IN THE CORONER'S COURT
IN CHRISTCHURCH

I TE KŌTI KAITIROTIRO MATEWHAWHATI
KI TE ŌTAUTAHI

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**

FURTHER SUBMISSIONS FOR MR TARRANT

DATED: 24 FEBRUARY 2022

NEXT HEARING: TUESDAY, 22 FEBRUARY 2022 TO THURSDAY, 24 FEBRUARY 2022

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MAY IT PLEASE THE CORONER, Counsel for the Mr Tarrant respectfully submits:

1. INTRODUCTION

1.1 There can be no question that the Coroner is charged by statute to determine the circumstances of the relevant parties' deaths.

1.2 The only permitted exception is where an earlier inquiry has already done so by way of a rights-compliant inquiry, that has discharged the state's duty to investigate that arises under s 8 of the New Zealand Bill of Rights Act.[1]

1.3 The Coroner may, as we will see, look at the combined effect of those enquiries to see whether this function has already been satisfied.

1.4 Here, the two previous inquiries, (being first the police investigation and the Crown prosecution resulting in guilty pleas, and secondly the Royal Commission) fail to comply with the requirements of such an enquiry. Because pleas of guilty were entered, the criminal prosecution did not satisfy the state's duty. The Royal Commission's scope was limited, it was not an open investigation where the interested parties were involved and the evidence was in public or made public, and as a result there are factual errors that infect its findings and recommendations. This impacts as much on the families of the deceased as it does on other interested parties including Mr Tarrant.

1.5 Accordingly, Mr Tarrant supports the families' interest in a full, thorough, independent and public investigation of the facts leading to the death(s).[2] At the very least it will provide the answers the families seek and will correct errors that currently exist, which serve no party well.

1.6 Mr Tarrant will also, and separately, seek to correct the Royal Commission's report through correspondence and judicial review, if required, now he has at least finally received the report.[3]

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1 *Wallace v Attorney-General* [2021] NZHC 1963.
2 Being the wording used by the Court to describe a rights-compliant inquiry in *Wallace* at [423].
3 As detailed in counsel's previous submissions dated 21 February 2022.

2. STATUTORY PROVISIONS RELEVANT TO THIS INQUIRY

2.1 Section 63 of the Coroners Act 2006 provides:

> **63 Decision whether to open and conduct inquiry**
>
> In deciding whether to open and conduct an inquiry, a coroner must have regard to the following matters:
>
> (a) whether or not the causes of the death concerned appear to have been natural; and
>
> (b) in the case of a death that appears to have been unnatural or violent, whether or not it appears to have been due to the actions or inaction of any other person; and
>
> (c) the existence and extent of any allegations, rumours, suspicions, or public concern, about the death; and
>
> (d) the extent to which the drawing of attention to the circumstances of the death may be likely to reduce the chances of the occurrence of other deaths in similar circumstances; and
>
> (e) the desire of any members of the immediate family of the person who is or appears to be the person concerned that an inquiry should be conducted; and
>
> (f) any other matters the coroner thinks fit.

2.2 Counsel notes:

- First, it is mandatory that the Coroner have regard to matters (a) to (f);
- Here, the deaths certainly involved the actions or inactions of any other person (being paragraph (b));
- Similarly, it is hard to imagine circumstances that are of greater public concern (being paragraph (c));
- Finally, paragraph (e) is squarely engaged given the intense desire of the families to participate; and
- These same factors must also guide consideration of scope for any resumed inquiry.

2.3 Section 80 provides:

> **80 Decision to hold inquest**
>
> (1) A coroner conducting an inquiry into a death must decide whether to hold an inquest for the purposes of the inquiry.
>
> (2) Without limiting subsection (1), a coroner deciding whether to hold an inquest into a death must consider whether either, or both, of the following applies:
>
> (a) the death was a death in official custody or care and the death would not reasonably have been expected by a doctor who had access to the person's health information (as defined in section 22B of the Health Act 1956):
>
> (b) an inquest would assist the inquiry into the death by providing an opportunity for persons who have not been involved in the inquiry to—
>
> (i) scrutinise evidence considered by the coroner as part of the inquiry; or
>
> (ii) offer new evidence in respect of the death.
>
> (3) A coroner who decides under this section not to hold an inquest must comply with section 77.

