Appraisal Report for Coroners Court records

Appraisal Report

Functions, activities and records evaluation for

Ministry of Justice Coronial records

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Purpose
Coronial records have not been covered by a continuing disposal authority (hereafter schedule) since the expiry of a schedule in 2011 (file reference OP 2001/74). The development and implementation of a schedule for coronial records is an objective of the Ministry of Justice *Public Records Act* audit compliance work-plan which is being implemented following completion of the 2014/2015 recordkeeping audit of Courts and Tribunals. An ad-hoc authority was completed in 2009 (DA373) but was limited to District Office legacy files generated under the *Coroners Act 1988* and earlier legislation. With the expiry of this ad-hoc disposal authority, several classes of District Office records are included in this schedule to allow disposal of remaining legacy records. The new schedule takes account of changes to legislation especially with implementation of the *Coroners Act 2006* which brought substantial changes to many coronial processes. See the Agency and System Information section below for more information.
Scope

The proposed schedule covers paper coronial records including both current and legacy records (pre-dating the *Coroners Act 2006*).

Electronic records will be included in a separate multi-jurisdictional electronic records schedule.

The schedule also excludes Ministry operational and management records generated by the Coronial Services Unit, which supports Coroners but is separate from the coronial process. Again, these will be included in a separate records schedule.

There were 3,343 coronial case files in 2015. The annual number of cases is relatively stable over time.

Format

Paper records.

Agency and System Information

The purpose of the coronial process is to investigate circumstances and causes of death in a respectful and professional manner. The findings of these investigations are used to make recommendations for the improvement of public safety and to prevent deaths in similar circumstances.

The *Coroners Act 2006* (which replaced the *Coroners Act 1988*) brought substantial changes to the coronial process including:

- Provision for up to 20 legally qualified full-time Coroners (replacing the 55 part-time Coroners used previously)
- Appointment of the Chief Coroner
- Establishment of the Coronial Services Unit (CSU)
- Clarification of the role of Coroners and other agencies involved in investigating deaths
- Clarity of deaths that must be reported to the Coroner
- Better recognition of the different cultural and spiritual needs of families and those with a close relationship to the deceased
- Enhancing the inquiry and inquest processes and allowing greater public access to information.

The CSU was established in July 2007 to provide support to the Chief Coroner and the Coroners; to enable them to fulfil their legislative responsibilities, functions and duties. This includes hearing and case management, administrative, secretarial, research and registry support services for the new Coroners.

The CSU operates in three main regions - Auckland, Wellington and Christchurch, along with offices in Whangarei, Rotorua, Hamilton, Hastings, Palmerston North and Dunedin. There are currently 16 Coroners in the 9 locations who work circuits to provide a nation-wide service.

The content of coronial files generated under the *Coroners Act 2006* is similar to that contained in the files dating from the *Coroners Act 1988*.

A key difference in process is that, prior to the *Coroners Act 2006*, Coroners created and maintained custody of files until cases were completed and then forwarded the closed files to the Ministry for registration and storage. However, since the *Coroners Act 2006*, the National Initial Investigation Office (NIIO) creates and registers files into the Courts Management System (CMS) and adds the preliminary documents such as initial reports received from the New Zealand Police. These documents are then distributed to coronial offices that create physical files.

The files proposed for transfer to Archives New Zealand contain two categories of documents, coronial documents and documents provided to the Secretary of Justice.

The documents provided to the Secretary of Justice consist of the following:

Section 64 Natural causes of death

1) Coroners decision not to open an inquiry into a death including reasons (COR 2)
2) A signed, witnessed statement identifying the deceased person

Section 67 Opening an inquiry

3) Coroners decision to open an inquiry (COR 22)

Section 70 Death investigated by another agency

4) Coroners decision not to open or resume an inquiry as the cause and circumstances of death have been adequately established in the course of a criminal proceedings (COR 9)
5) Coroners decision not to open or resume an inquiry as the cause and circumstances of death have been adequately established in the course of another investigation (COR 10)

Section 93 Interim findings

6) Coroners certificate and written reasons of interim findings (COR 8)

Section 94 Findings

7) Coroners certificate of findings including written reasons and any specified recommendations or comments (COR 7)
8) All dispositions of evidence admitted for the purposes of the inquiry
9) A certificate of the registration of the death (if applicable)
10) A copy of the Solicitor-General's authority to open an inquiry (if applicable)

The remaining documents on file are the Coroners'.

