MINISTRY OF JUSTICE
Tāhū o te Ture

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5 December 2024

Lauren Doocy
By email: fyi-request-29027-e0ad7d65@requests.fyi.org.nz

Our reference: OIA 117279

Tēnā koe Lauren,

Request for Coroners Court information regarding ambulance service related deaths

Thank you for your request of 2 November 2024 to the Office of Hon Paul Goldsmith, Minister of Justice, seeking information related to ambulance service related deaths. Your request was transferred to the Ministry of Justice (the Ministry) on 6 November under section 14 of the Official Information Act 1982 (the OIA), as it more closely aligns with the functions of the Ministry. I am responding to your request under both the Coroners Act 2006 (the Coroners Act) and the OIA. Your request is made up of six parts.

1. ***Advice the minister has received from the chief coroner about these cases.***

The Ministry is responding to part 1 of your request under the OIA.

In order to respond to part 1 of your request, the Ministry has consulted with the Office of Hon Paul Goldsmith who have confirmed that the Office does not have any record of receiving any information from the Chief Coroner on this topic. Therefore, I am refusing this part of your request under section 18(g) of the OIA as the information requested is not held by the Minister, nor are there grounds for believing that the information is held by or connected more closely with the functions of another department, Minister of the Crown, or organisation.

2. ***Figures related to the number of cases that the coroner is currently investigating about ambulance service-related deaths.***

The Ministry is responding to part 2 of your request under the Coroners Act.

In response to this part of your request, please see Table 1 enclosed. Table 1 provides the total number of active cases referred to the coroner where the death occurred in an ambulance or ambulance depot from 1 November 2019 to 31 October 2024.

3. ***Figures related to the number of cases that the coroner has investigated in the past five years about ambulance service-related deaths.***

The Ministry is responding to part 3 of your request under the Coroners Act.

In response to this part of your request, please see Table 2 enclosed. Table 2 provides the total number of closed cases where the death occurred in an ambulance or ambulance depot, notified to the coroner between 1 November 2019 and 31 October 2024.

4. ***Figures related to the number of cases that the coroner has decided to pass to other agencies, which raise concerns about ambulance service-related deaths***.

The Ministry is responding to part 4 of your request under the Coroners Act.

In response to this part of your request, please see Table 3 enclosed. Table 3 provides the number of closed external investigation cases where the death occurred in an ambulance or ambulance depot notified to the coroner between 1 November 2019 and 31 October 2024.

A closed external investigation case is one in which the coroner is satisfied that the death is being investigated under an enactment other than the Coroners Act, and therefore the coroner does not conduct an inquiry into the death. Please refer to sections 68 and 69 of the Coroners Act for more information.

5. ***To what extent does the coroner currently not investigate ambulance service-related deaths due to concerns about resourcing?***

The Ministry is responding to part 5 of your request under the OIA.

Part of the coroner's role includes deciding whether to open and conduct an inquiry into a death. The coroner makes their decision based on the evidence available to them for each individual death. As coroners are independent judicial officers, the Ministry is unable to comment on their decision-making or how they conduct their investigation. A coroner's deliberations are court information which is excluded from the OIA as per section 2(6)(a). Therefore, I am refusing this part of your request under section 18(g) of the OIA as the Ministry does not hold the information you have requested, nor are there grounds for believing that the information is held by or connected more closely with the functions of another department, Minister of the Crown, or organisation.

6. ***Provide any briefs, emails or meeting minutes from the past year that relate to concerns about inadequate funding of the coroner's office, preventing timely investigation of deaths notified to the coroner.***

The Ministry is responding to part 6 of your request under the OIA.

The Ministry has interpreted 'coroner's office' to mean the Coroners Court. The Ministry does not hold any information for the period from 2 November 2023 to 2 November 2024 relating to funding constraints that impact timeliness in the Coroners Court. Therefore, I am refusing this part of your request under section 18(g) of the OIA as the information requested is not held by Minister of the Crown, nor are there grounds for believing that the information is held by or connected more closely with the functions of another department, Minister of the Crown, or organisation.