2.4 S80(2)(b) applies here. The families and Mr Tarrant are "persons who have not been involved in the inquiry" to a satisfactory extent to date, and who should be afforded the opportunity to scrutinise the existing evidence and if necessary offer new evidence.

2.5 Neither was permitted as part of the Royal Commission's investigation and report. It is important that opportunity exits within this proceeding.

2.6 Section 57 provides:

> **57 Purposes of inquiries**
>
> (1) A coroner opens and conducts an inquiry (including any related inquest) for the 3 purposes stated in this section, and not to determine civil, criminal, or disciplinary liability.
>
> (2) The first purpose is to establish, so far as possible,—
>
> (a) that a person has died; and
>
> (b) the person's identity; and

(c) when and where the person died; and

(d) the causes of the death; and

(e) the circumstances of the death.

(3) The second purpose is to make recommendations or comments (see section 57A)….

2.7 Relying on the wording of "*so far as possible*"[4] Counsel Assisting the Coroner earlier oral submission suggested that the only issues that should be within scope are those that appear at this stage to be such that a concrete and certain finding would follow.

2.8 But s 57 inherently anticipates that issues will arise as part of a Coroner's inquiry that cannot be determined to that level of exactitude. That does not prevent the inquiry, or justify an issue impacting on the circumstances of the death being out of scope.

2.9 The *purpose* of an inquiry is to "establish, so far as possible", that a person has died, their identity and so on. The wording "so far as possible" qualifies the purpose of establishing the matters described in s 57(2)(a) to (e). It simply means that any determination can only be made to the extent the evidence permits. The enquiry is not to be never ending if the evidence does not permit one of the required findings. It can be reopened later, if further evidence become available.

2.10 But all that presupposes the Coroner accepting the task, then receiving and weighing the available evidence at the conclusion of the inquiry. The Coroner will not know what determinations or recommendations can be properly made unless the task is undertaken. As your Honour correctly noted yesterday, the cart should not go before the horse, given the Coroner role as investigative.

2.11 If the Coroner cannot make a determination, or one beyond that reached by the Royal Commission, that does not matter. However, that may be available given the different and wider nature of the Coroners inquiry and hence the evidence and submissions ultimately received.

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[4] As found in s 57(1) quoted above.

2.12 Certainly, the Coroner should not be hesitant about going further than the Royal Commission given the broad nature of the Coroner's inquiry and the evidence that may ultimately be received.

2.13 Further, issue of jurisdiction and resourcing are not matters that should properly drive scope especially given the nature of this inquiry and the important public interest to be served by it. None are insurmountable and any restrictions can be part of any investigation, finding or recommendation.

2.14 In summary, the Coroner should not predetermine what may be achieved before the inquiry itself has been undertaken.

2.15 Section 57A provides for the Coroner's power to make recommendations or comments in the course of an inquiry. The section provides:

> **57A Recommendations or comments by coroners**
>
> (1) A responsible coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death.
>
> (2) Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.
>
> (3) Recommendations or comments must—
>
> (a) be clearly linked to the factors that contributed to the death to which the inquiry relates; and
>
> (b) be based on evidence considered during the inquiry; and
>
> (c) be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

2.16 Importantly, the Coroner's power to make such recommendations is closely linked to the matters placed before the Coroner as part of the inquiry he or she conducts. The recommendations or comments your Honour makes *must* "be based on evidence considered during the inquiry".

2.17 If the Coroner classifies important issues in this hearing as being "out of scope" at this stage, but then the ultimate recommendations or comments the Coroner makes are related to or based on (for example) findings made

in the Royal Commission's report, then real problems will arise. This is because, if those issues are considered "out of scope" because the Royal Commission has considered them, they will not be the subject of evidence during the inquiry.

2.18 This again counsels in favour of an inclusive and broad inquiry, so that the Coroner's power to make recommendations and comments is not hamstrung once the inquiry is completed.

