** (**Category B**);

   2.3. Issues 2-9, 48-50 and 52 are **not in scope because they were considered by the Royal Commission of Inquiry (**the **RCOI)** (**Category C**);

   2.4. Issues 11-18, 27, 31, 33-43 and 55 are **able to be dealt with, at least initially, by information request** (**Category D**).

3. In these submissions:

   3.1. Counsel respectfully agrees the issues in Category A are in scope.

   3.2. As to the issues in Category B (i.e., said to be outside of jurisdiction), counsel submits that is incorrect as to Issues 10 and 32. Those matters ought to be within scope and therefore be the subject of inquiry and possible comments and recommendations.

   3.3. As to the issues in Category C (i.e., said to be not in scope by reason of the RCOI investigation), counsel submits:

      3.3.1. First, such issues must be regarded as within scope so far as the Coroner's statutory functions of investigating causes and circumstances, and making comments and recommendations, are concerned.[1] Even if the Coroner were to make no further factual inquiries into the matters considered by the RCOI, she must nonetheless go on to make an inquiry that satisfies the criteria in s 57 of the Coroners Act 2007 (the **Act**) (by making findings on the s 57 matters and particularly in the making of comments and recommendations). Those functions are not abrogated by

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[1] The Coroner may have intended this, and may not have intended that these matters were literally "outside the scope of the Inquiry" (the phrase used in Appendix 1) – only that the facts involved will not be the subject of further investigation. This important issue can usefully be clarified at the hearing on the question of scope.

the fact of another inquiry. They are a statutory requirement and the Coroner's inquiry must comply with them to be lawful.

3.3.2. Second, but equally importantly, it is not the case that the simple fact that there was a Royal Commission means that its conclusions on the questions referred to it can be simply adopted by the Coroner. The Coroner operates a statutory jurisdiction and her inquiry must be the one envisaged by the statute – an effective investigation into the causes and circumstances of the deaths accompanied (as appropriate) by comments and recommendations. Any reliance on other investigations must be in service of this primary obligation and must pay due regard to the particular context of the other investigation. Relevantly, here, that context includes the structure and processes of the RCOI, its Terms of Reference (the **TOR**), and the specific nature of its conclusions on particular matters. If that were not the case, there would not be an independent investigation into the causes and circumstances of deaths as required by the Act. Indeed, as s 3(2)(c) suggests, the Coroner's role is to liaise with other authorities permitted or required to investigate deaths, but not substitute the findings of those authorities for the independent investigation that a Coroner must undertake.

3.3.3. Third, the Coroner may, in particular circumstances, consider that it is appropriate to rely on or give weight to the findings of other authorities (here, including the RCOI), but only insofar as the Coroner has determined that the other authority has undertaken an investigation into a particular issue that is sufficiently clear, thorough and robust for the Coroner to determine that the investigation was "effective" and "establishes" all or some of the factors identified in s 57 of the Act. In the present case, when considering which, if any, of the matters determined by the RCOI may be relied on by the Coroner without her own inquiry (or with a more limited inquiry), careful attention must, in light of the above, be paid to the nature of each issue. For example, if the TOR precluded any inquiry into social media and/or social media platforms and the part it plays in the social acculturation towards prejudice, then that substantially undermines reliance on the RCOI's conclusion on issues such as "how was the terrorist radicalised?". On this example, if the Coroner failed to undertake an investigation into social media and the role of social media platforms, the issue would never have been properly investigated, its role identified as a cause or circumstance of the deaths and no recommendations or comment made by the Coroner (or by any other authority, since the RCOI would be precluded by its own TOR from doing so). The result would be subversion of the core purpose of the Act.

3.3.4. On this basis, many of the issues which the Coroner provisionally regards as not in scope are submitted by counsel to be properly in scope – both for coronial inquiry and certainly (in all cases) for comments and recommendations.

4. As to issues in Category D (i.e., to be dealt with initially by "information request") different considerations arise. This must necessarily be an interim step because the precise extent to which these issues are in scope cannot be fully known until the formation is provided and assessed. The Minute's allocation of issues into this category therefore has to be understood as essentially deferring the question of their being in scope until the information is provided. Further comments on this are made on this in the final section of these submissions but, for the reason just given, the matter cannot be taken further at this stage.

5. It is for the Coroner to determine the scope of her inquiry. But in doing so, the Coroner must comply with the requirements of the Act, construed in light of its text. context and purpose,[2] and, in accordance with the legislative instruction in s 6 of the Bill of Rights, in accordance with the requirements of s 8 of the Bill of Rights. Section 8 was affirmed in *Wallace v Attorney-General*[3] to incorporate and reflect both the state's investigative obligation in cases where the state, as here, is involved in the "circumstances"[4] leading to the deaths under inquiry. The Act, read in the light of the Bill of Rights, sets the legal standard that the Coroner must comply with and against which any decisions made by the Coroner would fall to be assessed (regardless of whether the Coroner carries out a separate determination of compliance with human rights issues).

6. Further, s 8 incorporates a "protective obligation" – in the sense that it imposes duties on the state when it is in a position of knowledge of potential risk to a person and fails to take steps to avert that risk.[5] That, too, bears upon a coronial inquiry in the sense of determining matters of cause and, especially, circumstances (and associated comment and recommendations). Each of these components of s 8 of the Bill of Rights must be taken into account when interpreting the Coroners Act, and especially the Coroner's jurisdiction and the meaning of s 57.

7. Against that background, the key point is that a Coroner's inquiry must be an "effective" investigation if it is to satisfy the state's obligation. The Act is to be read in that light. The obligation to undertake an "effective" inquiry is the legal standard that is required by the Act, read in the light of the Bill of Rights (as it must be).[6] An effective inquiry is one that will effectively "establish" the matters that s 57 of the Coroner's Act requires be established. Such matters will include not just the "cause" of death but the "circumstances" surrounding it. If an issue

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2 Legislation Act 2019, s 10(1)
3 *Wallace v Attorney General* [2021] NZCA 506 at [275].
4 These being a matter for inquiry under s 57(2) of the Coroners Act.
5 *Osman v United Kingdom* [1998] ECHR 101, cited by the Chief Coroner in the Minute at [60].
6 See *R v Fitzgerald* [2021] NZSC 131, in particular Winkelmann CJ at [36] to [57].

relating to any of the listed matters is to be excluded from scope, there must be a legitimate basis for that exclusion. It must not result in the investigation failing to meet the standard set by the Act as properly interpreted.

8. Counsel anticipates the propositions above will not be controversial. The Chief Coroner cited *Wallace* in her Minute, noting Ellis J's comment that a coronial inquiry was "the most apt and rights compliant investigative forum in a case of this kind".[7]

9. This has a critical bearing on determining the issues within coronial jurisdiction (category B above). It does so similarly with category C – matters considered by the RCOI. As to the latter category there is the further point that the Coroner already has recognised these matters to be *within* jurisdiction; the provisional ruling is that they are then *excluded* from scope because the RCOI has made an inquiry into them.

10. These submissions will contest that exclusion:

    10.1. The limited scope of the Terms of Reference for the RCOI means that its Report of 15 March 2019 did not meet the standard for an "effective" inquiry as articulated by the High Court in *Wallace v Attorney-General*.[8]

    10.2. The processes of the RCOI did not accommodate a number of features that would have been required to make it an effective investigation – notably high-level expert participation from the victim community and opportunity for input from next of kin.

    10.3. Some of the issues were not considered in sufficient depth to amount to conclusions upon which the Coroner ought to rely.

11. Counsel notes that the *Wallace* case itself was an example of the inaptness of the Coroner (and IPCA) adopting a conclusion reached elsewhere – in that case, that a jury's acquittal in a private prosecution had "established" the killing of Mr Wallace to be justified as self-defence, when in fact the not-guilty verdict meant only that the prosecution had not negatived the existence of a reasonable doubt that the killing was in self-defence.

12. Care must therefore be taken in looking at the RCOI Report. The Coroner has her own, primary, obligations under the Coroners Act. These are not displaced by the fact of another investigation. The relevant question is whether the Coroner properly *fulfils* the statutory duty – and, if this is the path chosen – whether she can fulfil that duty by adopting conclusions reached by the RCOI on each of the issues specified in the Minute.

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7 At [55].

8 *Wallace* at [397].