In the context of the *Public Records Act 2005*, there are significant implications for access and disposal with storing both Secretary of Justice and coronial documents on the same files. In the context of the *Public Records Act 2005*, there is a different administrative head for each category of documents. For the documents provided to the Secretary of Justice, the administrative head is the Secretary of Justice and for the coronial documents, it is the Chief Coroner.

This delineation means that approval of both the Chief Coroner and the Secretary of Justice (or their delegates) is required for decisions relating to public access and records disposal.

Standard file tabs are used for most coronial files. All file types contain the preliminary documents, correspondence and if applicable, graphic material such as photographs. They

may also contain evidence reports and witness statements. The only substantial difference is that the COR 7 files also include inquest documentation, i.e. evidence given at an inquest.

Tab	Document type
INQUIRY	**includes** COR 8, COR 7,COR 9,COR 10,COR 2,CORONER Review and Directions, CORONER File Notes, INQUEST Findings, Inquest Transcripts, Pre Inquest Conference Minutes
CORRESPONDENCE	**These include ALL** correspondences – incoming and outgoing Letters, Fax Receipts, E-mails, Case Manager Notes, Requests for Information, etc
EVIDENCE REPORTS	**These include ALL** Evidence on the Coronial File i.e. Statements, Post Mortem Report, Toxicology Report, Reports, Submissions, Clinical Records, Police Deposition. **Note:** Where there is more than ONE post mortem report, i.e. where a post mortem has been amended or reissued, all copies are retained on the file.
PRELIMINARY ORDERS	**These include** POL 47, Statement of Identification, Life Extinct, COR documents (POST MORTEM direction, COR 3, COR 11), PPM, AB Form, Preliminary Fax receipts to and from NIIO, Preliminary Correspondences to and from NIIO, NIIO Notification
GRAPHIC MATERIAL	These include photographs of deceased person, suicide notes, and any photographs of the body of the deceased. **Note:** • All graphic material is filed into the grey envelope at the time of compiling the file. The documents are then secured in the envelope by hole-punching through the documents and the envelope. • A CAUTION-photographs and /or Graphic Documents sticker is placed on the front cover of the file and also onto the grey envelope. • The CSU case file number on the sticker for the grey envelope. • Case Notes are entered into CMS.

An electronic case file is also created and named with the same CMS file number as the paper case file. When generated, the following documents are scanned and filed into the electronic case file:

- Police notification form
- Post mortem report
- Toxicology report
- Coroners decision

These documents are stored in a Ministry network drive and used to answer research requests. The Ministry also provides the documents to the Australian based National Coronial Information System (NCIS) which is an internet-based data storage and retrieval

system for Australian and New Zealand Coronial cases. Since October 2014, weekly transfers of closed New Zealand case files have been automated. The following is a link to NCIS: http://www.ncis.org.au/

While the electronic case files are used to facilitate research and public requests for information, the paper case file remains the primary record.

Methodology

An assessment was made of the categories of documents contained within each record class and their standard content reviewed against the Archives New Zealand appraisal criteria.

Local Precedent: the previous schedule (OP 2001/74) identified inquest files and associated registers for transfer to Archives New Zealand 5 years after closure. There was little discussion of the relative archival value of the records or explanation of the unusually short 5 year retention period. The former schedule is therefore of limited precedent value.

An ad-hoc appraisal (DA373) was completed in 2009 that identified records for transfer which "contributed to the knowledge and understanding of New Zealand history and communities" and referred back to the earlier schedule (OP 2001/74). Due to the factors identified above in about the expired schedule, DA373 also lacks substantial precedent value.

Changes are proposed to several of the disposal classes in DA373. While the destruction class for District Office case files is retained, the retention classes for files documenting the discovery of human bones/skeletal remains and high profile cases containing information not recorded in the head office file is removed. An analysis of these precedents provided insufficient justification to warrant permanent retention.