2.19 Sections 69 and 70 are also very important in determining the correct legal approach where the matter at issue has already been the subject of investigation. A Coroner may adjourn or postpone an inquiry where an investigation into a death is taking place under another enactment and either:

- The purposes of an inquiry under s 57(2)(a) to (e) will be satisfied under that inquiry; or
- Opening a coronial inquiry is likely to prejudice the existing investigation.

2.20 Section 70 provides for the circumstances when a Coroner may be justified in deciding not to open or resume a postponed or adjourned inquiry. Subsections (2) and (3) of s 70 provide:

> (2) A coroner may decide, or the chief coroner may direct the coroner, not to open or resume an inquiry to which subsection (1) applies.
>
> (3) Before making a decision or a direction under subsection (2), the coroner or the chief coroner (as applicable) must be satisfied that the matters specified in section 57(2)(a) to (e) have, in respect of the death concerned, been adequately established in the course of the relevant criminal proceedings or investigation.

2.21 Plainly this section does not squarely apply here, given that the inquiry in this case has definitely resumed. However, the policy of the section still applies insofar as the preliminary scope of hearing minute anticipates no inquiry being made into the matters already touched on by the Royal Commission.

2.22 Section 70(3) expressly anticipates that the Coroner must be satisfied that the purposes of inquiry under s 57(2)(a) to (e) have been "adequately

established" in the course of the separate proceedings at issue. We say that this statutory provision reflects the case law described in *Wallace*, to which counsel now turns.

3. RIGHTS-COMPLIANT INVESTIGATIONS UNDER *WALLACE*

3.1 As the Coroner is aware, Ellis J in the *Wallace* case examined whether any of the inquiries there met the requirement for a rights-based review mandated by s 8 of the New Zealand Bill of Rights Act 1990, being the right to life. In that case there was a Police investigation, trial through a private prosecution to verdict, coronial hearing and a IPCA investigation and report. All were ultimately found by Ellis J to have not been sufficient to meet the requirements of a rights-compliant investigation.

3.2 It is accepted that a rights-compliant investigation may take many forms and that this may be achieved by a combination of different rights compliant investigations – as long as they are procedurally effective in totality.[5]

3.3 To satisfy the requirements of s 8, the House of Lords has held that what is required is:[6]

> "… a full, thorough, independent and public investigation of the facts surrounding and leading to the death but not necessarily culminating in any decision on whether the state or any individual is responsible."

3.4 Following this authority, Ellis J held that the focus of the inquiry in determining compliance with s 8 is a consideration of the inquiry's:[7]

- Independence;
- Effectiveness;
- Accountability;
- Timeliness; and
- Family involvement.

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5 As noted by Ellis J in *Wallace* at [386] to [387].
6 *Middleton* at [30].
7 *Wallace* at [423].

3.5 Further, the inquiry should in all cases involve the next of kin to the extent necessary. In *Edwards*, the House of Lords found that only giving evidence and then waiting for a report was not sufficient to the extent necessary to safeguard their interest under the European equivalent to s 8.[8]

3.6 In *Amin*, the House of Lords also held that given the investigation was held in private, with no opportunity for the family to attend save when giving evidence themselves, and without power to obtain all relevant evidence, that no rights-compliant investigation had occurred.[9]

3.7 These principles have real resonance in the present circumstances. Here, the Coroner must review whether any earlier inquiry was tainted, inadequate or incomplete.

3.8 Here, for the reasons we describe below, the Royal Commission's investigation and the criminal process were both inadequate and incomplete.

3.9 Overall, as with *Wallace*, there is a clear need for accountability in particular.[10]

4. THE SCOPE OF THIS INQUIRY

4.1 Judge Marshall's minute dated 28 October 2021 sets out what is clearly only a provisional view for the assistance of the parties and to focus submission.

4.2 It is for the Coroner undertaking the inquiry, here into the circumstances of the death(s) (which is acknowledged to involve a very wide scope), to take responsibility for the inquiry and its scope. It is accepted that your Honour has accepted that duty and undertaken to exercise that discretion.