13. The balance of these submissions develops these points in more detail. It concludes by setting out the issues that counsel considers to be in scope:

    13.1.1. Issues 10 and 32 in Category B (wrongly, counsel submits, said to be beyond jurisdiction) and likely many of the further issues;

    13.1.2. All the issues that were considered by the RCOI (Category C, wrongly said to be out of scope for that reason); and

    13.1.3. Likely also, all or many of the issues on which information is to be provided (Category D).

14. For further reference, these submissions are by supplemented by **Appendix 1: "Table of Live Issues"** which elaborates on certain matters specifically relevant to each live issue number corresponding to "Appendix One: Issues raised in submissions" annexed to the Minute.

B. THE RELEVANT LAW

15. The three purposes of coronial inquiries are set out in s 57 of the Coroners Act 2006. They are to "establish" the matters listed in s 57(2); to allow for "recommendations" or "comments" (s 57(3)); and possible reference of the matter to another investigating authority (s 57(4)). It is the first two purposes that are especially relevant in this case. (There is no suggestion of reference to another body; although the Chief Coroner points out that s 57(4) is support for the proposition that other investigations may be an appropriate forum for inquiries into deaths.)

16. It is axiomatic that "establish" in s 57 must mean "effectively establish". If that was ever in doubt, the doubt is removed by *Wallace* and the international authority it cites.[9] An investigation must be "effective" if it is to meet the standard implied by s 8 read in light of article 6 of the International Covenant on Civil and Political Rights (and the interpretation given by the European Court of Human Rights to the equivalent provision in the European Convention on Human Rights).

17. The "causes" and "circumstances" of the deaths are to be established (s 57(2)(d) and (e)). The findings are to be the matter of possible comment or recommendation. That is especially salient here because the state is implicated in 51 deaths perpetrated by a terrorist. It is implicated first because its officers and employees were amongst the first responders to the incident; second, the state bears protective duties (reflected in s 8 of the Bill of Rights) such that the "right not to be deprived of life" must at all times be protected by adequate legal and operational measures that serve to prevent wrongful deprivations.

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[9] *Wallace v Attorney-General* [2021] NZHC 1963 at [385] and following, as discussed in the Minute.

18. The contours of that protective application (existing independently of the investigative obligation) have been more fully explored in the jurisprudence under article 2 of the ECHR – both in the European Court of Human Rights and (relevantly for New Zealand) the case-law of the United Kingdom. Those authorities were considered in *Wallace* and held to be applicable to s 8 of the Bill of Rights.[10] *Wallace* itself was a case of a death from a bullet fired by an officer of the state. But case-law from the United Kingdom and the European Court of Human Rights confirms that a state may be responsible under article 2 for failure to prevent a deprivation of life in circumstances where it was aware of the risk and failed to take reasonable steps to prevent it. This is not something that requires a determination by the Coroner (as the Chief Coroner's Minute suggests); rather it establishes that the protective obligation in s 8 of the Bill of Rights informs the interpretation of the Act and represents the legal standard against which a coroner's inquiry (including decisions as to scope) falls to be assessed.

19. A coronial inquiry is not, of course, a forum for attributing criminal guilt or civil liability. However, as noted, it *is* a forum for effectively establishing cause and circumstances, and possible comment. For these reasons, the fact of the state's having these protective obligations is highly salient to this inquiry. It is an ineliminable part of the "circumstances". Failings may therefore be a part of the "cause".

20. To be clear, it is not suggested that this inquiry must inevitably make findings that there have been failings. Nor is it suggested that the state is necessarily in breach of its protective obligation or that, if it were, the Coroner is required to find it so. The submission is simply that the question of *whether* there were failings is a necessary part of the inquiry. Indeed, counsel do not understand the Coroner to be suggesting otherwise: the premise of the Minute is that the *only* reason for excluding the matters in Category (c) is that an investigation into them has already been made by the RCOI. It is not that they are not relevant circumstances.

21. The submission is that there is no sufficient basis for excluding the matters particularized below. The facts pertaining to them have not been effectively established in a manner that satisfies the Coroners Act read in light of s 8 of the Bill of Rights. Unless they are so established, the Coroner will be unable to discharge the duties in s 57 including the duty to comment and make recommendations.

22. Put another way, the criteria for an effective investigation must inhere in each part of an investigation. To the extent the Coroner relied on the RCOI, then it is the RCOI that must (in the relevant respect) display the required characteristics of an effective investigation.

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10 Ibid.

23. *Wallace* sets out the criteria of an effective investigation, drawing upon the international authorities:[11] it must be "independent", "effective", "timely", "conducted in public" and "provide an opportunity for the family of the deceased to be involved".

24. Plainly the Coroner in this matter is striving to comply with all those criteria: the fact that next of kin are participating as interested parties is welcomed, as is the iterative process in determining the question of scope. But it means that if the Coroner is to rely on the result of an investigation by the RCOI she must first be satisfied that the RCOI itself meet the effectiveness criteria. (*Wallace*, as noted, was an instance of an erroneous reliance.)

    The independence and timeliness of the RCOI are not reasonably open to challenge but each of the other criteria are, in respect of the particular matters stipulated in the Minute where RCOI conclusions are said to put a matter beyond scope.

C. ISSUES PROVISIONALLY RULED OUT FOR JURISDICTIONAL REASONS

25. It is submitted that an issue is not "outside the scope of the inquiry" because it was "considered by the RCOI". Rather the correct approach is to inquire into what issues were addressed and to what degree, and what matters must, to fulfil the requirements of the Coroners Act, be further inquired into.

26. The Chief Coroner's Minute deals with this category – described as Category B in these submissions – in paragraphs [67] and [73] of her Minute, in conjunction with the list of issues in Appendix 1 which allocates matters to that category. Paragraph [67] is a distillation of principles arising from cases discussed: matters must be relevant to the cause and circumstances surrounding a death; not too remote to be causative; not relate to high level government policy or otherwise be not amenable to coronial inquiry; and may be a matter that enables a comment or recommendation for avoidance of future deaths. Counsel does not take the Coroner to have intended to be exhaustive in setting out the principles.

27. Ultimately the issue of jurisdiction is a relatively straightforward one of statutory interpretation. It concerns the operation of s 57 of the Act, and whether a matter is salient to any of the factors the Coroner is required to inquire into in respect of a death. Significantly, and as the Chief Coroner's distillation of issues in paragraph [67] appears to accept, the New Zealand coronial jurisdiction is a wide one insofar as it requires "comment or recommendations" arising out of the circumstances.

28. In this section it is respectfully suggested that the Coroner's provisional assignation of issues to Category B is over-inclusive. There are matters, discussed

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11 Notably *Jordan v the United Kingdom* [2001] ECHR 327.

below, that are properly in scope as relevant to cause and circumstances, and possible comment – and *not* excluded by countervailing considerations.

29. By way of general introduction to this section, the "circumstances" of a death must necessarily include all those that pertain to the death, extending beyond its cause. In turn, the purpose of making comments and recommendations must be understood against the background that "circumstances" must be read that way. The circumstances are obviously wider than just a description of the cause. They will include how the cause *came about*. Plainly that is the intended reading for otherwise the making of comments and recommendations would be needlessly narrowed and not be as the Act intends.

30. Against that background, each excluded matter is considered. This section addresses Issues 10, 32, 44-47, 51, 54 and 56.

Issue 10 *"Why was the terrorist RCOI interview suppressed for 30 years?"*

31. This question is submitted to be in scope. It is assuredly relevant to the Coroner's making of any recommendation or comment that may arise from the "circumstances". There may well be lessons to be learned, and implications drawn, from the interview that have a bearing on how radicalisation of extremists can be detected and defeated, or the risk of its occurrence mitigated. The Coroner may well be persuaded that to have the interview rendered inaccessible to *all* – even under appropriate conditions – for 30 years means that an important piece of information is excluded from availability to those who can learn from it. To rule that possibility out *ab initio* is unnecessary. In any event it cannot be said to be beyond jurisdiction for the Coroner to consider the possibility that the 30-year suppression is problematic for these reasons and to make comments judged appropriate.

Issue 32 *Were first responders from Police confrontational or aggressive towards those shot?*

32. This question is submitted to be in scope. To the extent that this claim, if made out, suggests serious shortcomings in the Police response it is again a matter on which comment or recommendations may be required. It is clearly part of the circumstances in which the deaths may have occurred. Whether the claim is correct or not is therefore potentially salient to an effective inquiry as envisaged by s 57 of the Act.

Issues 44-47, *Dissemination of information; no unsupervised access to bodies; lack of consultation on post-mortem procedures; cultural response of Coroner*

Issue 51 *Terrorist's family obligations*

Issue 54 *Delayed communication with families after the attack*

Issue 56 Documentation deficiencies

34 These too all relate to circumstances surrounding the deaths. They will be addressed orally. Appendix II outlines issues relevant to the process to which this issue is related.