International Precedent: the most relevant precedents are Australian disposal authorities. The disposal actions of the most relevant authorities are summarised below:

State of Victoria disposal authority for Coroner's Office records	Body cards (documentary material relating to the investigation of a reportable death or fire)	
	Class 1.1.0 Investigations involving inquests	**Destroy 15 years** after case completion
	Class 1.2.0 Investigations where the cause of death is determined by another court; such cases include homicides, suicides, culpable driving and infanticides or the case is resolved by a chambers hearing	**Transfer 5** years after case completion
	Class 1.3.0 Natural causes cases investigations not involving an inquest and in which the findings is classified as a "natural causes" death	**Destroy 25 years** after case completion
	Class 2.0.0. Inquest deposition files created for coronial investigations in which an inquest was held	**Transfer 5** years after case completion

New South Wales disposal authority for Court proceedings and administration	**Class 1.3.3** Records relating to Coroners matters where: I. the matter proceeded to a hearing of an inquest or inquiry or II. the matter was dispensed with but a brief of evidence was called for or further investigation undertaken **Class 1.3.2** Records (from 1940) relating to Coroners matters where the inquest or inquiry was dispensed with and no brief of evidence was called for or further investigation undertaken	**Transfer** to State archives (no transfer date provided) **Destroy** after a minimum of 100 years following last action
Queensland State Archives	**Class 3.2.1** Hearings relating to inquests conducted in the Coroners Court **Class 3.3.1** Reportable deaths – records relating to the investigation of reportable deaths such as Police reports, autopsy reports, witness statements, toxicology certificates, photographs, medical reports and Coroners findings	**Retain permanently**

While there are variations in disposal authorities between Australian states, files containing inquiry and inquest reports are generally identified for permanent retention. There are variable practices for non-inquest/investigation files between long-term retention followed by destruction or permanent retention where substantial evidence has been gathered.

Appraisal statement: the following Archives New Zealand high level appraisal criteria are most relevant to coronial records:

Criteria 2 Accountability: Records that are fundamental to providing citizens with trust in government; providing evidence of the well-being of the community and the impact of government activities on them, in compliance with relevant legislation and regulations.

Some classes of coronial records which reflect Criteria 2 represent an invaluable primary resource for a broad range of mortality based research including changes in patterns of preventable deaths. This, in turn, informs a wide range of health research initiatives. Comprehensive use of information extracted from coronial records is made by the Australian based National Coronial Information System (NCIS) and Ministry of Health supported research initiatives.

More broadly, some classes of coronial records document one of the most intrusive and direct state interventions in individual's lives (and deaths) and represent the most detailed accountability record of the circumstances surrounding deaths.

Criteria 6. Knowledge: Records that will substantially contribute to knowledge and understanding of New Zealand, its history, geography, society, culture and achievements and New Zealanders' sense of their national identity

Some classes of coronial records contribute substantially to knowledge about how New Zealanders live their lives both at an individual and community level. Research using coronial records contributes to the knowledge in a broad spectrum of subjects ranging from work place accidents through to patterns of suicide. Coronial records are also commonly used as a primary genealogical resource by family members of the deceased.

Destruction criteria: Coronial records recommended for destruction are those where an inquest or investigation is not required. While these files often contain considerable quantities of evidence from various sources which have demonstrated research value, they are not considered to be of permanent archival value for the following reasons:

1) In the absence of an investigation or inquest, these files do not represent the public inquiry function which is the fundamental purpose of the Coroners Court
2) Longer retention periods are provided for record classes in recognition of medium term research value.

Consultation

Internal consultation
[Name removed]
[Name removed]
[Name removed]
[Name removed]
[Name removed]

Chief Coroner for approval to commence external consultation and final submission of the disposal recommendations to Archives New Zealand.

External consultation
Consultation commenced following the Chief Coroners approval with the draft appraisal report and schedule circulated to the following agencies and groups with 3 weeks to respond:

- New Zealand Police
- Ministry of Health (Mortality Collection Unit)
- Auckland University School of Medicine
- Otago University School of Medicine
- Accident Compensation Corporation
- The Royal College of Pathologists of Australasia
- Statistics New Zealand
- All District Health Boards
- Genealogical Society of New Zealand
- Professional Historians Association of New Zealand/Aotearoa (PHANZA)
- Archives and Records Association of New Zealand (ARANZ)

Note that as consultation progressed, it was recommended that the Ministry also consult with the Transport Accident Investigation Commission (TAIC) and the relevant documents distributed as a consequence.

