IN THE CORONER'S COURT
AT AUCKLAND
(IN-CHAMBERS)

I TE KŌTI KAITIROTIRO MATEWHAWHATI
KI TĀMAKI MAKAURAU
[I TE TARI]

CSU-2019-CCH-000165
CSU-2019-CCH-000166
CSU-2019-CCH-000167
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CSU-2019-CCH-000212
CSU-2019-CCH-000213
CSU-2019-CCH-000214
CSU-2019-CCH-000326

UNDER THE CORONERS ACT 2006

AND

IN THE MATTER OF An inquiry into the deaths of
Khaled Mwafak Alhaj-Mustafa
Mohammad Omar Faruk
Ansi Karippakulam Alibava
Mucaad Aden Ibrahim
Husna Ahmed
Syed Areeb Ahmed
Ramiz Arifbhai Vora
Muse Nur Awale
Hamza Khaled Alhaj-Mustafa
Muhammad Zeshan Raza
Karam Bibi
Ghulam Hussain
Linda Susan Armstrong
Musa Vali Suleman Patel
Mohamad Moosid Mohamedhosen
Mohammed Imran Khan
Ashraf El-Moursy Ragheb
Ali Mah'd Abdullah Elmadani
Matiullah Safi
Mounir Guirgis Soliman
Maheboob Allarakha Khokhar
Abdukadir Elmi
Syed Jahandad Ali
Kamel (Moh'd Kamal) Kamel Darwish
Ahmed Gamal Eldin Abdel-Ghany
Amjad Kasem Hamid
Zakaria Bhuiya
Abdelfattah Qasem
Ata Mohammad Ata Elayyan
Mohsen Mohammed Al-Harbi

Muhammad Haziq Bin Mohd-Tarmizi
Hussein Mohamed Khalil Moustafa
Arif Mohamedali Vohra
Hussein Al-Umari
Naeem Rashid
Talha Naeem
Muhammad Suhail Shahid
Ashraf Ali (Razak)
Haroon Mahmood
Lilik Abdul Hamid
Sayyad Ahmad Milne
Farhaj Ahsan
Muhammad Abdus Samad
Ashraf Ali
Junaid Ismail
MD **Mojammel Hoq**
Tariq Rashid Omar
Ozair Kadir
Osama Adnan Yousef Abukwaik
Haji Mohemmed Daoud Nabi
Zekeriya Tuyan

Date of Minute: 28 October 2021

MINUTE OF JUDGE MARSHALL RE SCOPE OF INQUIRY

Introduction

[1] An inquiry has now been opened, pursuant to s 59 of the Coroners Act 2006 (Coroners Act), into the deaths of each of the 51 people who died as a result of terrorist attacks carried out in Christchurch on 15 March 2019.

[2] Those with status as interested parties[1] were given until 9 September 2021 to make submissions on issues that could properly form the basis of a coronial inquiry, and any inquest that may form part of such an inquiry.

[3] The purpose of this Minute is to:

(a) set out the background context involving the criminal investigation and prosecution, and the Royal Commission of Inquiry;

[1] The term "interested party" is defined in s 9 of the Coroners Act 2006. To date, about 80 people/organisations have registered as interested parties.

(b) provide a collated summary of the submissions received (attached at **Appendix A)**;

(c) set out the framework of relevant statutory provisions, jurisprudence and extrinsic materials that informs my approach to determining the scope of the coronial inquiry;

(d) indicate my initial assessment of the submissions in light of that intended approach; and

(e) set out the next steps.

[4] This Minute is intended as a starting point in what I anticipate will be an iterative process to refine the scope of the coronial inquiry. Interested parties will have an opportunity to make further submissions on issues to be included within the scope of the inquiry. This will include a hearing to allow an opportunity for families and other interested parties to be heard on those submissions. The hearing will be conducted by Coroner Windley, following which she will issue a decision on the scope of the coronial inquiry.

[5] Whether a joint inquest[2] hearing is to be convened as part of the coronial inquiry, to hear and test evidence under oath in relation to any of the inquiry issues, will be considered and determined in due course. There will be a future opportunity for families and other interested parties to make submissions on whether a joint inquest hearing is needed as part of the coronial inquiry.

Background

[6] On 15 March 2019, a 29 year-old Australian citizen residing in New Zealand, referred to for the purposes of this Minute as "**the Individual**", drove from his home in Dunedin to Christchurch.

[7] The Individual went first to the Masjid An-Nur. In all, 44 people died as a result of the shooting at Masjid An-Nur. Two of those injured at the mosque on 15 March 2019 later died in hospital. After leaving the Masjid An-Nur, the Individual drove to the Linwood Islamic Centre. There he fired at people in and around the Islamic Centre. Seven people died at this location.

[8] The Individual was subsequently located and arrested by Police. A criminal investigation was undertaken and the Individual was prosecuted for 51 charges of murder under ss 167 and 172 of the Crimes Act 1961, 40 charges of attempted murder under s173 of the Crimes Act 1961, and one charge of engaging in a terrorist Act under s6A(1) of the Terrorism Suppression Act 2002.

[2] Pursuant to s 84 of the Coroners Act, a Coroner may decide to hold a single joint inquest where two or more separate inquiries are opened into two or more deaths arising out of the same incident or series of incidents.

[9] The Individual pleaded guilty to all charges. On 27 August 2020, the Individual was sentenced to life imprisonment without parole on the 51 charges of murder. He was sentenced to concurrent terms of 12 years imprisonment on the charges of attempted murder, and to life imprisonment on the charge of committing a terrorist act.

[10] The families and friends of the deceased have been deeply affected by the deaths and the nature of the deaths. Many other people were injured as a result of the Individual's actions. Of the injured, many have suffered life-changing physical and mental injuries.

Royal Commission of Inquiry

[11] On 8 April 2019 a Royal Commission of Inquiry into the Terrorist Attack on Christchurch Mosques on 15 March 2019 (the **RCOI**) was established by the Government.[3] At that time, and for much of the period during which the RCOI undertook its inquiry, the Individual was awaiting trial. On 2 December 2020 the RCOI made public its report titled *Ko tō tātou kāinga tēnei Report of the Royal Commission of Inquiry into the terrorist attack on Christchurch masjidain on 15 March 2019* (**RCOI Report**).

[12] The RCOI's Terms of Reference were wide-ranging and directed that it inquire into:[4]

> (a) the individual's activities before the terrorist attack, including—
>
> (i) relevant information from his time in Australia; and
>
> (ii) his arrival and residence in New Zealand; and
>
> (iii) his travel within New Zealand, and internationally; and
>
> (iv) how he obtained a gun licence, weapons, and ammunition; and
>
> (v) his use of social media and other online media; and
>
> (vi) his connections with others, whether in New Zealand or internationally; and
>
> (b) what relevant State sector agencies knew about this individual and his activities before the terrorist attack, what actions (if any) they took in light of that knowledge, and whether there were any additional measures that the agencies could have taken to prevent the terrorist attack; and

[3] Royal Commission of Inquiry into the Attack on Christchurch Mosques on 15 March 2019 Order 2019.

[4] Schedule to the Order in Council. See also William Young and Jacqui Caine *Ko tō tātou kāinga tēnei* Report of the *Royal Commission of Inquiry into the terrorist attack on Christchurch masjidain on 15 March 2019* (December 2020), Part 1, Chapter 3 ["RCOI Report"].

(c) whether there were any impediments to relevant State sector agencies gathering or sharing information relevant to the terrorist attack, or acting on such information, including legislative impediments; and

(d) whether there was any inappropriate concentration of, or priority setting for, counter-terrorism resources by relevant State sector agencies prior to the terrorist attack.

[13] Notably, the RCOI's Terms of Reference permitted the RCOI, in exercising its powers and performing its duties, to make findings of fault or recommendations that further steps be taken to determine liability. The Terms of Reference precluded the RCOI from making findings in respect of any person of civil, criminal or disciplinary liability, guilt or innocence, and specifically directed that the following matters were outside its inquiry scope:

(a) amendments to firearms legislation (because the Government is separately pursuing this issue):

(b) activity by entities or organisations outside the State sector, such as media platforms:

(c) how relevant State sector agencies responded to the attack on 15 March 2019, once it had begun.

[14] The RCOI's Terms of Reference further required that it report its findings on:

(a) Whether there was any information provided or otherwise available to relevant [Public] sector agencies that could or should have alerted them to the terrorist attack and, if such information was provided or otherwise available, how the agencies responded to any such information, and whether that response was appropriate; and

(b) The interaction between relevant [Public] sector agencies, including whether there was any failure in information sharing between the relevant agencies; and

(c) Whether any relevant [Public] sector agency failed to anticipate or plan for the terrorist attack due to an inappropriate concentration of counter-terrorism resources or priorities on other terrorism threats; and

(d) Whether any relevant [Public] sector agency failed to meet required standards or was otherwise at fault, whether in whole or in part; and

(e) Any other matters relevant to the purpose of the inquiry, to the extent necessary to provide a complete report.

[15] The principles of inquiry set out in the RCOI Terms of Reference acknowledged that matters under the RCOI's investigation gave rise to certain sensitivities specifically in relation to operational practices of relevant State sector agencies (including intelligence and security agencies). The strong public interest in those

practices remaining confidential is made clear in the Terms of Reference. In recognising such, the principles of inquiry required that where it was considered necessary to preserve such confidentiality, the inquiry must be held, in whole or in part, in private. In addition, the RCOI was required to restrict access to inquiry information where it considered it necessary to do so for reasons including protecting New Zealand's security or defence interests, protecting the identity of witnesses or other persons, avoiding prejudice to the maintenance of the law, and ensuring protection of fair trial rights. The RCOI was expressly prohibited from reporting information with a sensitive security classification.

[16] The RCOI's Terms of Reference also expressly recognised the need to report on the matters under inquiry urgently to reassure the New Zealand public, including its Muslim communities, that all appropriate measures are being taken by relevant State sector agencies to ensure their safety and protection. A stated expectation was that the RCOI connect with the Muslim communities on the matters under inquiry, and consider evidence of relevant agency officers and employees, and of other relevant persons, including members of the Muslim communities.