D. ISSUES PROVISIONALLY RULED OUT ON THE BASIS OF THE ROYAL COMMISSION'S INQUIRY AND FINDINGS

When a Coroner may rely on other investigations

33. The starting point is to identify the statutory authority for the Coroner's provisional conclusion that a matter may be excluded from being inquired into on the basis that it has been the subject of a different investigation.

34. There are categories of deaths where a Coroner must open an inquiry (s 60). In respect of other deaths, the Coroner "must decide whether" to open one (s 62). Here the Coroner has decided: the inquiry has been opened under s 59 (the Coroner "may open an inquiry".

35. Every inquiry will have the "s 57 purposes". In a case such as the present (implicating s 8 of the Bill of Rights) it must be "effective" (by dint of that Act, as already discussed above). As noted above, this is the legal standard that is required under the Act (interpreted consistently with the right affirmed in s 8 of the Bill of Rights) and also the standard that any decision of the Coroner, including an exercise of discretion, pursuant to that Act must satisfy to be lawful.

36. The proposition that an inquiry need not be made into such matters as have been the subject of another investigation is not clearly set out in the Act. The following provisions bear on the issue:

    36.1. Section 3(2)(c) of the Act envisages that the Chief Coroner will "liaise" with other authorities investigating a death to achieve the Act's purposes (as set out in s 3(1)).

    36.2. Section 60(1)(c) of the Act applies when "matters required by this Act to be established by an inquiry are already adequately disclosed in respect of the death by information arising from investigations or examinations *the coroner has made or caused to be made*". That is not apt here.

    36.3. Section 69, for its part, allows postponement of an Inquiry where it appears the matters it would consider are to be the subject of another investigation. But that is not the case here: the Inquiry is commencing after that investigation and has not been commenced and postponed.

36.4. Section 70 allows a Coroner not to re-open a postponed inquest where the death has been the subject of another investigation but, again that has not happened here.

36.5. Section 7(2)(d) confers a function on the Chief Coroner – to help to avoid unnecessary duplication in investigations into deaths by liaising, and encouraging co-ordination (for example, through issuing practice notes or developing protocols), with other investigating authorities, official bodies, and statutory officers). But this is not apt to cover this case, which is not about liaising or encouraging co-ordination.

37. There appears, then, to be no explicit authority for the general proposition that the Coroner may decline to investigate a matter on the ground that another body has made the necessary investigation. Indeed, such an approach is arguably inconsistent with the Coroner's duty to establish certain factors, as well as the statutory purpose of ensuring that there is an independent investigation by the Coroner (who can, at most, "liaise" with other authorities, but not substitute the findings of those authorities for her own or use them to avoid discharging the coroner's responsibility under the Act).

38. That said, it is accepted that the presence of ss 60, 69 and 70 show that there are at least some cases – inquiries commenced but adjourned in light of the pending investigation – where the Coroner may do so. To that extent the present case shows a lacuna in the legislative scheme (where the "other investigation" precedes the opening of a Coroner's inquiry). It is certainly a premise of *Wallace* that in principle (and as has been held in the United Kingdom) Coroners may rely on the relevant findings of (non-private) criminal trials (when they *amount* to findings – which may not always be the case).[12] In *Wallace* itself the relevant Coroner's inquiry had been opened but then adjourned and so the point now being discussed did not strictly arise.

39. In these circumstances, counsel proceeds on the basis that the Coroner has an implicit discretion to rely on the findings of the RCOI on particular matters (and so not make its own inquiry into those matters or not make full inquiry into them) to the extent that those findings are sufficiently clear and robust that they constitute an "effective"[13] investigation into the particular issue and have "establish[ed]"[14] the factors identified by the Act in s 57. That seems an appropriate implication given that if Inquiry were opened and adjourned it could rely on a subsequent "other investigation".

40. The critical question is whether it is appropriate for the inquiry to rely on the findings of the RCOI. Each instance of proposed reliance must be considered

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12 See the discussion at paragraphs [480] to [506].

13 The requirement of s 8 of the Bill of Rights as interpreted and applied in *Wallace*.

14 The wording of s 57.

separately. It is not appropriate to apply a "blanket" approach. The following submissions will examine the issues one by one. But some preliminary observations are made first because they inform the assessment of each issue.

Limitations in the structure and functions of the RCOI

41. The RCOI acknowledged limitations flowing from the ToR:

42. The TOR were not drafted in consultation with any of the affected communities. This also meant that there was limited cultural input into the ToR. It was also not drafted with Treaty of Waitangi partnership input which would have provided input perspective into the conception and drafting exercise.[15]

43. Critically, the TOR also precluded the RCOI from considering certain matters. As the RCOI recorded:[16]

> The Terms of Reference directed that certain issues were outside our scope – the guilt or innocence of the individual charged with offences in relation to the terror attack, amendments to firearms legislation, activity by entities or organisations outside the Public sector agencies (such as media platforms) and the response to the terrorist attack once it had begun.

44. To the extent these issues assist in establishing the cause(s) and circumstances of the deaths (or the making of recommendations to reduce the possibility of future deaths), the RCOI has not addressed them. The necessary investigation and, if appropriate, making of recommendations, falls to the Coroner in accordance with the Act.

45. This is particularly important for issues such as the role played by social media and social media platforms as both a cause and a circumstance of the deaths. The individual's social media activity was widespread and well-documented. It is a necessary part of any effective investigation to establish the cause(s) and

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15 As Moana Jackson pointed out, the attacks are another reminder of the Treaty of Waitangi and the truth-seeking and acknowledgement of the history and ongoing perpetuation of the "misremembering: "If the Christchurch tragedy is to be properly understood, and the risk of further pain diminished, the healing must be based on a recognition that the dark day of March 15, 2019 was, sadly, only one of many dark days in this country's history. A failure to recognise that fact is not just to misremember history but to erase and silence it. The courage and resilience shown by the Muslim community and the compassion shown by so many others will not be properly acknowledged unless the hopes for a better future are based on a similar honest reckoning of everyone's past. The Treaty envisaged that better "us", and Hone Tuwhare knew that, even in the most *drear and dreamless time*, a torn and ravaged tree may

strike fresh roots again
Give soothing shade to a hurt and
Troubled world

16 Report, p 49.

circumstances of the deaths that are the subject of the inquiry and touches on a number of the different issues that it is suggested should be excluded because the RCOI has considered them.

46. Similarly, the potential to recommend changes to existing firearms legislation obviously requires consideration by the Coroner to the extent that it may reduce the chances of further deaths in similar circumstances. Such matters must, it is submitted, be in scope. This does not necessarily mean that discrete factual findings of the RCOI cannot be relied on, but that is very different from the proposition that the issues are not in scope at all in the coronial inquiry.

47. Each of the specific issues addressed below must be assessed with these considerations in mind. But the questions of (1) gun control and regulatory authority and (2) social media regulation and propaganda for violence loom very large over the events being inquired into. It will be submitted that it is not appropriate to exclude them. As to the first, there is no reason for there not to be comment or recommendation on the RCOI findings; as to the second, social media was excluded from the TOR and the Coroner has no findings on which to rely. One of the salient principles in [67] of the Coroner's Minute principle is whether a matter lends itself to comment and recommendations. That is submitted to be assuredly the case with gun control and social media controls, and the further issues to be discussed next.

48. More detailed analysis on the factual findings and the limits of the RCOI conclusions now follow.

Issue 2 How was the terrorist radicalized and how can this be prevented in the future?

49. This involves various sub-issues:

i) When and how did his racist views develop as a child?

ii) Why his views were not interrupted?

iii) Why online activity and devices are largely uninvestigated?

iv) Influences as a teen/young adult.

v) Activities that engaged extreme radicalisation.

vi) What combination of digital websites and online gaming environments incite dehumanisation and violence?

50. The following paragraphs set out why the RCOI's findings on this issue are not sufficient, if relied on exclusively, for an effective investigation.

51. The RCOI, with limited time and resources, did not have a clear direction to look into what happened in Australia. This includes the long-term (18 years, since the age of 14 as the RCOI identifies it) radicalization of T.

52. T's long-term consumption of radicalization was said, by one official, not to be picked up by Australian officials.[17]

53. The RCOI was not able to delve properly into his radicalization and to what extent that could or should have been picked up by Australian authorities, and to what extent NZ had access to such information through its intelligence alliances.