Responses were received from 12 agencies.
The key points arising from external consultation can be summarised as follows:

1) The Lakes District Health Board, the New Zealand Police and several other respondents indicated that the disposal recommendations and retention periods were appropriate.
2) Otago Medical School, the Ministry of Health and several other respondents indicated that the proposed retention periods for classes of records identified for destruction was either too short or all records should be retained indefinitely, i.e. transferred to Archives New Zealand.
3) Archives and Records Association of New Zealand (ARANZ) and the New Zealand Society of Genealogists and others raised the issue of retention of electronic documents, i.e. in NCIS, as a rationale for destroying paper records.

The following changes are recommended to the appraisal report and schedule on the basis of feedback obtained as a consequence of external consultation:

- Reference to retention of electronic coronial documents as a rationale for destroying paper records have been removed from the appraisal report.
- On balance, the delineation of records classes for transfer to Archives New Zealand and those for eventual destruction are retained though the retention periods for each changed (see point below).
- On the basis of the consistent view on the long-term research value of most classes of records recommended for destruction, the retention periods for all but one of these classes retention is increased to 50 years.
- The one exception to 50 years retention for destruction classes is for District Office coronial files as these largely duplicate the content of head office records and do not justify long term retention.

CLASS 1: Coronial case records created pursuant to the Coroners Act 2006

Schedule sub-class 1.1 – COR 7 Coronial inquiry case files

Description

Prior to the *Coroners Act 2006*, Inquest files (COR 7 files) documented the activities of Coroners, specifically individual inquests. The *Coroners Act 2006* replaced the *Coroners Act 1988* and introduced a new structure for the management of coronial services (see agency information and system section above).

These files document the core functions and work of Coroners in establishing the cause of death in specific instances including violent or unnatural death, death in prison, care, psychiatric hospital or children's home, suicide and death under certain medical procedures, i.e. anaesthetic.

While under the *Coroners Act 1988* all COR 7 files included an inquest, under the *Coroners Act 2006*, a decision to include an inquest or not is at the discretion of the Coroner. Findings are issued by the Coroner when an inquiry is completed either by Chambers Findings "Hearing on Papers" or Inquest. Hearings on paper may be held in particularly sensitive instances such as suicides.

Coronial case managers are responsible for creating files with the names of the deceased, file number (generated via the Court Management System CMS), date of opening and closing to be recorded on each file cover.

To support the consistent management of the coronial process, Section 132 of the *Coroners Act 2006* permits the Chief Coroner to issue Practice Notes to Coroners. Several Practice Notes include rules surrounding file management practices such as file structure and the use of document templates, i.e. 2014-1 Practice Note Role of the National Duty Coroner, 2015/1 Practice Note The Conduct of Inquests.

Files are arranged in alphabetical order and stored in assigned cabinets.

While active coronial files are managed within each district, once a case is completed, a final check is made of each file to ensure that all papers are filed under the appropriate tab. Any staples, paper clips and post it flag stickers are removed and a check is also made to ensure that all graphic material is appropriately filed, identified and enveloped. All Court Management System (CMS) actions are checked and finalised including recording date of the findings, status, i.e. complete, and file transfer details. Closed coronial case files are couriered to National Office in Wellington within 5 days of the Coroner's findings for storage.

Value statement

Inquest files constitute a record of a public enquiry into deaths that occur in specific circumstances (outlined in the Description field above).

Permanent retention is justified as these records represent an invaluable primary resource for a broad range of mortality based research including changes in patterns of preventable deaths.

This in turn, informs a wide range of health research initiatives. More broadly, they document one of the most intrusive and direct state interventions in individual's lives (and deaths) and represent the most detailed accountability record of the circumstances surrounding deaths as described above.

Coronial records also contribute substantially to knowledge about how New Zealanders live their lives both at an individual and community level. Research using coronial records contributes to the knowledge in a broad spectrum of subjects ranging from work place accidents through to patterns of suicide. Coronial records are also commonly used as a primary genealogical resource by family members of the deceased.