[17] The RCOI's reported approach was to conduct its inquiry process in private, while at the same time recognising that limiting public participation meant it needed to provide transparency in other ways. The approach to balancing these competing imperatives was explained in some detail in the RCOI Report as follows:[5]

> The matters that we were investigating directly concerned the operational practices of Public sector agencies, including the methods used by the intelligence and security agencies to gather information. Our Terms of Reference required us to ensure that information we received from relevant Public sector agencies remained confidential, where this was necessary, to protect public safety and the security and defence interests of New Zealand, a requirement that extended to information supplied in confidence from international partners.
>
> We ensured that current and former Public sector employees and contractors (including those who worked for the intelligence and security agencies) could contact us confidentially. We were concerned that, without these arrangements, some may have been deterred from providing us with information for fear of repercussions in their current or future roles within the Public sector.
>
> At the same time, we were aware of the significant public interest in our proceedings. Our report had to provide reassurance to the New Zealand public, particularly New Zealand's Muslim communities, that all appropriate measures are being taken to ensure their safety and protection. Connecting with the public was a necessary part of providing this reassurance.

[5] RCOI Report at Part 1, Chapter 4.1, [1]–[7].

> After careful consideration, we reached the view that our Terms of Reference practically required our process to be conducted in private. They directed us to ensure that sensitive information was protected, the operational tradecraft of intelligence and security agencies remained confidential and the fair trial rights of the individual were preserved. As well, we wanted to protect the privacy of affected whānau, survivors and witnesses of the terrorist attack, and to respect the wishes of some people who would have been concerned about possible repercussions if their names or comments became public. A private process meant that we could address those concerns.
>
> We took steps to achieve a reasonable measure of transparency and, in this way, provide reassurance to the New Zealand public. For example, we undertook broad-based engagement through meetings with New Zealand communities, including Muslim communities, and provided regular updates on progress through the Royal Commission's website. In respect of our updates, we published the names of most people we interviewed, procedural minutes, meeting notes from the Muslim Community Reference Group and outlined each stage of our inquiry as we progressed.
>
> In relation to gathering information and evidence, we adopted an iterative and inquisitorial process including:
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> (i) engaging with affected whānau, survivors and witnesses;
>
> (ii) meeting with Muslim communities;
>
> (iii) meeting with ethnic and religious communities and interest groups;
>
> (iv) receiving submissions;
>
> (v) requesting evidence from Public sector agencies;
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> (vi) meeting with local authorities;
>
> (vii) meeting with the integrity agencies;
>
> (viii) requesting information from businesses;
>
> (ix) interviewing Public sector employees, including chief executives of the named Public sector agencies, under oath or affirmation;
>
> (x) seeking information from relevant Australian organisations;
>
> (xi) meeting with and consulting experts;
>
> (xii) interviewing former and current ministers of the Crown; and
>
> (xiii) interviewing the individual.

[18] The RCOI's Terms of Reference also required that it make such recommendations as it considered to be appropriate in relation to the following:

(a) whether there is any improvement to information gathering, sharing, and analysis practices by relevant State sector agencies that could have prevented the terrorist attack, or could prevent such terrorist attacks in the future, including, but not limited to, the timeliness, adequacy, effectiveness, and co-ordination of information disclosure, sharing, or matching between relevant State sector agencies; and

(b) what changes, if any, should be implemented to improve relevant State sector agency systems, or operational practices, to ensure the prevention of such terrorist attacks in the future; and

(c) any other matters relevant to the above, to the extent necessary to provide a complete report.

[19] A summary of the RCOI's recommendations, and reported actions taken to date in response to those recommendations is attached as **Appendix B**.

Coroners Act 2006 statutory framework

Decision to open an inquiry

[20] The Coroners Act provides the legislative footing for the coronial jurisdiction and the role, duties and powers of a Coroner in relation to a death. A Coroner's role includes deciding whether to open an inquiry and, if one is to be conducted, whether an inquest should be held as part of that inquiry.[6] A Coroner's jurisdiction to inquire into a death is conferred by s 59 of the Coroners Act, limited only by s 59A. The limited purposes for which a coronial inquiry is conducted is provided for under s 57 of the Coroners Act as follows:

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)

(4) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and

[6] Coroners Act, s 4(1)e

> to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

[21] Plainly Coroners do not have an exclusive interest in death investigation; the third purpose provided under s 57(4) acknowledges in some cases the public interest will be best served by an investigation undertaken by another investigating authority. Of particular note is that "other investigating authority" is defined under s 9 to include both the New Zealand Police and a Royal Commission of Inquiry. Efforts geared toward avoiding unnecessary duplication in investigations into deaths with other investigating authorities are amongst the stated functions of the Chief Coroner under s 7(2)(d).[7]

[22] The decision whether to open and conduct an inquiry, for one or more of the purposes provided for in s 57, requires that the Coroner also have regard to the range of considerations set out under s 63 as follows:

> **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.

[23] Not every death over which jurisdiction is taken will necessitate a coronial inquiry being opened and conducted. The statutory regime makes additional provision for specific categories of cases. In some cases, the suspected self-inflicted nature of the death, or the legal status of the deceased, will require that an inquiry must be opened.[8]

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[7] The Chief Coroner's statutory functions include under s 7(2)(d) of the Coroners Act to "help to avoid unnecessary duplication in investigations into deaths by liaising, and encouraging co-ordination…with other investigation authorities, official bodies, and statutory officers".
[8] Section 60.

[24] In other cases, including the deaths of the 51 Shaheed, a person will have been (or may be) charged with a criminal offence relating to the death or its circumstances. If the Coroner is satisfied that to open (or proceed with) an inquiry might prejudice that person, s 68 provides that a Coroner may either postpone opening an inquiry, open and then adjourn an inquiry, or adjourn an inquiry if one has already been opened.

[25] Similarly, in some cases an investigation into the death or the circumstances in which it occurred may be (or likely to be) conducted under another enactment. If the Coroner is satisfied that investigation is likely to establish the cause and circumstances of the death, or that opening or continuing with a coronial inquiry would likely prejudice that other investigation, then s 69 provides that a Coroner may either postpone opening an inquiry, or adjourn an inquiry already opened.

[26] Whether, pursuant to ss 68 or 69 a decision to open an inquiry has been postponed, or whether an inquiry has been opened and adjourned, where the criminal proceedings do not eventuate or have been finally concluded, or an investigation by another investigating authority is completed, the Coroner must then return to the decision of whether to open (or resume) a coronial inquiry. Whether or not the Coroner is satisfied that the cause and circumstances of the death have been "adequately established" (to the standard of proof applicable in the coronial jurisdiction) in the course of that criminal proceeding or other investigation is central to that decision.[9]

Scope of coronial inquiry

[27] As I make reference to above, when making decisions about proceeding with an inquiry the statutory scheme, in particular ss 69(3) and 70, clearly anticipates that a Coroner may take account of other investigations that have been undertaken. Most often another investigating agency is likely to have a particular investigative focus which will not necessarily deliver complete answers to all s 57(2) matters upon which a Coroner must make findings. Even so, a Coroner may be appropriately satisfied that certain of the s 57(2) matters have been "adequately established", and that no further inquiry into those specific aspects is therefore required in the coronial jurisdiction. It follows that a Coroner may therefore define the scope of the coronial inquiry to reflect only those residual matters which were either not under investigation by another agency or have not been adequately established to the Coroner's satisfaction.

[28] In making the decision to open an inquiry into each of these 51 deaths I am acutely mindful of the extent to which the criminal investigation and prosecution, and the RCOI, have been relevantly engaged in determinations involving the cause and circumstances (both immediate and wider) of each of

[9] Section 70.

these deaths. As I have made reference to earlier, the RCOI has also made a number of recommendations with an eye to preventing future deaths in similar circumstances.

[29] Nonetheless, my review of the submissions received from interested parties reveal some aspects of the circumstances of the deaths of the 51 Shaheed that do not appear to have been adequately established, at least at this point in time, and are within the parameters of the coronial jurisdiction to inquire into.

[30] Having opened an inquiry into each of the 51 deaths (collectively, **the Inquiry**), it is necessary to undertake a closer assessment of the appropriate scope or parameters of that Inquiry, which will lead, in due course, to consideration being given to whether a joint inquest hearing also forms part of the Inquiry.

Approach to Defining the Scope of the Coronial Inquiry

[31] In approaching the decision as to the scope of the Inquiry, I set out below the relevant provisions and jurisprudence that I consider provides the relevant framework to properly inform my decision on scope.

The s 57 purposes of an inquiry

[32] I return first to s 57 and the purposes of a coronial inquiry. The first purpose includes establishing, so far as possible, the circumstances of the death. No statutory definition is provided to aid in defining the parameters of an inquiry in pursuit of this purpose.

[33] The second purpose, established under s 57(2), and further provided for under s 57A of the Coroners Act, is to make recommendations or comments for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Section 57A(3) requires that recommendations or comments must be clearly linked to the factors that contributed to the death.

[34] Section 57(2)(e) requires me to explore the circumstances of each death. Plainly not every matter that forms a circumstance of every death will be amenable to a comment or recommendation of the kind provided for under s 57A. A coronial inquiry may therefore properly explore matters which, while a circumstance of death, will not be matters in respect of which a comment or recommendation can ultimately be made to reduce the chances of future deaths. In that sense, I do not consider s 57A operates to constrain the scope of a coronial inquiry into the circumstances of death to just those matters for which comments or recommendations can potentially be made.

[35] The Coroners Act, and the stated purposes of a coronial inquiry, reflects a deliberately wider context of death investigation than exists in some other common law coronial jurisdictions. In its report on Coroners, the New Zealand Law Commission considered that coronial inquiries should not be "*limited to matters of mere formality but should be of social and statistical significance in a modern community*".[10] That does not mean that a coronial inquiry into the circumstances of a death is implicitly open-ended and entirely unfettered.