54. Completing the RCOI's inquiry in respect of such aspects as his radicalization in Australia feeds into the aspect of social media which connects both country's intelligence systems, given the inherently close collaboration between Australian and NZ intelligence systems.

55. Given that the prevailing NZ Police intelligence framework is that of the Australia New Zealand Counter-Terrorism Committee,[18] there is an inherent substantive link between both, and the liaison on which online cross-border intelligence is based.

56. Online activity that the RCOI regarded as most chilling[19] in its analysis of the significant Barry Harry Tarry comments (Part 7, Chapter 2, -- Chapter 2: The three ways the individual may have been detected), this is clearly one area the RCOI regarded as most significant but was unable to properly explore due to social media being absent from its mandate.

57. Very little technological information and expertise is apparently able to be relied on by the RC. International advice is mentioned at certain points by the RCOI, yet in relation to key technological matters no such advice is mentioned to apparently taken. The RCOI was required to cover and report on a huge range of sensitive matters in a short period of time, a significant part of which was affected by the lockdown.[20] The RCOI understandably did not have the ability to forensically investigate technological issues.

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17 The RCOI was therefore forced to rely on absolute, blanket statements completely evading connection or responsibility such as the one relied on here: Part 6, 4.2, [14].

18 "New Zealand Police note they continue to use the Australia New Zealand Counter-Terrorism Committee framework, which is very similar" Report of the RCOI, Part 8, 12.5, [39]

19 "The comments also gave indications of his thinking. Even without the benefit of hindsight, there is a chilling quality to his final remarks." Report of the RCOI, Part 7, 2.1, [7]

20 Due to the sensitivity of information involved, the RCOI team was not, it is understood, able to continue working remotely. RCOI time, resource, personnel constraints are detailed further in Appendix I.

58. Nor is it apparent (from the very limited information available) that Police have enlisted the expertise available across national and international intelligence and technological capability to examine these issues to an adequate standard. This is especially relevant given the high level of such expertise inherent in intelligence work. The coroner (and thus families) is presently left to rely on police entirely for all aspects of information: extraction, collation, retention, analysis, disclosure. etc. It is known from far less complex and far less serious cases that the Police are not able to be solely relied on for all such phases of information.

Issue 3 What is known about the terrorist's travel history and is there any evidence of him having trained overseas?

59. T is not a NZ national. His travel to countries of security and intelligence interest was extensive, along with overlaying issues such as movement of money, donations to far-right groups,

60. The limited information received one day before these submissions were due disclosed that the family has relevant information that can feed into assessment of his travel and his activity, priorities and objectives of travel and during travel.

61. It has been noted in counsel's previous submissions[21] that the military style employed by T was both highly proficient, required extensive training, and involved techniques unfamiliar (then, at least) to military personnel in this region and their key military partners. It is at least conceivable that T would have sought to further his already-fixed objectives of attack during the subsequent rounds of travel to these countries.

62. Such concerns remain speculative to a degree, but that is the very concern; understanding the level of proficiency he was able to gain is not explained by what is said to be very limited and mundane activity at the gun club. No experience is said to have been taken in Australia prior to moving to NZ. So any advanced hands-on training, if not at NZ gun clubs as is insisted, would have been undertaken overseas. This magnitude of success in shooting is said by experts to not be the hallmark of someone watching You tube videos.

63. The RCOI did not have enough time to investigate matters with other countries. Getting relevant information out of many of these countries would take a considerable amount of time.

64. This is also apparent from the sweeping conclusions the RCOI is forced to make without any real proper investigation into those matters. For example the RCOI was forced to make some broad estimations on very limited information:

> Given the limited periods of time he stayed in the countries he visited, there would not have been much

21 Paragraph 221, page 33.

> opportunity to do so. This is particularly so given the individual travelled between cities and towns in each of the countries. Nor is there evidence of the individual meeting up with right-wing extremists. As well, most of the countries in which the individual spent substantial periods of time have no association with right-wing extremism.

65. It is not clear to what extent the RCOI went to be able to make these conclusions but from their generality and non-specific descriptions it does not seem any real investigation was undertaken before drawing these conclusions.

66. The absence of investigating and analysing overseas travel then reduces the value of the other affected matters including the question of finances and what training may have been undertaken by T.

Issue 4 Were red flags missed by intelligence/Police?

67. The following paragraphs explain why counsel submit the RCOI's conclusions on this point cannot be adopted by the Coroner without further inquiry.

68. A number of issues are drawn to abrupt conclusions seemingly testament to the increasing rush and time pressures the RCOI was under. These include the Barry Harry Tarry issue.

69. The RCOI was left to accept the nature of the leads as described by the agency that did not prioritise it, without the benefit of input from alternative or counterpart agencies in other countries who are not so conflicted by the implicit allegation of failure to prevent the shootings.

70. This included the assessment of the lead which must necessarily be viewed in the context of the RCOI's that the priorities were misplaced with the result that RWE was not prioritised. It must follow that the assessment of such a lead cannot be readily accepted.

71. The significance of T accessing the Oslo manifesto may not have been (made) apparent to the RCOI. The RCOI appears to have been told by the SIS that there were good reasons that the lead was not a high priority. The RCOI finds that T followed the operational instructions of the Oslo manifesto. The RCOI appears not to have had sufficient opportunity to reflect on its own findings that the Oslo manifesto was central, including operationally, to T's preparation – which bore all the hallmarks of the Oslo manifesto.

72. The Oslo attack is confirmed by the RCOI to have resulted in a specific warning about the risk of such attacks occurring using firearms.[22]

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22 Executive Summary [20]

73. At the specific relatively small location where the lead had pointed to there was a new person in that same small town who was following all of the operational aspects of the Oslo manifesto including accessing a gym, accessing steroids and testosterone, and seeking out firearms (and seeking medical attention due to the extent of doing so). In addition he was known to be shooting unusually at a gun club, had no regular referees, lived in an empty flat, and was, potentially from the fact that the IP address was difficult to trace, trying to keep his electronic tracks clean. Indeed that was in itself a reason to make additional (readily accessible, through the GCSB) efforts to trace the IP address rather than to, on the contrary, close the lead. Such an attitude towards the lead could only have been possible as a result of taking a predetermined view of the nature of lead, which in this case was its lack of likelihood of being Islamic extremism due to accessing the Oslo manifesto. This demonstrated a complete inaptitude towards the significance of the Oslo manifesto. Events since have of course made clear how importance the Oslo manifesto is thanks to attackers acknowledging both the Oslo and, in turn, the Christchurch terrorist **("T")**. The significance of the Oslo attack as the source of all of this long-standing GTR ideology has now become abundantly clear.

74. The RCOI did not bring in any relevant expertise in this area. There was no apparent expertise available within the commission in any of the relevant areas of:

    RWE and White supremacism

    Colonisation and racism

    Islamophobia and Religious Vilification[23]

    Diversity & Inclusion

    Systemic and unconscious bias

    Religious and civilisational conflict (historic and current) between Christianity and Islam.[24]

75. The input from experts in this area was also limited again by its overarching constraints of time vs the various broad areas the RCOI needed to focus on.

76. This issue necessarily intersects with the fact that in many ways **T** was not a lone actor – he actively pursued followed and had solidarity with a dedicated community. That community also included the community who acquiesced to specific extremist rhetoric. This was primarily his online environment which had practical manifestations including monetary donations, and which support extended to both his firearms licence application referees, his gun club environment.

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23 The terminology used by the New South Wales Anti-Discrimination Amendment (Religious Vilification) Bill 2021 (Australia)

24 That is the central focus of philosophy underlying the 1518 pages of the Oslo Manifesto and which the RC, albeit only once in passing, acknowledges at Part 4, 3.1 [2] & [3].

77. There was clearly an absence of monitoring of financial donations to these groups are and the failure to do so as a joint responsibility of the joint Australasian framework. At various points, police and other intelligence had their duty of care raised further, including most prominently at the points of the application for a firearms license and the lead provided by Operation Solar.

78. The various scenarios hurriedly run through by the royal commission within the brief time they had appearing to discount the possibility that the IP address may have led to the attacker, or even that the attacker could still have used a vehicle even if his firearms licence was cancelled, is indicative of the constrained time and resources the RCOI had to answer these questions: no vehicle-incident could have caused anywhere near as much mortality as the amassing, modification, training and expert use of multiple semi-automatic firearms.

79. The RCOI was not able to help verify its theory of discounting whether the IP address belonged to T by asking him, despite their utilising information from T quite readily. This was again due to a limitation on the RCOI, in this instance due to the lead information being classified[25]. Of course, if the person accessing such specific information as similar as T was not, as the RCOI hypothesises, was not T, then it only raises concerns regarding who else may have been involved in assisting him research.