4.3 The Royal Commission and the Coroner maintain separate but concurrent jurisdictions. They are complimentary.

4.4 The Royal Commission's role is under the Inquiries Act 2013 and governed by the scope prescribed by the relevant Order in Council. The Coroner's

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8 *Edwards v UK* (2002) 35 EHRR 487 at [71].
9 *R v Secretary of State for the Home Department, ex parte Amin* [2004] 1 AC 653 (HL).
10 *Wallace* at [403].

role is under the Coroner's Act, with its own and quite separate but broad functions on behalf of the community.

4.5 Neither statute suggests that one is to be conducted at the expense of the other or should operate as a bar or limit on the others investigation except to the extent that the Coroners talk has already been undertaken to the standard required.

4.6 Certainly, the relevant Order in Council or the Government's announcement of the Royal Commission's investigation did not seek to preclude or limit any later or wider inquiry by the Coroner. It would have been quite wrong to do so and implicitly it can be expected that the Coroner would be left to perform the Courts own and important statutory function uninfluenced by government as a separate and independent judicial officer.

4.7 The Coroner's inquiry needs to be conducted in light of s 8 of the NZBORA, the "the right to life". The Royal Commission's investigation was not so governed. In fact, it was anticipated and required that important aspects of its work would be in camera and kept secret, albeit how that was managed was for the Commission. That approach is contrary to that required for a rights-based proceeding such as this.

4.8 It is only to the extent that such a rights-based inquiry has already been undertaken, that the Coroner may properly seek to limit the scope of its own inquiry.

4.9 Given the important engagement of NZBORA issues here, and the scale of the relevant event under investigation, and the need for reliable answers to the many questions posed, the Coroner should be very hesitant to limit the scope of its inquiry based on the Royal Commission's investigation and report.

4.10 The Royal Commission's work was extremely focused by its own scope, which is clearly set out in the Order in Council that gave it life.[11] That focus was on Mr Tarrant's activities before the events on 15 March 2019, the knowledge of state actors about him and his activities, additional measures that may have prevented the event, impediments to the sharing of

11 Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019 Order 2019.

information between state actors and any inappropriate focuses of state actors.

4.11 Further, the way the Royal Commission undertook its investigation is important in reaching this view. The Royal Commission operated in relative privacy so that the material it received was untested and then kept secret (clause 10(2), (3) and (4).). Its approach cannot be seen as a rights-based enquiry, even into the matters it was required to investigate and report on, let alone on any required and broader issues that the Coroner is required to inquire and report on.

4.12 The fact that there may be cross over or the Coroner may revisit some aspects that were looked at or reported on by the Royal Commission does not restrict the Coroner's work. More than one agency or judicial officer may investigate and report on the same event. A difference of view may only reflect the different nature of the inquiry, the evidence it was able to receive or the scrutiny under which it was placed.

4.13 The limited scope of the Commissioner's function and the way the Royal Commission chose to conduct its work both mean that the Coroner is not restricted by the Commissioner's investigation or report and or should be bound by its findings.

5. CRITICISMS OF THE ROYAL COMMISSION OF INQUIRY AND MR TARRANT'S INTENTION TO CORRECT ERRORS OF FACT

5.1 The Royal Commission excluded many interested parties. While such parties could have been made "core participants"[12] including the families and Mr Tarrant they were not. The most likely explanation for this was the speed such a report was called for and the need for secrecy given the defined and narrow scope. Also, as touched on above, because the Coroners open role was always anticipated.

5.2 While families or other relevant parties have been spoken to on a limited basis, it is hard to disagree with the concerns they raise about the absence of the provision of information or their ability to be engaged in the process.

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[12] Inquiries Act 2013, s 17.

5.3 The same applies to Mr Tarrant. One would have thought that any information from him may have been pivotal to its investigation and or its findings.

5.4 However he was spoken to once from 9am to 3pm (with an hour for lunch). Physical restrictions were cited within the report for this despite his acknowledged cooperation. He was not provided with any transcript of the interview, a draft report or the final report until 15 February 2022. The restriction of the report being provided to him was governed by the Department of Corrections, and not the Royal Commission or the Coroner.