Coroner's broad discretion

[36] While s 57 provides the statutory parameters of an inquiry by reference to the purposes sought to be achieved, as well as those expressly excluded, in making a decision on scope within those parameters, it is well established that a Coroner has a broad discretion.

[37] While concerned with the 1988 predecessor to the Coroners Act, Randerson J in the High Court decision of *Abbott v Coroners Court of New Plymouth*, stated:[11]

> There is nothing in the language of s 28(6) or any other parts of the Act to suggest that the Coroner does not have a discretion to limit the scope of the inquest so long as he complies with the Act. It is not for the parties to an inquest to determine the scope of the inquiry. The nature of the inquiry is prescribed by the Act and it is well established that an inquest is a fact finding exercise, not a method of apportioning guilt.

[38] This is consistent with other jurisdictions. The Court of Appeal for England and Wales in *Coroner for the Birmingham Inquests (1974) v Hambleton* observed:[12]

> A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory function to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of the evidence adduced, is for the coroner.

[39] The Court further cautioned that the scope of an inquest is also not determined by looking at the broad-based circumstances of what occurred and requiring all matters touching those matters to be explored.[13] Ordinarily the matters to be explored will have some anticipated causal nexus with the death.

[40] Issues of causation and remoteness are key considerations in determining the scope of a coronial inquiry. United Kingdom and Australian authorities provide some guidance. In Australia, Nathan J in the Victoria Supreme Court for

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[10] Law Commission *Coroners* (NZLC R62,2000) at 3.
[11] *Abbott v Coroners Court of New Plymouth* HC New Plymouth CIV 2004-443-660, 20 April 2005 at [25].
[12] *Coroner for the Birmingham Inquests (1974) v Hambleton* [2018] EWCA Civ 2081, [2019] 1 WLR 3417 at [48].
[13] At [51].

example discussed the scope of inquiry in relation to deaths in a prison fire and held:[14]

> The enquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of "remoteness". Of course the prisoners would not have died if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. … such an inquest would never end, but worse it could never arrive at the coherent, let alone concise findings required by the Act, which are the causes of death etc. Such discursive investigations are not envisaged or empowered by the Act. They are not within jurisdictional power.

[41] In *Re Doogan* the ACT Supreme Court undertook a judicial review of the Coroner's decision to hold an inquiry into deaths from bush fires, and similarly observed that while many factors may have contributed to the development of the fire:[15]

> Each of these questions could, of course, lead to yet others and, ultimately to a virtually infinite chain of causation. Yet the scope for judicial inquiry pursuant to s18(1) must be limited. Whilst none of these suggested issues could be said to be irrelevant, they are somewhat remote from the concept of the cause and origin of the fire, and any adequate investigation of them would involve not only substantial time and expense, but also delving into areas of public policy that are properly the prerogative of an elected government rather than a coroner, or indeed, any other judicial officer.
>
> Section 18(1) does not authorise a coroner to conduct a wide-ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between some act, omission or circumstance and the cause or non-mitigation of the fire. …
>
> A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be determined not by the application of some concrete riule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in *March v E & MH Stramore Pty Ltd (1991) 171 CLR 506*. …

[42] In the United Kingdom a Coroner's inquiry has, in most cases, a more limited mandate. A Coroner is required to establish, amongst other matters, "how, when and where the deceased came by his or her death". The "how" typically being a *"limited question directed to the means by which the deceased came by his death"* rather than ascertaining how the deceased died *"which might raise general and far-reaching issues".* Since 2004, and as reflected in the current Coroners and Justice Act 2009, the "how" has been extended to require a determination of *"by what means and in what circumstances"* where a breach of

[14] *Harmsworth v State Coroner* [1989] VR 989 (VSC) at 995–996.

a State duty is indicated in the death. The requirement for a "rights-compliant" investigation in such circumstances is discussed in further detail below.

[43] In addressing issues of causation and remoteness in *R v West Inner London Coroner, ex parte Dallaglio*, Sir Thomas Bingham MR found:[16]

> It is for the coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form proper part of his investigation. That question, potentially a very difficult question, is for him. If these inquests were to be resumed and I emphasis if, the question would have to be answered by the new coroner, exercising his judgment as best he can and all the information available in the knowledge that, wherever he drew the line, his ruling would be unwelcome to some. It is, however, clear, as was accepted by counsel for the applicants in argument, that the treatment of the bodies of the deceased after death could not form part of a properly conducted inquest.

[44] In a 2010 inquest into the deaths of 52 people who died as a result of London suicide bombings on 7 July 2005, Lady Justice Hallett rejected the application of a bus company to be considered an interested party on the basis that the actions of the bus driver (in letting one of the suicide bombers board the bus prior to the attack) were within the scope of the inquiry. Her Honour held:[17]

> The bus driver's "action of allowing Hussain to board the bus" is, in my judgment, too remote in the chain of causation to be properly and purposively construed as an act or omission that "caused or contributed to the deaths" of the deceased.

[45] In July 2020 guidance issued by Judge Teague, the Chief Coroner of England and Wales, on COVID-19 deaths and the workplace, His Honour cautioned the bench against using the forum of a coronial inquest to address concerns about high-level government or public policy, particularly where such concerns are causally-remote from the death under inquiry. The Guidance sets out the following:[18]

> There have been a number of indications in the judgments of the higher courts that a coroner's inquest is not usually the right forum for addressing concerns about high-level government or public policy, which may be causally remote from the particular death. See for example *Scholes v SSHD* [2006] HRLR 44 at [69]; *R (Smith) v Oxfordshire Asst. Deputy Coroner* [2011] 1 AC 1 at [81] (Lord Phillips) and [127] (Lord Rodger). In the latter case, Lord Phillips observed that an inquest could properly consider whether a soldier had died because a flak jacket had been pierced by a sniper's bullet but would not "be a

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[15] *R v Coroner Doogan, ex parte Lucas-Smith* [2005] ACTSC 74, (2005) 193 FLR 239 at [27]–[29]. The Coroners Act 1997 (ACT) allows a Coroner to inquire into the circumstances of a fire.
[16] *R v Inner West London Coroner ex parte Dallaglio* [1994] 4 All ER 139 (CA) at 164.
[17] *Coroner's Inquests into the London Bombings of 7 July 2005*, 21 May 2010 (Decision following pre-inquest hearing from 26 to 30 April 2010) at [106] and [117] ["London Bombing Inquest"].
[18] Office of the Chief Coroner "Guidance No 37 COVID-19 deaths and possible exposure in the workplace" (1 July 2020) <www.judiciary.uk> at [16]–[17].

> satisfactory tribunal for investigating whether more effective flak jackets could and should have been supplied by the Ministry of Defence." However, it is repeated that the scope of inquiry is a matter for the judgment of coroners, not for hard and fast rules.
>
> When handling inquests in which questions such as the adequacy of personal protective equipment (PPE) for staff are raised, coroners are reminded that the focus of their investigation should be on the cause(s) and circumstance(s) of the death in question. Coroners are entitled to look into any underlying causes of death, including failures of systems or procedures at any level, but the investigation should remain an inquiry about the particular death.

Deaths implicating State actors in arguable breaches of protected human rights

[46] As noted earlier, where a coronial inquiry follows a Police investigation and criminal prosecution, a Coroner's decision on scope will need to carefully factor the extent to which the cause and circumstances of death have been adequately established in the course of the investigation and proceedings.

[47] Lord Lane CJ in *R v South London Coroner, ex parte Thompson* identified the fundamental differences between an inquest and criminal trial as follows:[19]

> Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial
>
> ...
>
> The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires.

[48] The High Court decision in *Abbott* reaffirmed the Coroner's discretion in determining the scope of the coronial inquiry in such cases. Following the acquittal of the Police officer who shot Mr Wallace and had defended the murder charge brought by way of a private prosecution on the basis of a self-defence justification, the Coroner sought to rely on the criminal proceedings as a proper basis upon which to resume the coronial inquiry, but with a narrow scope in relation to the circumstances of Mr Abbott's death. Randerson J held:[20]

> … the Coroner was obliged to resume the inquest… for the purpose of establishing any remaining issues about the circumstances of the death [but has] a discretion under [the predecessor of s 70] to confine the inquest to those aspects of the circumstances of the death which he does

[19] *R v South London Coroner, Ex P Thompson* QB DC/277/81, 8 July 1982 per Lord Lane CJ.
[20] *R v Abbott*, above n 11, at [24].

> not consider to have been adequately established in criminal proceedings.

[49] Death directly at the hands of Police will plainly involve additional public interest considerations that will factor into the Coroner's decision on scope. However, further considerations also arise where any 'State actor' is implicated in a death, either by way of action or inaction, in so far as the state is obligated to undertake a "rights-compliant" investigation, and a coronial inquiry is a means by which to satisfy that obligation.

[50] The recent High Court decision of Ellis J in *Wallace v Attorney-General* involved further proceedings brought in relation to the death of Mr Wallace at the hands of a Police officer.[21] Following the acquittal of the Police officer, Mr Wallace's family brought proceedings against the crown for a breach of Mr Wallace's right to life, as affirmed and protected under s 8 of the New Zealand Bill of Rights Act 1990 (**NZBORA**).

[51] NZBORA affirms New Zealand's commitment to the International Covenant on Civil and Political Rights (the **ICCPR**), with s 8 of NZBORA giving domestic effect to the right to life expressed under Article 6 of the ICCPR.