80. When the arms officer visited T, his bare empty flat would have been apparent, as well as, readily available, information on his previous travel, lack of contacts and connectivity.

81. The medical authorities were not required by intelligence to report gunshot injuries and (as the RCOI notes), potential Arms Act 1983 offences, but critically, medical notes on his file had by the time of the gunshot injury recorded reported and evident (moon-face) use of illicit steroids and substances. However, the RCOI did not consider the agency failures in ensuring that gun incidents and concurrent concerns (in this case illicit drug use) were not reported. These two hallmarks of the Oslo manifesto operations manual not being part of any detection system confirms that there had been no implementation of concerns around the Oslo operationalisation risks.

82. The RCOI's TOR again highlight gaps: it refers to information the state agencies had i.e. what they did know. The RCOI does not, therefore, focus on information that the agencies should have set up a system for retrieving based on key criteria triggered by specific elements in this case for example the Oslo manifesto operations manual. It did not identify the high-risk areas in for

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25 Part 6, 3.5, [65]

example the South Island where previous racial attacks on Mosques had occurred.

83. In one such attack, there had been a conviction following prosecution. The man, Philip Arps, made clear references to the kind of sentiment in the Oslo manifesto, for example:

> "Bring on the cull! Get the f***ers out. The rules are changing. White power. White f***in' power. White power. F***in' oi."
>
> "It was deliberate - deliberate attack, deliberate offence against Muslims, were the Judge's words. He obviously knows me well."

84. Arps' Christchurch work van displayed the price $14.88. 14 refers to a 14-word slogan penned by American white supremacist David Lane.[26] The same reference is made in T's TradeMe username: "14words". This was the same account used to trade firearms sales. Against this background of international prominence of the Oslo manifesto, emphasised and reminded by the lead from Operation Solar, and the ideology clearly being a problem specifically directed to the Christchurch mosque by a man advertising 14 words. The RC merely states that the Trademe username did not apparently attraction any attention, without going into why not.[27]

85. The RCOI makes numerous references to the Oslo manifesto and clearly acknowledges its centrality. It did not seem to have occasion to ask why agencies had no system to detect anyone following the manifesto's detailed distinctive instructions. The manifesto contains hundreds of pages of specific operational instructions which the RCOI notes T was specifically following and which he did through his entire preparation period.

86. The RCOI had to, due to its apparent limitations, telegraph to the ultimate question which for the RCOI was whether or not any issues would have made a difference to the outcome. It did not, however, have the time or luxury to break down and analyse the individual different components of its conclusions or alternatives within its logical analysis that led to the conclusion that, essentially, all failures were inconsequential; that no failures would have impacted a lone actor.

87. This is despite the many operational security issues the RCOI itself identifies that were lapses which raised several key red flags but which were not being looked out for.

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26 88 stands for "Heil Hitler" - H being the eighth letter of the alphabet.

27 Part 4, 4.6 [41] of the Report

88. Accordingly, when it is noted that no alert or detection system was in place to detect a person employing the Oslo manifesto operational guidance, it is no surprise that the Operation Solar lead relating to the Oslo manifesto was not seen as a priority.

89. The RCOI acknowledges that, given that he followed the Oslo operational manual, he was not, in a sense, a lone actor.[28]

90. All of the above is missing a critical piece of information, which is the patent signs of long-term radicalisation which slowly escalated to increasingly explicit comments on social media including the ones the RCOI describes as "chilling":[29]

> Though I must say, it is far better to have separate schools and it ensures they are always seen as outsiders, and there is no intermixing of cultures or races. Them having separate schools is something we should support. Plus it makes them all gather in one place....JK JK JK

91. There is also a clear reference to an actual attack – termed a "prank". The FB applicable comment is:

> Otago Muslim Association [official] was both surprised and delighted by the announcement. "I'm very, very pleased. It will be a great asset for the Muslim community in Dunedin, as well as New Zealand." What in the fifty fires of fuck have I stumbled upon here? A ... muslim bankrolling an Islamic learning school in New Zealand? This dude is No.1 on the prank list.

92. The RCOI states:[30]

> When we put these comments to the individual, he acknowledged that the expression, "No. 1 on the prank list" could be seen as a threat of harm. We note that the 15 March 2019 terrorist attack is sometimes referred to on far right forums as "the mosque prank".

93. The RCOI's articulation seems to reflect an early stage of considering these statements by T, but its comments are again insightful. With the benefit of reflection on these insightful comments, it is now undoubtedly clear what a prank is, and what was meant. This is not a new term and one that far-right familiarity would and should have picked up.

94. This underscores the absence of social media from the RCOI scope of inquiry.

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28 Chapter 5, 8.2 "Was the Individual Really a Lone Actor"?

29 "The comments also gave indications of his thinking. Even without the benefit of hindsight, there is a chilling quality to his final remarks." Part 7, 2.1, [7] The BHT Comments.

30 Part 4, 4.6, [36].

95. Related intelligence failures to pick up on extensive clear final instructions emailed to himself are not elaborated upon.

96. The emails contact ominous final signs of his attack. The RCOI mentions at one point[31] in describing T generally that he knew how to encrypt emails. But at no point does the RCOI go into the matter of how or why his emails to himself were missed, let alone encrypted.

97. The RCOI was well aware of the importance of emails, stating:

6.1 Evidence on which we rely

Distressing Content

> Evidence of the individual's preparation for the terrorist attack comes from a variety of sources including what he told us directly, his interview with New Zealand Police on 15 March 2019, a series of emails he sent to himself, mobile phone location data, electronic information on the SD card of his drone and an external hard drive (both of which he had sent to his sister). We also reviewed social media activity shortly before the terrorist attack and the individual's manifesto. Some of these sources warrant brief discussion.
>
> The individual used his email account to send notes to himself for future reference. Although he deleted his emails before the terrorist attack, a few were recovered. Some of the recovered emails record elements of his planning and preparation.

98. The RCOI reproduces ominous emails such as:

> Date: 20 December 2018, 5.01 am From: [The individual] To: [The individual]
>
> > kill an armed invader and [receive] a medal, kill an unarmed invader and receive a life sentence, but the invaders threat remains the same.

99. The fact that these emails were recovered suggests they were not encrypted but the RCOI neither confirms this nor comments on this aspect.

100. T's travel history should also have been known to authorities but for some reason was not, including when he entered the country for the sole purpose of carrying out the attack. While Australians do not require a visa, the visa system is a separate system to the profiling alert immigration intelligence system under which ordinary NZ citizens of migrant backgrounds are stopped and questioned due merely to their ethnic origin and, of course, faith.

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31 Part 4, 4.6 [45].

101. Immigration NZ is part of the NZ CT effort.[32] Section 16 of Tte Immigration Act 2009 was not complied with:

> **16 Certain other persons not eligible for visa or entry permission**
> (1) No visa or entry permission may be granted, and no visa waiver may apply, to any person who—
> (a) the Minister has reason to believe—
> (i) is likely to commit an offence in New Zealand that is punishable by imprisonment; or
> (ii) is, or is likely to be, a threat or risk to security; or
> (iii) is, or is likely to be, a threat or risk to public order; or
> (iv) is, or is likely to be, a threat or risk to the public interest; or
> (b) is a member of a terrorist entity designated under the Terrorism Suppression Act 2002.
> (2) This section is subject to section 17.

102. T was not checked on any of the occasions he travelled to NZ after travelling to various countries otherwise of his interest. This is in contrast to the what the RCOI recorded as the experiences of many including migrant communities including, ironically, the victim community.[33]

103. This demonstrates a starkly discriminatory immigration profiling system which failed to pick up on any of the red flags Immigration NZ usually uses to hold many NZ migrants (NZ citizens) at the border each year.

104. The RCOI's omission of why the emails were not picked up is therefore inexplicable on the one hand but perhaps understandable given the aforementioned lack of time and technological resource available.

105. Such explicit signs of intentional action were alongside important statements of moral support for extreme groups. This support then also extended to numerous financial contributions. This phase is one that began in Australia and continued while in NZ. This represents a collaborative Australasian Counterterrorism failure which the RCOI did not have sufficient time, mandate and opportunity to properly explore, as well as the handicap of having social media excluded from its TOR.