5.5 Now that Mr Tarrant has the Commissioner's report he has identified many errors of fact upon which the recommendations have been made. Many of the same errors have been repeated by the parties heard in this hearing in their written and oral submissions.

5.6 Mr Tarrant has been prevented from having any opportunity to correct those errors. He will seek to do so now and if required seek to judicially review the Commission's approach to its work and the errors it has made.

5.7 While some may be critical of this position given his admitted role, it provides no advantage to our community if he does not take steps to correct these errors. The value of the report is diminished if it contains substantial errors as the exercise therefore fails to strengthen or to protect our community through its recommendations.

5.8 Further, the way the Royal Commission worked has failed to assist the families impacted as we have heard from all contributors on behalf of the families. They have not received all the material, like Mr Tarrant. Their engagement was limited, referred to as "contact". Accordingly, it is hard to find any criticism in their complaints and hence they feel left out and let down by a process that was meant to have and could have included them. Again, the same applies to Mr Tarrant.

5.9 The Royal Commission was effectively held in private. The only participation many parties had was a single meeting or perhaps meetings. So, for most parties, their only participation in the process was receiving the Report. That is insufficient to discharge the state's duty to conduct a rights-compliant inquiry.

5.10 Mr Tarrant has also been denied what we should expect for all key participants (given his involvement) as a matter of straight-forward and the quite ordinary observance of natural justice. There can be no excuse for this and any civilised community should be able to accept the credibility of such a complaint and the need that it be rectified.

5.11 Given the factual inaccuracies in the Royal Commission's report, as well as the procedural issues created in the way it conducted it's work in secret and to the exclusion of interested parties, the Coroner must not consider the scope of this inquiry should be limited by the Royal Commission's work.

6. THE PROSECUTION IN THIS CASE ALSO DID NOT DISCHARGE THE STATE'S DUTY TO CONDUCT A RIGHTS-COMPLIANT INQUIRY

6.1 Similarly, Mr Tarrant's prosecution in this case also did not discharge the state's duty to conduct a rights-compliant inquiry. Counsel notes the authorities cited in Ellis J's judgment in the *Wallace* case on this point.[13]

6.2 The House of Lords in *Middleton* commented that "an inquest is how [the] obligation is usually discharged noting that the only likely exceptions were 'where a criminal prosecution intervenes or a public inquiry is ordered".

6.3 However, Ellis J refers to and agrees with the categorisation of a homicide trial by Mr David Boldt in his article as "an imperfect vehicle for determining the 'circumstances of death'".[14]

6.4 The House of Lords in *Middleton* has commented that criminal proceedings may well fail to discharge the state's duty under s8 in such circumstances, as follows:[15]

> "It is unlikely to be so if the defendant's plea of guilty is accepted … or the issue at trial is the wider mental state of the defendant … because in such cases the wider issues will probably not be explored."

6.5 Further, the House of Lords has held that:

> "In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that *his* inquest is the means by

13 *Wallace* at [480] et seq.
14 D Boldt "The coroner as judge and jury" [2020] NZLJ 246.
15 *Middleton* at [30].

which the state will discharge its procedural investigative obligation under article 2."

6.6 Accordingly, the particular circumstances of the criminal prosecution must be examined. In this case, a trial didn't take place given Mr Tarrant's guilty plea.

6.7 Therefore there was no public hearing, where all interested parties could challenge the evidence or even be informed of it.

7. CONCLUSION

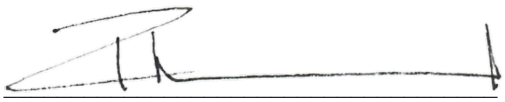
7.1 Given this background as described in the preceding two sections, it is clear that to date no rights-compliant investigation has yet occurred in this case.

7.2 That leaves to the Coroner that important statutory role that has not been restricted in scope by the prior investigation and prosecution or Commission's investigation and report.

7.3 The scope must necessarily be wide and the process inclusive and public.

7.4 Nothing less will satisfy the requirement for a rights-based inquiry into the deceased's right to life. Or, the right for all interested parties to natural justice, no matter their involvement or interest. Any record of the relevant events needs to be correct. No one is well served, if not.

Dated at Auckland this 24th day of February 2022



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