[52] Ellis J observed that the prohibition on depriving others of life would be *"…toothless without a parallel obligation to interrogate and test the circumstances in which such a deprivation has occurred in the individual case"*. Indeed, the ICCPR *"… as an instrument for the protection of individual human beings requires that its provisions be interpreted and applied in a manner that makes its safeguards practical and effective."* On that basis, Ellis J found s 8 of NZBORA not only permits, but in fact requires, the inclusion of an obligation to investigate a death that has occurred at the hands of a State actor.[22]

[53] The various inquiries into Mr Wallace's death had included a Police homicide investigation, an internal Police review which resulted in a decision not to prosecute the officer (supported by the Solicitor-General), a Police Complaints Authority investigation, a depositions investigation (JP decision), and a Coroner's inquiry and Finding. Ellis J found that satisfaction of the State's obligation to investigate does not require any particular kind of investigation but drew on *Jordan v United Kingdom* as the guiding authority for the following features as requirements of a "rights-compliant" investigation:[23]

(a) Be independent

(b) Be effective

(c) Be timely

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[21] *Wallace v Attorney-General* [2021] NZHC 1963.
[22] At [382]–[384].
[23] At [388], citing *Jordan v United Kingdom* [2001] ECHR 327 at [103].

(d) Be conducted in public; and

(e) Provide an opportunity for the family of the deceased to be involved.

[54] While in the particular circumstances of *Wallace* the Police homicide investigation and internal investigation could never have been independent in the sense required to be "rights-compliant", Ellis J also found that neither the IPCA investigation (which was not completed) or the coronial inquiry satisfied the State's investigation obligation.

[55] Notably, Ellis J considered that typically a criminal trial could be sufficient to discharge the State's investigative obligations under s 8 of the NZBORA. But the prosecution in *Wallace* had been brought privately, not by the State, and along with the resulting acquittal, did not satisfy the State's obligation to investigate whether Mr Wallace had been unjustifiably deprived of life in breach of s 8 of the NZBORA. That investigative burden then fell to the Coroner in the context of inquiring into factual matters which disclosed the circumstances of Mr Wallace's death. Ellis J considered a coronial inquiry to be *"the most apt, and rights compliant, investigative forum in a case of this kind."*[24] In the coronial inquiry proceeding on the basis that the criminal prosecution and verdict constituted a positive finding that the Police officer had killed Mr Wallace in self-defence, Ellis J found there had been no "rights-compliant" investigation by the State, as s 8 required.

[56] The s 8 obligation for a "rights-compliant" investigation is not confined to cases where death is directly and immediately at the hands of the State, such as in Police shootings. Deaths resulting from a breach of the State's protective duties also engage an obligation for a "rights-compliant" investigation.

[57] On assessing issues of causation and remoteness in cases involving alleged failures in the State's protective duties, and specifically any obligation related to planning and control, Ellis J identified that the causal link required is between the relevant act or omission by the State, and the risk to (but not the actual deprivation of) life. In rejecting a requirement for causation in the tortious sense (i.e. involving a material lack of care) Ellis J expressed support for causation requiring that the State actor, knowing of a real and identifiable risk to the life of an individual, failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid the risk. The question to ask being: *"what would a reasonable state actor in the particular circumstances do to protect the relevant right?"*.[25]

[58] The House of Lords in *R (Middleton) v West Somerset Coroner* extended the United Kingdom's ambit of the coronial inquiry into "how" the deceased died for cases in which an investigation is required by Article 2 (right to life) of the

[24] At [481].
[25] At [542]–[546].

European Convention on Human Rights (**ECHR**).[26] In that case no lethal force had been used by a State actor resulting in the death of the deceased. Rather the Court recognised the obligation under the ECHR to investigate the possibility that systemic failures of public authorities contributed to the death. The Court observed:[27]

> …while the use of lethal force by agents of the state must always be a matter of the greatest seriousness, a systemic failure to protect human life may call for an investigation which may be no less important and perhaps even more complex…it would not promote the objects of the Convention if domestic law were to distinguish between cases where an agent of the state may have used lethal force without justification and cases in which a defective system operated by that state may have failed to afford adequate protection to human life.

[59] Similar to Ellis J in *Wallace*, the House of Lords in *Middleton* further found that a State may discharge its procedural obligation to investigate in a number of ways, including an intervening criminal prosecution, or a public inquiry into a major incident, usually involving multiple fatalities.[28] The Court observed that the State's obligation is most likely to be met when the defendant defends the charge and the trial involves a full exploration of the facts surrounding the death.[29]

[60] The *Osman v The United Kingdom* proceedings heard by the European Court of Human Rights involved the deaths of a student and their father by a teacher in the wake of the teacher's campaign of harassment directed at two students.[30] Proceedings were brought alleging Police failure to protect the lives of the two deceased. The Court was clear that Article 2 of the ECHR may imply a positive obligation on the authorities of a Contracting State to take preventative measures to protect the life of an individual from the danger of another individual.[31]

[61] In looking more specifically at the protective duties of a State actor in relation to acts of terrorism causing death, and whether s 8 (or other NZBORA rights) is engaged to require a "rights-compliant" investigation with the features set out above, the following United Kingdom authorities provide some additional guidance.

[62] In deciding the scope of the inquest into the London suicide bombings on 7 July 2005, Lady Justice Hallett rejected arguments that the need for an investigation arose because the State was responsible for the deaths of the victims. Her

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[26] *R (Middleton) v West Somerset Coroner* [2004] UKHL 10, [2004] 2 AC 182.
[27] At [19].
[28] At [20].
[29] At [30]. See also *Osman v The United Kingdom* [1998] ECHR 101 at [67] where the accused pleaded guilty so the matter was considered by the European Commission of Human Rights to establish the facts and make findings.
[30] *Osman v The United Kingdom* [1998] ECHR 101.
[31] At [107].

Honour held the victims were not *"under the 'complete control' of the state or in an especially dangerous position"*; she considered that for there to be an arguable breach of Article 2 of ECHR, there needs to be:[32]

> The knowledge or deemed knowledge on the part of the State of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and a failure to take reasonable measures within the scope of its powers to avoid that risk.

[63] By factual contrast, the inquest into the deaths of 11 people at the hands of three attackers in the 3 July 2017 London Bridge terror attack involved circumstances in which the three attackers were shot by Police, and one of the attackers had been under active monitoring by MI5 prior to the attack. In addressing the State's obligation to investigate under Article 2, Jude Lucraft QC, the Chief Coroner of England and Wales, considered the fact that one of the attackers was under active monitoring and was a known terrorist threat meant there was an arguable breach of Article 2 in relation to that aspect.[33] However, in addressing whether the lack of protective barriers on London Bridge also amounted to an arguable breach of Article 2, His Honour concluded that there was no authority "*which should have appreciated a real and immediate risk to life and taken reasonable action within its powers which could realistically have averted the risk.*"[34]

Preventability and survivability issues

[64] Whether there were potential opportunities to take action, take alternative action, or refrain from taking action, that may have disrupted the causal chain and changed or improved the outcome for the deceased are properly matters which a Coroner must consider when determining scope. Most often such assessments will necessarily involve some degree of speculation.

[65] In her decision as to scope in the inquiry into the London suicide bombings on 7 July 2005, Lady Justice Hallett agreed the "preventability issue", namely whether there was anything the intelligence services could reasonably have done to prevent the bombings, and the emergency response related to the bombings, were within the range of matters that she could potentially consider. Her Honour noted that there were two redacted reports to the Intelligence and Security Committee of Parliament (ISC) in the public domain. Despite these reports, the families of the deceased and survivors of the attacks still had questions about why the suicide bombers (who were known to MI5) were not put under

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[32] London Bombing Inquest, above n 17 at [116].
[33] *Inquests arising from the deaths in the London Bridge and Borough Market terror attack on 3 June 2017*, August 2019 at [67].
[34] At [88].

surveillance, and whether this would have prevented the attacks from occurring.[35]

[66] It is important to note that in this case there had been no public inquiry into this incident in the nature of a Royal Commission of Inquiry with a mandate to inquire into such issues. In the exercise of her broad discretion to decide the scope of the inquiry Her Honour had no doubt some sort of independent inquiry conducted in public and involving the families was required on issues that went beyond the immediate aftermath of the incident. She observed that this would help put minds at rest, confirm or allow the rumour and suspicion generated by "conspiracy theorists", and most importantly, answer those questions of the families' that could be answered.[36]

Proposed scope of the Inquiry

Key considerations

[67] Having regard to the framework I have set out above, I distil the following key considerations in guiding my assessment of each of the submissions I have currently received on matters for inquiry:

(a) Is the issue relevant to the cause or circumstances of a death under inquiry?

(b) Is the issue too remote from the death(s) to be regarded as sufficiently causative?

(c) Does the issue raise concerns about high-level government or public policy which may be too remote from the death(s) or is otherwise not amenable to reasonable inquiry in the forum of a coronial inquiry and inquest?

(d) Does the issue lend itself to potential comments or recommendations to reduce the chances of future deaths in similar circumstances?

(e) Was the issue within the mandate of another inquiry, proceeding or investigation to inquire into and make findings on? If so, did that other independent inquiry, proceeding or investigation adequately establish any of the matters required to be established (so far as possible) by a Coroner under s57(2)?

(f) Is the issue the subject of a recommendation that has been made by the RCOI?

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[35] London Bombing Inquest, above n 17 at [104]–[112]
[36] At [70] and [111].

(g) Is the issue otherwise addressed by legislative reform in the intervening period?

Issues proposed to be treated as within scope

[68] A large group of submissions focussed on the emergency first response to provide medical aid to victims and the survivability of those who died. Specific issues raised are set out in **Appendix A**, issues 19-26 and 28-30.

[69] Subject to further written and oral submissions that may be received or made on scope, my provisional view is that issues related to first response and survivability of those who died have not been the subject of an independent inquiry (and were expressly excluded from the RCOI's Terms of Reference). Accordingly, I propose to treat such issues as being within the scope of the Inquiry.

Issues proposed to be dealt with in the nature of an information request response

[70] I also anticipate a number of issues raised in submissions may be able to be dealt with by direct contact between my office and the individual submitter and/or their counsel. This is because the issue raised appears to be in the nature of an information request and may be able to be dealt with by the provision of evidence already gathered during the police investigation (such as the provision of CCTV footage, timelines, forensic evidence, statements), or by provision of additional expert evidence.