Accordingly, while many useful aspects have been addressed by the RC, there are significant gaps on issues which the RCOI itself raised which it either did not have enough time or resource (or both) to address in full, or did not have mandate in the required areas to be able to exhaust the relevant factors; instead the RCOI was

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32 Public sector agencies involved in the counter- terrorism effort: The Department of the Prime Minister and Cabinet, the Government Communications Security Bureau, Immigration New Zealand, New Zealand Customs Service, New Zealand Police and the New Zealand Security Intelligence Service. P118 Glossary

33 Part 3, 4.6, [58]-[59]

able to come to conclusions within the limited timeframe and information and mandate it has.

Issue 5 Did defective firearms licensing regime contribute to deaths?

106. The absence of causation found between the firearms licence and the attack is untenable. This is a highly controversial issue which, in order to avoid wholesale disrepute to the report and the inquiry, must be revisited and corrected.

Issue 6 Why was there no reporting of firearms and ammunition purchases?

107. On this issue the RCOI does not reach the point of analysing the overall gravity of missing ammunition purchases on the basis of:

a. The amount of ammunition purchased.

b. The RCOI was not able within in its short lifespan to find out how much was purchased.

c. The fact that the majority was purchased online.

d. The fact that the ammunition purchased was Magpul which matched the Operation Solar lead.

e. That ammunition accumulation was consistent with the Oslo manifesto.

f. The fact that the ammunition related to a licence application that had been, at the very least, weak.

g. The gun-club concerns related to the amount of ammunition being used and, most ominously, "and appeared to be firing at extremely fast rates and changing magazines quickly".[34]

108. They were also aware and some were concerned about, his apparent access or talk of accessing large capacity magazines.

109. The RCOI may not have had occasion to reflect on the contradiction between the many diverse concerns raised and the denial of members that he raised any concerns, all of which warranted deeper investigation into the club.

110. The RCOI was also, typically, reliant on what they were told in respect of the amount of ammunition purchased, the NZ Police armourer telling the RCOI that the amounts of ammunition brought were not unusual. There is no apparent evidence offered for this view. It is again apparent that the RCOI has limited practical ability to be able to verify information provided by the same

34 Part 4, 5.4, [32]

agency who were stood to lose the most from any of their oversights being of consequence.[35]

111. There is similarly very little about whether any detection mechanisms were available or in operation to enforce the unlawfulness of using large capacity magazines on his semi-automatic firearms.

112. The RCOI confirmed it simply relied on such NZ Police employees as Subject Matter Experts (SME).[36] At no stage in the report do the NZ Police armourer's answers or input suggest that there is any interest in confronting the gravity of the oversights by the NZ Police. Indeed, despite listing the NZ Police armourer as one of the few such SMEs, the RCOI does not then cite the armourer other than on two minor inconsequential occasions[37].

113. This matter, like others, needs to have the benefit of independently verified SMEs (as any court would require) in order to verify basic yet seminal assertions such as how typical it was for that much ammunition to be brought. This should be done only after, of course, some expert analysis and estimation can be made of just how much ammunition was brought. The conclusion of those who told the RCOI that such purchases were not unusual seem eager to be drawn given that it was known by the RCOI itself how much was purchased.

114. Overall, therefore, while there is useful inquiry into this issue, it is now left for genuine SMEs to analyse the key factors involved.

Issue 7 – Gun Club regulation

115. An explanation is offered by T in the report that he used the large capacity once when no one was there (which is not evidently confirmed by records), which as the RCOI notes, is in line with his overestimating his operational security standards. But it is inconsistent with his being able to practice to the extent needed for such an attack and with the extent to which he was evidently practising the kind of firing he used in the attack.[38]

116. The RCOI accepts that T's conduct and shooting style was unusual, but does not go as far as asking why these were not reported or why there was no system for it to be reported.

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35 The RCOI is forced to simply conclude: "In any event, his purchases did not give rise to any reporting of concerns by the sellers to New Zealand Police." The RCOI did not extend to asking why this was the case when the ammunition purchases were, in fact, high; the RCOI appears to have been forced to settle for an assertion beyond which they were apparently unable to inquire.

36 Part 1, 4.8, [29]

37 At: Part 4, 5.3, [18] (prevalence of online videos demonstrating how to modify the gun trigger) and Part 6, 7.4, [29] (reason for error leading to T's injury)

38 Part 4, 5.3, [15]

117. T did not apparently comply with the limited purpose for which a military style semi-automatic could be acquired which included:

> …participates in an identifiable shooting discipline or sport at an incorporated sports club with rules encouraging the safe and legal use of firearms and a range certified for the shooting activity and intends to use the [military style semi-automatic firearm] in an event at that sports club;

118. The gun club clearly failed to fulfil this obligation (to ensure such members were encouraged to use safe and legal firearms and to ensuring they were going to being used at an event) but this is not a matter which the RCOI notes nor inquires into. The RCOI does not therefore adequately investigate the duties that fell on the club, and further investigation is necessary.

Issue 8 Why did the hospitalnot report the firearm injury the terrorist presented with in July 2018?

This is particularly relevant given what medical information there was already on file regarding his illicit drug use. There was thus a failure to peruse the medical files to ensure no reporting was in fact required.

Issues 48, 50 and 52 Protection of mosques; institutional bias against Muslims; too much focus by intelligence services on Islamic terrorists?

119. These three issues may be considered together. Issue 49 is considered separately, under the next heading,

120. Issues 48 and 50 are closely related to another set of issues – not articulated as such by the Coroner in the List – concerning the social culture within New Zealand and the prevalence of hate crimes and right-wing extremism. This is sometimes called a problem of "social cohesion" – meaning, of course, the lack of cohesion.

121. These issues are clearly relevant to the deaths under inquiry. Indeed, the RCOI's (promptly accepted) recommendation of a revision of hate speech laws and the Prime Minister's international promotion of the Christchurch Call are evidence that concerns about social cohesion and culture are acknowledged as self-evident. This phenomenon is undoubtedly a part of the "circumstances" of the deaths of the 51 victims of the attack. Comment and recommendations are both possible and likely called for.

122. As a result it is an issue that must be inquired into. The exclusion of a highly salient matter – social media and social media corporations – from the RCOI's TOR means that there is no finding on which the Coroner might even consider relying. It therefore falls within the issues that need to be in scope in the Coroner's inquiry.

123. The lack of state initiative to facilitate the reporting of hate crimes and record physical/verbal harassment resulted in a failure to measure and monitor the level of threat to the safety of the Muslim community.

124. The rise of islamophobia internationally evidently caused a spike of hate crimes in New Zealand where harassment or fear of attack was reported by many Muslims. The fear or risk of attack was neglected by police and SIS despite being advanced by the Muslim population in New Zealand.

125. An inquiry into these issues will likely have to address the Islamic Women's Council's approaches to SIS with numerous ideas prior to the 15 March 1 attack to address the potential risk or threat to the safety of the Muslim community. The constant engagement by Muslim representatives with state agencies was consistent throughout the years despite setbacks. The Council, for example, has expressed, inter alia, the following concerns:[39]

125.1. "In one reported incident a female Muslim youth was threatened by another customer at a petrol station. She called the Police but the police refused to come out".

125.2. "20 February 2019, a serious threat was made to burn a Quran outside a Hamilton mosque on Friday 15 March 2019, the police dismissed the matter. They said the writer was known to them and had mental health problems. The message was showing Christchurch as the sender's location".

125.3. Concerning threats and action include: The attack at the Avondale Mosque. A series of IWCNZ reports over the past few years. The Race Relations Commissioner's also presented strong concerns. IWCNZ suggest that "the police had enough intelligence to warrant a coordinated national strategy".

125.4. Abusive and Islamophobic comments that were made on 5 March 2019.

125.5. The president of the Waikato Muslim organisation received threatening calls prior to the March 15th mosque attack.

126. The lack of state-recorded evidence for complaints[40] does not render it non-existent but demonstrates the state's priorities and operational failures to record such complaints as well as reasonably respond.

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39 Rahman, A., Danzeisen, A. and Salama, M. (2019). *Submissions of IWCNZ to Royal Commission of Inquiry*. [online]. Available at: https://islamicwomenscouncilnz.co.nz/submissions-iwcnz/ [Accessed 25 Jan. 2022].

40 The RCOI references limited complaints although more appear to be known of by the state

127. The refusal to record hate crimes and harassment by police officers was due to institutional bias with resources being overly focused on monitoring Muslims believed to be a national and worldwide threat.

128. The outcome of this focus enabled an environment where 'other' forms of terrorism was undetected, unreported and other suspicious activity was not considered a priority where the risk of harm was thought to be low.

129. The complaints previously disregarded as insignificant by various state agencies, is evidence of a community who required protection and were vulnerable to far right extremist attacks.