If you require any clarification of the information contained in this response, please contact Joe Locke, Media & Social Media Manager, on 021 636 416, or email media@justice.govt.nz
If you are not satisfied with the decision on information released to you under the Coroners Act 2006 you can make a complaint to the Chief Coroner. The Chief Coroner may be contacted by email at officeofthechiefcoroner@justice.govt.nz or by writing to the Office of the Chief Coroner at DX SX 11166, Wellington.

If you are not satisfied with the decision on information released to you under the OIA, you have the right to complain to the Ombudsman under section 28(3) of the OIA. You can contact the Office of the Ombudsman by calling 0800 802 60; or emailing info@ombudsman.parliament.nz

I trust this information assists.

Nāku noa, nā

Andrea King
Group Manager, Senior, Employment, Environment and Coroners Courts

Encl: **Table 1**: Total number of active cases referred to the coroner where death occurred in an ambulance or ambulance depot from 1 November 2019 to 31 October 2024
Table 2: Total number of closed cases where death occurred in an ambulance or ambulance depot notified to the coroner between 01 November 2019 and 31 October 2024
Table 3: Number of closed external investigation cases where death occurred in an ambulance or ambulance depot notified to the coroner between 01 November 2019 and 31 October 2024

Table 1: Total number of active cases referred to the coroner where death occurred in an ambulance or ambulance depot from 01 November 2019 to 31 October 2024

	Total
Active Cases	6

- This data may differ from previously released or published data. This data was extracted from the Court's Case Management System as of 26 November 2024.
- Cases are included based on the date the case was notified to the coroner (this can differ from the date of death).
- This data includes active cases. Active cases are currently under investigation by the coroner; therefore, this information is provisional.
- This data counts instances where "Ambulance" or "Ambulance depot" is recorded as the location in which the death occurred.
- Due to the way information has been recorded by, or presented to the coroner, the statistics provided should not be taken as representing every such instance.
- To find the information you have requested, we searched key words in the Court's Case Management System, meaning the search was dependent on the way in which the information was received and recorded. It is therefore possible that we have not identified all cases related to deaths that occurred in an ambulance.

Table 2: Total number of closed cases where death occurred in an ambulance or ambulance depot notified to the coroner between 01 November 2019 and 31 October 2024

	Total
Closed cases	47

- This data may differ from previously released or published data. This data was extracted from the Court's Case Management System as of 24 November 2024.
- Cases are included based on the date the case was notified to the coroner (this can differ from the date of death).
- This data includes closed cases. Closed cases have been heard by the coroner and findings have been issued.
- This data counts instances where "Ambulance" or "Ambulance depot" is recorded as the location in which the death occurred.
- Due to the way information has been recorded by, or presented to the coroner, the statistics provided should not be taken as representing every such instance.
- To find the information you have requested, we searched key words in the Court's Case Management System, meaning the search was dependent on the way in which the information was received and recorded. It is therefore possible that we have not identified all cases related to deaths that occurred in an ambulance.

Table 3: Number of closed external investigation cases where death occurred in an ambulance or ambulance depot notified to the coroner between 01 November 2019 and 31 October 2024

	COR 9	COR 10
External investigation cases	2	0

- This data may differ from previously released or published data. This data was extracted from the Court's Case Management System as of 26 November 2024.
- Cases are included based on the date the case was notified to the coroner (this can differ from the date of death).
- This data includes closed cases. Closed cases have been heard by the coroner and findings have been issued.
- This data counts instances where "Ambulance" or "Ambulance depot" is recorded as the location in which the death occurred.
- We have interpreted your request to mean cases where the coroner did not conduct an inquiry, as per section 68 or 69 of the Coroners Act 2006.
- Due to the way information has been recorded by, or presented to the coroner, the statistics provided should not be taken as representing every such instance.
- To find the information you have requested, we searched key words in the Court's Case Management System, meaning the search was dependent on the way in which the information was received and recorded. It is therefore possible that we have not identified all cases related to deaths that occurred in an ambulance.
- A Cor 9 refers to a decision by the coroner not to conduct an inquiry under section 68 of the Coroners Act.
- A Cor 10 refers to a decision by the coroner not to conduct an inquiry section 69 of the Coroners Act.