[71] Accordingly, I have asked Police to gather evidence about the issues and to provide that evidence direct to the relevant submitter. Such evidence (subject to privacy considerations) may also be published on the dedicated Inquiry website to facilitate wider public access. This approach accords with that adopted by Lady Justice Hallett in the London suicide bombings inquiry.[37]

[72] I therefore propose to address issues 11–18, 27, 31, 33–43, and 55 at least in the first instance, by way of this approach. In the event this approach does not adequately address the specific concerns raised, I will revisit whether to include such issues within the scope of the Inquiry going forward.

Issues proposed to be treated as outside scope

[73] Subject to further written and oral submissions that may be received or made on scope, my provisional view is that issues 2–10, 32, 44–54, and 56 are not within scope as they are not relevant to the cause and circumstance of the deaths under inquiry. This category includes issues raised about the cultural response of coroners and the communication with families after the deaths. While these are

[37] At [38] and [39].

important issues, they do not assist me with establishing the cause and circumstances of the deaths and whether any recommendations or comments could be made to prevent similar deaths occurring in the future. This reflects the parameters of my jurisdiction, not an exercise of my discretion.

[74] As has been foreshadowed, the fact that the Inquiry follows an extensive Police criminal investigation, a successful prosecution, and the RCOI must sensibly bear on the exercise of my discretion as to scope and my view as to what is necessary, desirable and proportionate.

[75] The RCOI has undertaken a wide-ranging inquiry in keeping with its Terms of Reference. The matters which the RCOI was required to inquire into plainly include matters which might ordinarily be relevant circumstances of death and fall to a Coroner to inquire into. In particular, the RCOI had a clear mandate to inquire into the extent to which New Zealand Public sector agencies were, or ought to have been aware, of the Individual and the potential risks he presented. The RCOI explored the Individual's upbringing, social and family connections, travel, and potential influences on his radicalisation to violence. His actions and movements from his arrival in New Zealand through to and including the attacks on 15 March 2019 were examined. His travel out of New Zealand was examined. His ability to obtain firearms and a New Zealand firearms licence was the subject of focussed inquiry.

[76] I do not consider it strictly necessary to determine whether there has been an arguable breach of s 8 (or any other protected right) of NZBORA such that the State is obliged to undertake a "rights-compliant" investigation. Even if I was to proceed on the assumption that there is an arguable breach of the State's protective duties, at least in so far as any alleged failure to take reasonable measures to protect Muslim communities against the risk of a terrorist attack (which, to be clear, the findings of the RCOI do not in any way suggest there has been), the RCOI appears likely to discharge the State's obligation to undertake a rights-compliant investigation. While the RCOI inquiry process was openly acknowledged to have been largely undertaken in private, which the RCOI considered to be necessary for the specific reasons set out in its Report, the RCOI sought to balance the need for transparency by other means, including the publication of the detailed RCOI Report. On that basis it may be said to have demonstrated the requisite features of a "rights-compliant" investigation of the type referred to by Ellis J in *Wallace*.

[77] Moreover, while protection of the Individual's fair trial rights are no longer a relevant concern, a number of the confidentiality imperatives identified by the RCOI remain extant. It is not obvious to me that a coronial inquiry would be subject to a different disclosure setting such that I would have any greater ability to disclose to interested parties or the wider public, the aspects of the RCOI investigation which the public interest required to be kept confidential.

[78] It follows, therefore, that I propose to exclude issues 2–9, 48–50, and 52 from the Inquiry on the basis that they have already been the subject of the independent inquiry by the RCOI.

Next steps and timetabling directions

[79] Counsel and interested parties will be given time to consider my proposed approach to the submissions received on issues for inquiry as set out above.

[80] Any further written submissions on the issues for inquiry must be received no later than 26 November 2021Submissions can be sent to coronial.response@justice.govt.nz.

[81] The court hearing on the issues for inquiry will take place in Christchurch on 14-15 December 2021.

[82] If interested parties (or their lawyer if they have one) wish to make submissions in person at the court hearing, they must tell us no later than 26 November 2021 so arrangements can be made. This can be advised by sending an email to coronial.response@justice.govt.nz.

[83] Following that hearing, and further consideration of submissions made, Coroner Windley will finalise and issue a decision on the scope of the inquiry.

[84] Once the issues for inquiry are finalised, Coroner Windley will then consider whether an inquest hearing is required to address any of those issues.

Judge D Marshall
Chief Coroner

Appendix A: Issues raised in submissions

	Issue	Summary of submission	Proposed category
1	Importance of the Inquiry.	All submissions received considered that a public inquest should be held. Factors emphasised included that: the attacks were unprecedented in New Zealand, there has been no criminal trial, families were not able to participate fully in the RCOI process, the RCOI addressed only actions of public sector agencies, much of the RCOI evidence has been supressed, sanitized or excluded, and that this is the last public legal proceeding. Various submissions emphasised that they did not consider the RCOI had satisfactorily covered all issues or engaged at a sufficiently granular level to get specific answers and accountability expected, that the RCOI report itself was hard to engage with for victims (as a result of language, lack of professional support and other accessibility issues) and that they considered further recommendations are necessary to prevent future attacks. There was also a consistent theme that the issues victims and their families have had with prior legal processes have left them feeling unheard, and unempowered, and that a more restorative focussed process is now needed.	N/A

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2	How was the terrorist radicalised and how can this be prevented in the future?	Raised by a number of parties. Specific questions asked included: • When and how did his racist views develop as a child? • Why were his racist views not interrupted early? • Why have his online activity and his devices remained largely uninvestigated? • What influences put him on this path as a teenager and young adult? • What activities did he engage in that enabled radicalisation to such an extent? • What recommendations can be made to prevent future deaths occurring in similar circumstances? • Were there missed opportunities to intervene? • How can path of radicalisation and hate be interrupted from now on? • What regulatory, legislative or other steps can be taken in relation to accessing and controlling websites and online gaming that incite dehumanisation and violence? Concerns raised included that the RCOI did not adequately address the terrorist's online and social media use and whether State agencies could have detected the attack by properly concentrating resources on online extremism.	Outside the scope of the Inquiry (considered by the RCOI).
3	What is known about the terrorist's travel history and is there any evidence of him having trained overseas?	This issue was raised by a number of parties. Specific questions asked include why travel history did not raise red flags when he entered NZ and whether he might have trained and killed overseas (based on the sister's indication that he travelled to Afghanistan). A number of submissions refer, with concern, to the terrorist's apparent experience or competence with firearms and military tactics during the attack.	Outside the scope of the Inquiry (considered by the RCOI).

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4	Were red flags missed by intelligence/Police?	Specific issues raised include: failure of intelligence services to track "Barry Harry Tarry" or follow up – IP122.61.118.145 as well as firearm related issues below.	Outside the scope of the Inquiry (considered by the RCOI)
5	Did defective firearms licensing regime contribute to deaths?	Raised by various parties who disagree with RCOI finding that it could not determine whether issues with firearms process were causative of attack.	Outside the scope of the Inquiry (considered by the RCOI).
6	Why was there no reporting of firearms and ammunition purchases?	Families have expressed concern about the lack of reporting in respect of ammunition purchases and Police ability to trace and map significant purchases of, for example, high powered ammunition.	Outside the scope of the Inquiry (considered by the RCOI).
7	Regulation of gun club memberships.	Some families raised that members at the Otago Shooting Sports Rifle and Pistol Club and the Bruce Rifle Club had expressed concern about the terrorist and queried whether there should be mandatory reporting.	Outside the scope of the Inquiry (considered by the RCOI).
8	Why did the hospital not report the firearm injury the terrorist presented with in July 2018?	As above.	Outside the scope of the Inquiry (considered by the RCOI).

Appendix A: Issues raised in submissions

9	Should property owners have mandatory reporting requirements?	Some families are concerned about the terrorist's landlord failing to report the damage to the property rented by the terrorist, as a result of an accidental discharge of a firearm.	Outside the scope of the Inquiry (considered by the RCOI).
10	Why was the terrorist RCOI interview supressed for 30 years?	Various submissions note unhappiness with the inability of families to access suppressed information and to know if the Coroner has seen it.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
11	Did the terrorist have direct assistance from another person present on 15 March 2019?	Some parties have asserted another shooter or assistant was present. Concerns have been raised that the GoPro footage showed someone walking past the terrorist's car with binoculars in their hand and it was after that moment that the terrorist moved. There are also claims that other witnesses believe there was at least one other person outside Masjid an-Nur wearing black with no explanation. There is a witness who believes this person (and not the terrorist) was shooting at the right hand side of Masjid an-Nur. There are claims that some witnesses in Masjid an-Nur say they heard the terrorist talking to someone and asking for a warning if the Police arrived. Other submissions query whether there has been any analysis of the audio recording from inside the terrorist's car while he was driving to the Linwood Islamic Centre to establish who, if anyone, he was in a two-way conversation with?	This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

12	The Police allegedly reported the involvement of up to 9 other people initially.	Some submissions query whether this indicated multiple shooters.	This issue is proposed to be dealt with by an information request.
13	Were fingerprints or DNA taken from all firearms located at the scene?	Some submissions consider this could identify associates.	This issue is proposed to be dealt with by an information request.
14	Did the terrorist have a hiding place on standby for after the attack?	Some submissions consider this could have been an avenue for identifying associates.	This issue is proposed to be dealt with by an information request.
15	Did the terrorist have indirect support from online associates?	A forensically important evidence source is the hard disc of the terrorist's computer – its whereabouts should be investigated. Another submission raised the possibility of "confirmation bias" as a result of him being classified as a lone actor at the very early stages and noted that his manifesto contained language used in extreme right-wing websites and various in-jokes. Was the log from his router investigated in regard to his searches and browsing? Was all the information from the people he was in communication with followed up?	This issue is proposed to be dealt with by an information request.