130. It has long been observed that white terrorism does not receive the same attention and treatment as terrorism associated with foreigners, particularly Arab or Muslim peoples.[41] The threat of white terrorism was not taken seriously in NZ, even though it was in the US by law enforcement. There was significant discrepancy between the priority that the Five Eyes, and thus NZ as a Five Eyes partner, gave to RWE or white terrorism while on the ground in the US law enforcement were very clear about the significant risks based on statistics alone.

131. Due to the representation of Islam being shrouded by Islamist extremism and a narrative in common discourse that the actions of Islamist extremists portrayed

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41 Caroline Mala Corbin, Terrorists Are Always Muslim but Never White: At the Intersection of Critical Race Theory and Propaganda, 86 Fordham L. Rev. 455 (2017). Available at: https://ir.lawnet.fordham.edu/flr/vol86/iss2/5

Professor Caroline Mala Corbin
University of Miami School of Law prepared for:

Fordham Law Review symposium "*Terrorist Incitement on the Internet",* Fordham University School of Law. Overview of the symposium: Alexander Tsesis, *Foreword: Terrorist Incitement on the Internet*, 86 FORDHAM L. REV. 367 (2017).

The same article cites how clear it was to US enforcement authorities, domestically, that RWE was the real threat:

"Those responsible for public security are primarily concerned about right- wing extremism.(206) A recent survey asked local police departments and sheriffs' offices what they considered to be the most pressing terrorist threat in the United States.(207) Twice as many law enforcement officers listed right- wing terrorists compared to Muslim ones.(208) As one expert noted, "the reality is the most significant domestic terror threat we have is right wing extremism."(209) It is certainly the greatest threat to law enforcement: "Of the 45 police officers killed by domestic extremists since 2001, 10 were killed by left wing extremists, 34 by right wing extremists and one by domestic Islamic extremists." (210)

all of Islam,[42] this resulted in the state being oblivious to the threat of far-right terrorism, of which they ought to have had ample and prior knowledge.[43] The real and immediate risk to Muslim communities was further exacerbated by the South Island's history of racism and white supremacy,[44] a prevailing Islamophobic sentiment in experienced by the Muslim community in the wake of 9/11,[45] and complaints laid by Muslim communities that were inadequately handled.[46] Recommendation 42 directs Police to improve practises of recording hate-motivated crimes.[47] This highlights the deficiency of the previous position that meant the state could never assess the immediacy of a risk to Muslim communities despite the warning signs to do so. Through the neglect of Muslims as potential terror attack victims, as well as increased ostracisation from mainstream society, an attack on their religious practice became increasingly likely to occur and to be missed.

132. The RCOI does not find this discrepancy of prioritisation between white and Islamist terrorism to consequential, but any such conclusion of this gravity requires investigating the internal componentry to be inquired into in full.

133. Key state intelligence organisations failed to enlist and retain a diversity of thought, personnel and approach, that would have diversified their priorities objectively and according to risk to the public, rather than in accordance with pre-existing systemic biases. The state has maintained a civil society environment in which there is a very high threshold for person(s) for the white majority group to come to the attention of the authorities, and a very low likelihood of that same majority community reporting concerning behaviour from within its own community, especially in less diverse regions. This is in contrast with the very low threshold for those specific minority at-risk groups who also suffer from racial profiling from the moment they seek to enter or re-enter what is often their own country and throughout their life in NZ. The RCOI report appears to suggest social cohesion as a remedy for these "civil-society" failures but does not clearly identify the critical failures which have been missed while such social cohesion initiatives have been underway following the 9/11 attacks and response.

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42 Lara M Greaves, Aarif Rasheed, Stephanie D'Souza, Nichola Shackleton, Luke D Oldfield, Chris G Sibley, Barry Milne and Joseph Bulbulia "Comparative study of attitudes to religious groups in New Zealand reveals Muslim-specific prejudice" (2020) 15(2) Kōtuitui: *New Zealand Journal of Social Sciences Online*.

43 *Royal Commission of Inquiry into the Attack on Christchurch Mosques on 15 March 2019*. [online] Available at: https://christchurchattack.royalcommission.nz/the-report/part-5-the-terrorist/important-notice-2/ [Accessed 25 Jan. 2022].at 598.

44 Jarrod Gilbert and Ben Elley "Shaved heads and Sonnenrads: Comparing White Supremacist Skinheads and the Alt-Right in New Zealand" (2020) 15:2 Kōtuitui: New Zealand Journal of Social Sciences Online at 2. DOI: https://doi.org/10.1080/1177083X.2020.1730415

45 *Royal commission* Above n 27 at 135.

46 Rahman, A., Danzeisen, A. and Salama, M. (2019). *Submissions of IWCNZ to Royal Commission of Inquiry*. [online]. Available at: https://islamicwomenscouncilnz.co.nz/submissions-iwcnz/ [Accessed 25 Jan. 2022] at [52].

47 *Royal Commission* Above n 27 at 764.

134. In the case of T, there were enough incidents and issues that came or should have come to the attention of third parties in the community and thus, in turn, to the authorities, had the state been at all effective in establishing social cohesion and a sense of literacy around RWE risks in NZ. The government has to varying degrees acknowledged such failures and these have been more properly elaborated upon by human rights organisations. The Human Rights Commission (the **HRC**) in their reflection on the report of the RCOI, addresses concerns regarding potential breaches of fundamental human rights. The Government has acknowledged and recognised the existence of systemic discrimination within the intelligence and security agencies prior to the 15 March attack.

135. The RCOI acknowledges that there was inappropriate concentration of resources focusing on the Muslim community.[48] Yet, despite doing so, the RCOI omits the corollary which is that due to such inappropriate concentration, the resources were not used where they needed to be and accordingly, real and imminent threats were not addressed or addressed very superficially, such as in the case of the leads from the Operation Gallant Phoenix (Operation Solar).

136. This inherent and internalised representation of Muslims continues to be the root cause of monitoring a marginalised group constantly subjected to discrimination as a result of prejudice and the function of unconscious bias.[49]. It affects people's judgments, decisions, and behaviours in subtle and harmful ways. It is one thing for unconscious bias to exist but the implications of leading to discriminatory actions is significantly more probable and almost inevitable.

137. The level of motivation and their unconscious/consciously held beliefs, determines the extent to which an individual or body enables biases to manifest in action.[50] At the receiving end of these effects and the discrepancy of class, socio-economic backgrounds, race, religion, sexuality and gender are minorities from multi-ethnic and intersectional backgrounds.

138. In response to the Prime Minister's apology, the HRC have explicitly stated that the internal systemic discrimination amongst state agencies constitutes a

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48 State agencies are stated by the RCOI to have exerted immense resources and time on the surveillance of the Muslim community. This has slowly enabled an 'inappropriate concentration of resources 'as stated in the Prime Minister's apology. The 'disproportionate scrutiny 'of the Muslim community fueled by unconscious bias and implicit stereotypes, considers Muslims as a homogenous group where the radicalisation of one man represents the entire population. This failed to distinguish between any persons of Muslim background who were of concern, and the rest of the Muslim community who were at longstanding and increasing risk of being attacked.

50 Dasgupta, Nilanjana. "Implicit ingroup favoritism, outgroup favoritism, and their behavioral manifestations." *Social justice research* 17, no. 2 (2004): 143-169 at [143].

breach of human rights.[51] This agenda has turned a systemic blind eye to potential extremist threats and harm towards the Muslim community.

139. The question arises as to *how the state's view of a particular community impacts how they fulfil their protective duties and how they operate to fulfil (or not) those duties.*

140. Perceiving the Muslim community as a risk and threat entirely, has de-prioritised their needs and any protective measures enshrined in their rights as civilians. This ingrained assumption of the 'risk' or 'threat' makes it impossible for state sectors to consider the possibility that Muslims may be simultaneously 'victims' and vulnerable. The Muslim community bears the repercussions of gross negligence on the part of the state thereby limiting their access to basic fundamental human right as well as protective measures.

141. It is inadequate to say that all preventative measures in place could not have stopped the attack and despite the RCOI's findings, this was a permanent failure that infringed on the right to life.

142. The question of whether the state was indirectly responsible for the attack due to the internal systemic, unequal, and disproportionate operation, is clear. It is unjust to gloss over the impacts of biases and their consequences, which led to a failure in detecting the attack.

143. The Prime Minister has explicitly announced the need to restructure intelligence and security services to actively eliminate biases whilst aiming to monitor white supremacist and other extremist activity online. This indicates the presence of these undesirable characteristics prior to the attack.