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16	Did gaming friend help with gun modifications?	Families are not aware that this was investigated.	This issue is proposed to be dealt with by an information request.
17	Query where terrorist obtained steroids when preparing for attack.	Some submissions consider this could have been an avenue for identifying associates.	This issue is proposed to be dealt with by an information request.
18	Query where the terrorist stayed overnight on his route back from Christchurch to Dunedin, after his final surveillance mission to Masjid an-Nur.	Some submissions query whether an associate provided accommodation for the terrorist and whether they may have been involved in attack.	This issue is proposed to be dealt with by an information request.
19	What is known about each of the Shaheed's movements and could any deceased have been saved with faster medical treatment?	Raised by a number of parties along with requests for expert opinion on cause of death. Concern that current information is too generic or insufficiently detailed. Submissions have also raised that there is a need for insight into the moments before, during and after the attack for each shaheed and affected person, including (a) their travel to the Mosque, (b) their movements in the Mosque, (c) who they were with, (d) their movements in/around the Mosque, (e) the immediate cause/mechanism of death, and (f) exactly when and where each person died (to the extent that this is possible to ascertain).	This issue is within the scope of the Inquiry.

Appendix A: Issues raised in submissions

20	Were first responders sufficiently equipped with both training and resources?	Raised by a number of parties. Concerns were raised that there has been no public examination of how all the relevant first responders, namely the Police, the ambulance service, and Christchurch Hospital, responded on 15 March 2019. Families understand the extraordinary nature of what occurred and are grateful for the genuine efforts made by the first responders. However, they remain concerned about first responders not being equipped, whether by provision of 'material' or by training (including training with other responders), to deal with what happened. Specific questions include: • Were the members of the Police, Armed Offenders' Squad (AOS) and Special Tactics Group (STG) who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable," all trained as described in the evidential overview? • Were the members of the AOS and STG who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable", either AOS medics or STG medics as described in the evidential overview? • Did the members of the STG who "tended to the wounded, triaged those persons and removed them for further care as soon as practicable" have a current annual certificate; undertaken annual refresher training; and completed 40 hours of ride-along training with St John ambulance certified paramedics? • What is the reason why AOS medics are not trained to the same level as the STG medics? Should they be so trained? • Should 40 hours of ride-along training for the STG with St John ambulance paramedics be mandatory rather than "attempted"?	This issue is within the scope of the Inquiry.
21	Why did Police not arrive faster?	Submissions raise issue of terrorist manifesto being sent to authorities at 1:32pm.	This issue is within the scope of the Inquiry.

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22	How did the terrorist leave, re-load his weapon and re-enter Masjid an-Nur without Police intervening?	Some families are concerned that the terrorist started his attack and had time to go outside, reload his weapon and re-enter Masjid an-Nur. They also raise concerns about how the terrorist was so confident about timings and the lack of Police response that he did not hesitate to go out, reload and come back to shoot more people.	This issue is within the scope of the Inquiry.
23	What caused the delay in the medical response?	Various submissions raise delay in the ambulances arriving on scene and providing medical treatment.	This issue is within the scope of the Inquiry.
24	Why did first responders prevent civilians from re-entering the Mosque to provide assistance?	Raised by various parties. There is concern about the delay in entering Masjid an-Nur when the Police had been told by survivors/witnesses that the terrorist had left. People were trying to get back into the Mosque to save lives of those who were shot but were prevented by the Police from entering.	This issue is within the scope of the Inquiry.
25	Did Police prevent ambulance service from entering Masjid an-Nur and if so why?	Some families are also concerned that the Police 'held back' ambulance staff (and others) from going into Masjid an-Nur to render first aid. Some have asked whether there were any barriers to first medical responders imposed by the Police which may have had adverse impacts on the survival outcomes of some victims.	This issue is within the scope of the Inquiry.

Appendix A: Issues raised in submissions

26	Who triaged injured and deceased persons and how was this done?	Issue raised by a large number of families. Questions about this issue included: • How did first responders determine the person was not alive in each case? • Who determined if someone was alive and to be taken to hospital? • What steps were taken to ensure those of the shaheed who were later determined to have died in-situ, were not in reality still alive and could possibly have had emergency aid administered? • Could living victims have been mistaken for dead and not received medical treatment because of this? • Were determinations made about those that were alive and could survive and those who had organ function and movement but could not survive? If so how? • Were any victims showing signs of life but were left at the scene because first responders assessed they could not be saved? • What time were each of the deceased checked and by whom? • Are there any records of these triaging assessments? If not could/should such records have been kept? • Was there any system of picking up and collecting of victims or any other such systems of joint work to get victims out of the Mosque to treatment? • Were doctors from the local medical centre involved in triage at Linwood Islamic Centre? • What was the operational response of Police and paramedic services and any of the services providing first aid?	This issue is within the scope of the Inquiry.

Appendix A: Issues raised in submissions

27	Is there any evidence of assistance given to bullet injured at scene who survived?		This issue is proposed to be dealt with by an information request.
28	Did problems with radio contribute in any way to loss of life?	Various families want to know if the problems with radio protocol and real time tracking technology identified in the formal Police debrief, in any way contributed to the loss of life. The same questions apply to the ambulance service's triage process.	This issue is within the scope of the Inquiry.
29	Was there sufficient control and direction during the triage/medical assistance phase?	Concern raised that there are no records of who triaged which individuals and that various bullet injured were transported by members of the public or found their own way to hospital.	This issue is within the scope of the Inquiry.
30	Should Police have deployed a team to Linwood Islamic Centre when reports of shooting at Masjid an-Nur were made?	Some families are concerned that the Police did not deploy a team to the Linwood Islamic Centre once the shooting at the Masjid an-Nur was notified. Others have asked why other Islamic sites in the city were not secured?	This issue is within the scope of the Inquiry.

Appendix A: Issues raised in submissions

31	Could traffic CCTV have assisted in apprehending the terrorist before he reached Linwood Islamic Centre?	Issues raised as to the extent of CCTV footage which recorded the events of that day, including the terrorist's drive from Masjid an-Nur to the Linwood Islamic Centre, and whether any of this CCTV was Police monitored CCTV. If so, what was done in response to the terrorist's speed and erratic driving?	This issue is proposed to be dealt with by an information request.
32	Were first responders from Police confrontational or aggressive in approach to some survivors?	Concerns raised that some survivors have reported aggressive conduct by Police on 15 March 2019 towards those shot, stating "it is understood from survivors that the terrorist was not the only one to point a gun at those shot that day. This raises the question of additional trauma and shock from such behaviour contributing to any of the deaths."	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
33	Whether Police "allowed" the terrorist to escape.	Survivor asserts that he saw the Police were there at the same time as the terrorist and that they allowed him to leave.	This issue is proposed to be dealt with by an information request.
34	Could Police have stopped the terrorist on the way to the Linwood Islamic Centre?	Submissions raise that Police did not stop the terrorist despite him shooting at people as he left, speeding and driving the wrong way.	This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

35	Did high activity congestion on the emergency 111 line contribute to early calls from the Linwood Islamic Centre being missed?	Submissions raise that an initial 111 call from Linwood Islamic Centre was made when shots were first fired but was on hold for 6 minutes. Specific questions include: were all calls put through to Police, what capacity did Police have in terms of manpower to answer them, is there a support system available to boost communication and coordination of 111 calls in a mass shooter incident, and did congestion on the 111 line contribute to deaths at the Masjid?	This issue is proposed to be dealt with by an information request.
36	When and how was Christchurch Hospital notified of the attack?	Submissions ask whether it is correct that the Christchurch Hospital's first knowledge of the shootings was two men arriving on foot from Masjid an-Nur? If so, why was the Hospital not notified sooner? Refer to video of two men arriving.	This issue is proposed to be dealt with by an information request.
37	Were there any issues with role and processes of the Christchurch Hospital following attack / during immediate response	Specific questions include: • What information was shared between the CDHB, the Police and the ambulance service after the shootings were notified? • Was there any communication with the Christchurch Hospital in terms of criteria/tests for deciding death or for trying to save lives? • Could any hospital services have been performed at the Mosque to save lives? • What happened on the day? Did people know what they were doing? Could lives have been saved? • Were there any deficiencies in treating survivors that raise questions about how any of the Shaheed were treated?	This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

38	Did CDHB appropriately activate and use emergency policies?	Specific questions included:
		• What is the major incident plan? How does it relate to the Canterbury DHB Health Emergency Plan 2017? Is this best practice from an independent perspective? Was it followed and by whom? What staff training previously had been conducted on such plans? How frequently? At what staff levels?
		• Did the CDHB formulate or use any or all of the following on 15 March 2019?
		  ○ EOC: Emergency Operations Centre. An established facility where the operational response to an incident is controlled and provided.
		  ○ Emergency Coordination Centre: An established facility; the location where the response to any emergency is coordinated, and which operates the EOC.
		  ○ Coordinated Incident Management System. A structure to systematically manage emergency incidents which allows multiple agencies or units involved in an emergency to work together.
		• If any of the above was formulated or used, how did this work?
		• Were the various Centres established and the various systems and plans implemented in the required attempt to bring order into chaos?
			This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

39	Coordination of emergency services.	Submissions ask whether there was any preparation for responding to a terrorist attack and the coordination of emergency services. Specific questions included:
		• Was there any preparation for responding to a terrorist attack and were any policies, systems and practices developed?
		  ○ Did these policies include joint planning and exercises?
		• What was the compliance with these policies, systems and practices?
		• What were the local Mosque or national Islamic organisational protocols?
		  ○ What kinds of security systems had been advised by security agencies to Mosques following steadily increasing risk to them over the preceding years?
		• Did lack of training, preparation, or policy, or a lack of compliance with policies and systems, impact the responders' ability to save lives or in any other way contribute to the extent of the loss of life that occurred?
		• Did CDHB have provisions for:
		  ○ The coordination of hospitals, their adequacy and compliance with relevant planning, preparation, policies, systems and practices.
		  ○ Inter-agency communication and coordination between relevant emergency services, and with civilian services.
		  ○ The adequate utilisation and coordination of resources.
		  ○ the impact of all of the above on preparation for and execution of the emergency response.
			This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

40	Discrepancies raised between time of death and mobile communications?	Some parties were not satisfied with the comment in the General Evidential Overview at paragraph 8.4, which states: "Police investigations have shown that this is explained by an anomaly in the cellular phone and/or connectivity on the day." Some other victims were able to communicate with their families before dying.	This issue is proposed to be dealt with by an information request.
41	Inconsistencies in timeline of shooting.	A number of submissions note that the General Evidential Overview records the first shots being fired at 1:40pm while the reconciliation report records first shots 1:45pm. Other submissions also raise concerns about other inconsistencies that relate to individuals.	This issue is proposed to be dealt with by an information request.
42	Not all families have been given information such as the DVI post mortem report: they did not know this existed and that they could ask for this.	-	This issue is proposed to be dealt with by an information request.
43	Families have made information requests which have been refused or not answered.	-	This issue is proposed to be dealt with by an information request.

Appendix A: Issues raised in submissions

44	Could information dissemination processes have been improved?	A number of families have noted the difficulties they received in obtaining information from Hagley School and the Christchurch Hospital about missing loved ones.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
45	Why were families not allowed unsupervised access to loved ones' bodies?	Submissions highlight that this was distressing to families.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
46	Should families have been consulted on post mortem investigations before they were carried out? And were sufficient procedures in place with NZ Police, SJA and Christchurch Hospital to facilitate culturally appropriate treatment of Shaheed's bodies?	Parties understand the law in this regard but think it should be changed and/or that in the context of Muslim faith consultation should have occurred. They also consider that more cultural competence is required, for example ensuring no women touch bodies of deceased men. Common concerns raised in the submissions were that bodies of women should be washed and handled only by women and bodies of men should be washed and handled only by men. The victim's eyes and lower jaw should be closed and the body covered with a white sheet.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue)
47	Cultural response and coronial inquiry	Concerns have been raised by families regarding the need for the Coroner to be aware of and accommodate cultural and spiritual needs. This includes the correct spelling of the deceased's names and the masjiain.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue)

Appendix A: Issues raised in submissions

48	Protection of Mosques and Islamic Centres.	Submissions received raise whether, in the context of a rise in hate-inspired vandalism against religious properties in NZ, the government should have arranged for better security. Other submissions noted that the RCOI did not shed any light on the details of how many reports of suspicious activity there were in the years prior to the attacks to give any sense of urgency around safety at Mosques. Requesting the Coroner to investigate why Mosques were not given further protection.	Outside the scope of the Inquiry (considered by the RCOI).
49	Capacity deficiency in tracking lone actor terrorists.	Submissions received request that the Coroner investigate whether NZSIS had any strategies or competencies in place to detect lone actors.	Outside the scope of the Inquiry (considered by the RCOI).
50	Institutional bias against Muslims.	Issue was raised that the failure to follow up on right wing extremism was as a result of institutional bias against Muslims arising out of Islamophobia. Request that the Coroner investigate whether there was institutional bias against Muslims as an attributive factor.	Outside the scope of the Inquiry (considered by the RCOI).
51	Terrorist's family's obligations.	Some families have talked about the moral responsibility of the terrorist's family to let state sector agencies know of their concerns with his political views and their failure to act immediately when the terrorist texted them on 15 March 2019.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).
52	Shaheed comments.	What was the action of NZ's intelligence agencies? Was there too much focus on Islamic terrorists so no barrier to this terrorist coming into the country to prepare and do what he did?	Outside the scope of the Inquiry (considered by the RCOI).

Appendix A: Issues raised in submissions

53	Complaints process.	There have been complaints to Police about the treatment of Muslims in NZ – not taken seriously. There was an incident involving the Linwood Islamic Centre, Police promises to be armed and a week later Police still unarmed.	Outside the scope of the Inquiry (no evidence that the event Linwood Islamic centre occurred prior to 15 March 2019).
54	What were the causes of confused/delayed communication with families following the attacks and how can communication be improved after mass casualty events?	Submissions have noted that delays in receiving information or provision of incorrect information caused significant distress and resulted in families resorting to watching GoPro footage of the shooting to try and identify loved ones. Specific questions include: • Was there a review of the Police interviewing and statement-taking processes? o How could these processes have been completed more comprehensively, more promptly and more effectively, in order to get more, higher quality information, from more people? o Could the interview processes have yielded far more information at a much earlier stage when matters were fresh, rather than leaving out important details to emerge months or years later, such as through retraumatising conversations between victims? • How can connections, inferences and analysis be done in order to reconstruct and explain what happened to families in a more comprehensive manner?	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).

Appendix A: Issues raised in submissions

55	Whether there have been any internal reviews of the response to the attack.	Submissions have asked whether CDHB, Police, and St Johns Ambulance have reviewed their procedures following the attack, including interagency coordination and lines of communications, and what changes have been made. Specific questions include:
		• Was there an opportunity to have mutual coordinated awareness of the presence of all kinds of emergency services that day who could have coordinated a response?
		• How can the full spectrum of services in each of these emergency areas be aware of each other's location and ability to respond when needed?
		• Could a local operation command centre like the Justice Precinct if properly informed by the relevant agencies, play a role in maintaining a calendar of all emergency events and services on the ground, and assist with coordination of these services if required?
		  ○ Could such a communication command centre have played a key role in overall coordination?
		• Could some kind of emergency services identification could have alleviated the issue of Police needing to identify who were sworn officers?
		  ○ Could such coordination and identification enhancements have helped the predicament of not only Police identifying other officers but also victims being able to identify Police and emergency responders?
			This issue is proposed to be dealt with by an information request.

56	Documentation deficiencies.	One submission raised whether there is a definitive list of interested parties, and urged a new list from those previously used be created. The submission raised concerns about who is being treated as a victim. Concerns were also raised about the Death Certificate process and how the details for those certificates are settled. Similar concerns were raised about the DVI documentation used. Overall, the submission considered that the information that victims received, such as the Evidential Overviews, needed to be more tailored to their needs.	Outside the scope of the Inquiry (no jurisdiction to inquire into this issue).

Appendix B: RCOI Recommendations & assigned responsibility

Number	Theme / Recommendation	Responsibility/advancement
1	***National security*** – Appointment of a Minister with responsibility and accountability to lead and coordinate the Counter Terrorism (CT) effort.	Accepted in principle. Implementation being considered. Prime Minister Ardern, Prime Minister's Office/DPMC (Cabinet Office, NSG[1], PAG[2]).
2	***National security*** – Establish a new national intelligence and security agency (NISA) that is well-resourced and legislatively mandated to be responsible for strategic intelligence and security leadership functions.	Accepted in principle. Implementation being considered. Prime Minister Ardern, DPMC (PSC) responsible.
3	***National security*** – Investigate alternative mechanisms to the voluntary nature of the Security and Intelligence Board (SIB), including the establishment of an Interdepartmental Executive Board.	Accepted in principle. Implementation being considered. Prime Minister Ardern, DPMC (PSC) responsible. Improvements to SIB under consideration.
4	***National security*** – Develop and implement a public facing CT/Countering Violent Extremism (CVE) strategy.	Accepted. Prime Minister Ardern, DPMC (with CTCC[3] agencies) responsible.
5	***Legislation*** – Amend the Public Finance Act 1989 to require Intelligence and Security Agencies to provide performance information that can be subject of audit by the Auditor-General.	Accepted in principle. Implementation being considered.
6	***National security*** – Strengthen the role of the Intelligence and Security Committee (ISC).	Accepted in principle. Implementation being considered. Prime Minister Ardern, ISC, DPMC responsible.
7	***National security*** – Establish an Advisory Group on CT.	Accepted. Prime Minister Ardern, DPMC (with SIB[4] and CTCC agencies) responsible.
8	***National security*** – Include a summary of advice from the Advisory Group and actions taken in response, when providing advice on the National Security and Intelligence Priorities and annual threatscape report.	Accepted. Prime Minister Ardern, DPMC responsible.
9	***National security*** – Improve intelligence and security information-sharing practices.	Accepted in principle. Implementation being considered. Minister Little, DPMC responsible.
10	***National security*** – Direct access agreements to provide regular reporting to responsible minister for counterterrorism.	Accepted in principle. Minister Little, DPMC, NZSIS/GCSB responsible. DPMC tasked with working with relevant agencies to understand and overcome barriers and report to relevant ministers on this work.
11	***Information access*** – Review security clearances and appropriate access to information management systems and facilities.	Accepted. Minister Little, NZSIS, GCSB, DPMC, MBIE responsible. Significant work already completed in response to clearance and secure building/technology aspects.
12	***Law enforcement*** – Develop accessible reporting system for members of public to easily and safely report concerning incidents to single contact point within government.	Accepted. Minister Williams, NZ Police, DIA, NZSIS and CTCC Agencies responsible.
13	***Terrorism Indicators*** – Develop, publish and keep up to date public guidance on indicators and risk factors that illustrate behaviours indicating a person's potential for engaging in violent extremism and terrorism.	Accepted. NZSIS has completed a classified terrorism indicators framework for the NZ context. Work on making this publicly available is in progress.

1 National Security Group.
2 Policy Advisory Group.
3 Counter Terrorism Coordination Committee.
4 Security Intelligence Board.