The recommendations are solid in targeting different threats in the future and are broader. In retrospect, if this competency training and unlearning of biases had been implemented, it may have identified the threat to the security and safety of the Muslim community.

Issue 49 *Capacity deficiency in tracking lone actors*

144. The RCOI submissions distinguish between a 'lone actor' and extremist groups: a lone actor is less easily detectable and traceable. He or she operates on their own without consulting or communicating with another party. The likelihood of detecting an individual who prepares, plans and executes independently is

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51 New Zealand Human Rights Commission (2019). Reflections on the Report of the Royal Commission of Inquiry into the terrorist attacks on Christchurch Masjidain on 15th Human Rights Commission Te Kāhui Tika Tangata. [online] Available at: https://www.hrc.co.nz/files/3716/1588/7040/HRC_Reflections_on_the_report_of_the_RCI_on_terrorist_attacks_on_Christchurch_Masjidain_FINAL.pdf [Accessed 28 Jan. 2022].

substantially harder and *thus less vulnerable to counter terrorism measures than group- based terrorist*[52].

145. The premise that T was a lone actor is a dangerous one given the man systemic factors that enabled and covered for him, and obfuscates the environment in which anti-Islamic sentiments can develop without opposition. On a more individual scale, it also has the effect of dismissing safeguards the state should have had in place to detect violent extremists and which safeguards routinely pickup Islamist content consumers.

146. The characterisation of "lone actor" has been effectively used by the RCOI to make conclusive negative findings rather than to consider and exhaust the relevant aspects and questions for a comprehensive inquiry. From the perspective of a Coroner, these are questions for resolution and likely comment. The lone actor narrative risks the minimisation of the systemic failures that have permitted the preparation and execution of the attack to occur.

147. Two additional overarching issues have been added in the Appendix I table relating to overarching issues and which relate to this category of issues.

E ISSUES IN THE "INFORMATION REQUEST" CATEGORY

148. As foreshadowed in the opening submission, counsel submits that dealing with certain key issues raised by families by way of "information requests" is inadequate. Specifically, this method is not consistent with a rights-compliant framework because the "information provision" path does not speak to the ultimate question of whether the underlying issues are in scope or not (i.e., whether they need to be considered to establish the factors in s 57(2)(a)-(e) of the Act).

149. In other words, the idea of information requests simply provides a mechanism for ensuring that the different parties are better informed on certain issues. While the information contained within the information requests may be helpful in the inquiry, that is only the starting point. It is not often that one source of information can be the definitive answer to an issue and provide an adequate conclusion, especially when that information is not scrutinised. It is also extremely unlikely that the current information will be all that is available. Investigation leads to discovery of more and better-quality information. Sometimes that information exists but is in a different location. Sometimes that information has not come out. That is precisely why an inquiry is important.

150. Moreover, in the present case, the NZ Police's responses to the information requests have raised additional questions. Information has either not been

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52 Royal Commission of Inquiry into the terrorist attack on Christchurch masjidain on 15 March 2019, vol 3, part 8 (26 November 2020) at 410.

forthcoming at all, heavily redacted or significantly delayed all of which continues to impact the ability of survivors to have informed participation in the inquiry.

151. The correct approach is for the Coroner to assess the information provided and, here, the additional concern that survivors are being forced to try to participate in the inquiry without much or most of the relevant information and without the resources to be able to get into a position of being informed and able to participate in at least the major aspects of the hearing process.

F. NEXT STEPS

152. If the above submissions are accepted, the Coroner is required to inquire into the issues set out above.

153. Overall failures of the RCOI Process

154. The state failed to provide for a RCOI process that:

154.1. Was able to traverse the proper ambit of critical issues relevant to the attacks, due to its TOR excluding key areas

154.2. Had adequate literacy around the background issues and experiences such that that literacy could be utilised within the inquiry process. Instead, the RCOI was forced to learn about fundamental issues such as Muslim community experiences through the process itself, and by the end of the process had an appreciation of such issues and experiences, but by which time their report was due and concurrently conducted investigations – which had greater prominence in the Terms of Reference and needed to be reported on -- were undertaken and complete. The constitution of the core RCOI team was not equipped to take prerequisite expertise into the process and instead relied on add-ons like a Muslim Community Reference Group to provide general literacy on community experiences, but without substantive into the inquiry process.

154.3. Given the inherent lack of appropriate experience and expertise, the RCOI was also hampered in its ability to effectively involve the wider victim (Muslim) community and the victim families (despite the latter being facilitated to some limited degree towards the end of the RCOI process).

155. Procedural concerns

156. The RCOI did not involve families or the community in its substantive process, or even in its preparation or deliberations before or after inquiry sessions it held. The lack of literacy within the core of the RCOI played a significant role in it being unable to involve families in the substantive process and core issues, or to import their concerns into key aspects of RCOI investigation. Such impediment was due to the core legal director(s) not being equipped or otherwise assisted with

the awareness of underlying issues and thus being unable to incorporate them into the inquiry process.

157. Central duty to family members

158. Surviving family members are chief among those who have the right to a rights-compliant inquiry, under which relevant matters must be included and properly investigated to the extent that the inquiry is able to meet fundamental criteria such as answer the key fundamental questions asked about the deaths by the families or community.

159. This submission includes a list of those relevant matters and states why those issues should be included and not excluded from this inquiry.

160. The families have not yet been afforded independent engagement with the Royal Commission report or process in order to be able to a) digest the content of the report and b) respond to it in a way that enables them to articulate where they feel let down by the process.[53]

161. However, it is clear that fundamental answers such as the state's failure to detect chronic and acute issues since 9/11 and closer to the attacks respectively, were not adequately or robustly investigated by the RCOI in a way that would give the families the answers they would need (had they read and been able to engage with the report).

162. The state's failure to ensure that the families were able to engage with the RCOI report itself has prevented families from being able to articulate the shortcomings of the RCOI process. They are instead, as is familiar now, dependent on others who are now also undertaking a literacy process of learning about their experiences in order to try to articulate the concerns families may have or have held since the outset of the RCOI process.

163. Accordingly, while the RCOI process and report made a serious attempt to cover many relevant areas it was undermined by key process issues including:

163.1. Lack of transparency in their hearings and examination process.

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53 A legal team assisting families in the RCOI process attempted to do obtain and review and explain the RCOI report after the release of the RCOI report, but was prevented from doing so on the basis that all Ministers needed to have exclusive access to the report and this meant the families could not access the report. Accordingly, families had to wait to access the report until after all Ministers had received and read it, by which time they (Ministers) had virtually arrived in Christchurch for a series of meetings with families. Once the immediate government response started (without families reading or understanding the report), there has been far too much for the families to cope with while trying to keep up meetings and other activity, and which was shortly followed by the coronial process commencing.

163.2. Lack of cultural expertise embedded in their team and design processes.

163.3. Lack of clear language and decisive conclusions in their findings and their final report, leaving missing a sense of accountability or even awareness of the key underlying issues.

164. The above process issues led to the RCOI failing in certain areas to meet the required rights-compliant criteria.

165. The RCOI process *did* meet the following criteria:

165.1. The RCOI was independent: it was adequately independent of the state.

165.2. Timely: the RCOI process was undertaken in a timely manner.

166. The RCOI process *did not* meet the following criteria.

166.1. Effectiveness: because it failed to provide robust answers to the critical questions of why the state remained unaware of the T despite various leads being provided to it and various overt incidents occurring in the terrorist's preparation for the attack.

166.2. Involve next of kin: because many families were not able to engage with the process at all; and most were only able to learn and, on a few rare occasions, meet and talk with the commissioners about the process rather than participate in the process itself. Additionally, despite the key stake certain families had given their close proximity to the event, none were granted core participant status under s 17 of the Inquiries Act 2013.

166.3. Scrutinised by the public: because much of the process was behind closed doors, contradictors were not present for examination; questions and answers are not apparent; findings and recommendations are not able to be traced back to key pieces of evidence; such evidence is not known to have been challenged or otherwise appropriately tested.

167. Similarly, procedural concerns in the current process can be mitigated. There are substantial areas of concern about the procedural aspect of this coronial process in relation to meaningful rights of participation:

167.1. A required number of families should be formally confirmed as being aware of the nature of the process before and the option to participate with or without legal representation in order to be able to participate at the appropriate stages of the process.

167.2. Information relevant to the inquiry being available to families, so that they can progress towards a reasonable ability to instruct lawyers on relevant issues.

DATED *this 8th day of February 2022*

Aarif A Rasheed — ***Counsel***