Number	Theme / Recommendation	Responsibility/advancement
14	***National security*** – Establish a programme to fund independent NZ-specific research on causes and prevention of extremism and terrorism.	Accepted in principle. Prime Minister Ardern, DPMC responsible. Government has proposal to establish a National Centre of Excellence for Preventing and Countering Violent Extremism.
15	***National security*** – Create opportunities to improve public understanding on violent extremism and terrorism in NZ, with ongoing public discussions.	Accepted. Prime Minister Ardern, DPMC and Minister for NSI, (MSD, MOJ) responsible.
16	***National security*** – Establish an annual hui on CVE and CT.	Accepted. Prime Minister Ardern, DPMC responsible. DPMC will convene annual hui.
17	***National security*** – Require in legislation publication of the NSIPs[5] and referral to ISC for consideration; publication of an annual threatscape report; and the ISC to receive and consider submissions on the NSIPs and threatscape report.	Accepted in principle. Prime Minister Ardern, DPMC, NZSIS. National Security threatscape report to be provided to public session of ISC beginning 2021 and to be available online.
18	***Legislation*** – Review all legislation related to the counter-terrorism effort to ensure it is current and enables public sector agencies to operate effectively, prioritising consideration of the creation of precursor terrorism offences in the Terrorism Suppression Act, the urgent review of the effect of section 19 of the Intelligence and Security Act on target discovery and acceding to and implementing the Budapest Convention.	Accepted in principle. Minister Faafoi, MoJ, DPMC, NZ Police, NZSIS/GCSB responsible. Legislative work programme underway. Counterterrorism Legislation Bill 2021 completed third reading on 29/09/21 and is due to receive royal assent 4/10/21. Minister of Foreign Affairs notified request to join Budapest Convention in 2020.
19	***Firearms*** – New Zealand Police (or other relevant entity) to make policies and operational standards and guidance for the firearms licensing system clear and consistent with legislation.	Accepted. NZ Police responsible. Large programme of work significantly underway including updates to application forms (November 2020) and amendments to Arms Act (December 2020) to clarify fit and proper criteria and give police more compliance tools. Public consultation held in April 2021 on new regulations designed to help specify how police make the law work in practice.
20	***Firearms*** – New Zealand Police (or other relevant entity) to introduce an electronic system for processing firearms licence applications.	Accepted. NZ Police responsible. Interim electronic system in place. Review taking place from June 2021 to further review online application process.
21	***Firearms*** – New Zealand Police (or other relevant entity) to ensure firearms licensing staff have regular training and undertake periodic reviews of the quality of their work.	Accepted. NZ Police responsible. New training has been implemented.
22	***Firearms*** – New Zealand Police (or other relevant entity) to introduce performance indicators that focus on the effective implementation of the firearms licensing system	Accepted. NZ Police responsible. Work initiated on developing standardised performance measures.
23	***Firearms*** – New Zealand Police (or other relevant entity) to require new processes for applicants who have lived overseas for substantial periods in the proceeding ten years (1) overseas criminal history checks and (2) using technology to conduct interviews if applicant does not have family/close connections in New Zealand.	Accepted in principle. NZ Police responsible.
24	***Firearms*** – Introduce mandatory reporting of firearms injuries to New Zealand Police by health professionals.	Accepted in principle. Minster Williams, NZ Police, and Ministry of Health responsible. Amendments introduced to Arms Act in December 2020 to enable health practitioners to escalate medical concerns around safety for patients who are firearms licence holders.

[5] National Security and Intelligence Priorities.

Number	Theme / Recommendation	Responsibility/advancement
25	***Recovery Support*** – Ministry of Social Development to work with relevant public sector agencies to facilitate coordinated support for affected whānau, survivors and witnesses of the 15 March 2019 terrorist attack.	Accepted. Minister Sepuloni, MSD, NZ Police, ACC, MoJ, Immigration NZ, PSC responsible. MSD currently providing service through its specialist case management service set up after 15 March attacks.
26	***Recovery Support*** – Investigate establishing a Collective Impact Network, Board or other mechanism that enables public sector agencies, NGOs and affected whānau, survivors and witnesses to agree a work programme for ongoing wrap-around support services.	Accepted. Minister Sepuloni, MSD, NZ Police, ACC, MoJ, Immigration NZ, PSC responsible. MSD working with Te Kawa Mataaho Public Service Commission to implement.
27	***Social and community*** – discuss with whānau, survivors and witnesses what, if any, restorative justice process might be desired, and how they would be designed and resourced.	Accepted in principle. Further consideration to be given to appropriate lead agency. Minister Radhakrishnan, DPMC responsible.
28	***Social cohesion*** – Announce that the Minister for Social Development and Employment and the Ministry of Social Development have responsibility/accountability for coordinating a whole-of-government approach to building social cohesion, including social inclusion.	Accepted in principle. Minister Radhakrishnan assigned responsibility for the Government's Social Inclusion programme. MSD initially lead agency.
29	***Social cohesion*** – Direct the Ministry of Social Development to discuss and collaborate with communities, civil society, local government and the private sector on the development of the social cohesion strategic framework and a monitoring and evaluation regime.	Accepted. Minister Radhakrishnan, MSD, Social Inclusion Oversight Group responsible. Minister Faafoi and Radhakrishnan also covered social cohesion as part of the public consultation process looking at the Human Rights Act 1993.[6]
30	***Social cohesion***– Investigate the machinery of government options for an agency focused on ethnic communities and multiculturalism.	Accepted. Minister Hipkins (Public Service) and Minister Radhakrishnan (DIEC) responsible. Work is in train to establish a Ministry for Ethnic Communities as a DIA department.
31	***Social cohesion*** – Prioritise the development of appropriate measures and indicators of social cohesion, including social inclusion.[7]	Accepted in principle. Minister Radhakrishnan, MSD, Social Inclusion Oversight Group responsible.
32	***Social cohesion*** – Require Public sector agencies to prioritise the collection of data on ethnic and religious demographics to support analysis and advice on the implications of New Zealand's rapidly changing society, inform better policy making and enhance policy evaluation.	Accepted in principle. Minister Clark, Stats NZ, DIA (OEC) responsible.
33	***Workforce Diversity*** – Direct the chief executives of the Public sector agencies involved in the counter-terrorism effort to continue focusing efforts on significantly increasing workforce diversity, including in leadership roles.	Accepted. Minister Hipkins, PSC responsible.[8]
34	***Performance*** – Encourage the Public Services Commissioner to publish an annual report that assesses progress on the Papa Pounamu commitments and prioritises reporting on progress made by agencies involved in the counter-terrorism effort.	Accepted. Minister Hipkins, PSC responsible.
35	***Workforce Diversity*** – Encourage the Public Service Commissioner to continue focusing efforts on significantly increasing workforce diversity and attracting diverse talent for public service leadership roles.	Accepted. Minister Hipkins, PSC responsible.

6 https://www.beehive.govt.nz/release/social-cohesion-programme-address-incitement-hatred-and-discrimination.

7 Note that the HRC and teachers are creating a response to help combat racism earlier. https://www.hrc.co.nz/news/social-cohesion-requires-all- society-approach/.

8 PSC released a report outlining progress in June 2021, including an increased priority of D & U through the Public Service Act 2020, appointing a new deputy commissioner responsible for D&I across the public sector, annual reports, appointing Pap Pounamu co-chairs as functional co-leads, setting clear expectations for chief executive performance. https://www.publicservice.govt.nz/assets/SSC-Site-Assets/OIA-Releases/Policies-strategies-and-statistics-on-diversity-and-inclusion-leadership-demographics-and-information-relating-to-the-workforce-OIA-2021-0037.pdf

Number	Theme / Recommendation	Responsibility/advancement
36	***Diversity and Social cohesion*** – Invest in opportunities for young New Zealanders to learn about their role, rights and responsibilities and on the value of ethnic and religious diversity, inclusivity, conflict resolution, civic literacy and self-regulation.	Accepted. Minister Hipkins, MoE and MSD responsible. MoE has work underway to give practical effect and support in key areas specified by the report and recommendation 36. This also followed a period of significant community engagement beginning in 2018.
37	***Social cohesion*** – Create opportunities for regular public conversations led by the responsible minister for all New Zealanders to share knowledge and improve their understanding of social cohesion and the value of ethnic and religious diversity.	Accepted in principle. Minister Radhakrishnan, MSD, Social Inclusion Oversight Group responsible.
38	***NZ Public Service*** – require all public service community engagement to be in accordance with the Open Government Partnership commitments and better utilise the 'Involve and Collaborate' pillars of the IAP2 Public Participation Spectrum.	Accepted. Minister Hipkins, DPMC responsible. A survey was conducted[9] and results issued on 29 July 2021.[10]
39	***Hate Crime*** – Amend legislation to create hate-motivated offences in the Summary Offences Act that correspond with offensive behaviour, assault, and wilful damage/intimidation and in the Crimes Act that correspond with assault, arson and intentional damage.	Accepted in principle. Minister Faafoi, MoJ responsible.
40	***Hate Speech*** – Repeal section 131 of the Human Rights Act 1993 and insert a provision in the Crimes Act 1961 for an offence of inciting racial or religious disharmony.	Accepted. Minister Faafoi, MoJ responsible. Public consultation underway on proposed legislative changes. Submissions closed 6 August 2021.
41	***Classifications*** – Amend the definition of "objectionable" in section 3 of the Films, Videos, and Publications Classification Act 1993 to include racial superiority, racial hatred and racial discrimination.	Accepted in principle. Consideration to be given to form of legislation. Minster Tinetti, DIA and MoJ responsible.
42	***Hate Crime*** – New Zealand Police to revise the ways in which they record complaints of criminal conduct to capture systematically hate-motivations for offending and train frontline staff in identification, exploring victim/witness perceptions and recording hate motivations.	Accepted. Minister Williams, NZ Police, DIA responsible.
43	***Response implementation*** – appointment of a Minister to lead and coordinate the response to and implementation of the Report's recommendations.[11]	Accepted. Prime Minister Ardern, Prime Minister's Office/DPMC (Cabinet Office, NSG, PAG) responsible.
44	***Response implementation*** – establish an Implementation Oversight Advisory Group.	Accepted. Prime Minister Ardern, DPMC responsible. Group established on 12 June 2021.[12]

9 https://dpmc.govt.nz/our-programmes/policy-project/policy-community/open-government-partnership.

10 https://dpmc.govt.nz/publications/survey-results-community-engagement-government-policy-making.

11 Note: Completed with the appointment of Minister Little as Lead Coordination Minister for the Government's response to the Royal Commission's Report into the Terrorist Attack on the Christchurch Mosques.

12 https://dpmc.govt.nz/our-programmes/national-security/royal-commission-inquiry-terrorist-attack-christchurch-masjidain-2.