Owing to the ongoing use of these files following closure, retention for 25 years prior to transfer to Archives New Zealand is recommended.

Retention and disposal recommendation

Transfer to Archives New Zealand 25 years after file closure.

Schedule sub-class 1.2 – COR 2 Cases where findings are issued by the Coroner when an inquiry is not opened, i.e. for natural causes of death

Description

Based on evidence provided pursuant to Section 64(1) *Coroners Act 2006*, the Coroner has decided that an inquiry will not be opened and a finding of death by natural causes is issued.

COR 2 files use the same tabs as specified in the agency and system information section above with the exception of inquest documentation.

This class constitutes 65% (or about 2,000) of all case files generated annually.

This class consists only of case files generated under the *Coroners Act 2006*.

The 4 key documents types, i.e. the Police notification form, Post mortem reports, toxicology reports and the Coroners decision, are retained electronically and are currently referred to when responding to short-term research requests. However as there is no formal process for managing and preserving the electronic documents over the medium and long-term. Consideration was given to retaining these as a substitute to the paper case file.

Coronial inquest unnecessary files under the *Coroners Act 1988* are included in a separate legacy disposal class.

Value statement

This class is similar to the earlier non-inquest files prior to the *Coroners Act 2006*. Assuming that the types of research using these records will be similar to the well documented non-inquest files as below:

1) Families (and lawyers representing family) of the deceased for information concerning the family members death
2) Other individuals including friends and the media with an interest in an individual's cause of death
3) Mortality Review Committees who study the circumstances of children and youth deaths and recommend changes to health case based on research results. An example is the issue of co-sleeping and Sudden Unexpected Deaths in Infancy
4) Non-Government organisations (NGO's) involved in research
5) Medical professionals such as doctors with patient with conditions similar to a deceased relative researching links with family history illnesses and genetic disorders
6) Insurance companies and banks identifying causes/circumstances of deaths as part of investigations into insurance claims.

The Appraisal Statement Criterion 6 Knowledge which includes scientific/technical/engineering is most applicable to this class. As indicated above, research using information extracted from these files has been used for research in such substantive areas as Sudden Unexpected Deaths in Infancy. In addition, the use of medical information in the context of genetic disorders may increase over time though these files are unlikely to be the best source for such information.

The key question is whether the demonstrated research value of these records is sufficient to justify transfer to Archives New Zealand in terms of criterion 6. A review of the research uses indicates that an extended retention period should be sufficient to meet most research needs. In this context a minimum retention period of 50 years is recommended.

Retention and disposal recommendation

Destroy 50 years after file closure.

Schedule sub-class 1.3 – COR 9 Cases where a finding is issued when an inquiry will not be opened/resumed because the inquiry has been dealt with by criminal prosecution proceedings

Description

The prosecuting authority is usually the New Zealand Police involving serious charges such as murder.

COR 9 files use the same tabs as specified in the agency and system information section above with the exception of inquest documentation.

Value statement

Most documents contained in these files are generated by Police or other agencies. The prosecutions involve serious criminal charges led by the Police and the Police offence file should retain copies of the key documents such as the Police notification form and post mortem reports.

The Courts case file schedule (DA564) requires permanent retention of all High Court criminal case files and District Court files documenting significant offences such as wrongful death

prosecuted through the District Court. While these files contain Coroners Court findings they do not contain inquest reports for which the Coroner is accountable.

Records from this class are regularly requested for research purposes by:

1. Families (and lawyers representing family) of the deceased for information concerning the family members death
2. Other individuals including friends and the media with an interest in an individual's cause of death
3. Mortality Review Committees who study the circumstances of children and youth deaths and recommend changes to health case based on research results. An example is the issue of co-sleeping and Sudden Unexpected Deaths in Infancy
4. Non-Government organisations (NGO's) involved in research
5. Medical professionals such as doctors with patient with conditions similar to a deceased relative researching links with family history illnesses and genetic disorders.

Most of the type of research identified above will be completed within the recommended 50 year retention period.

There is a potential exception for research into genetic disorders. It is however, difficult to justify the permanent retention of large quantities of records on the basis of a theoretical future use. In addition, District Health Board patient files (which presumably would have more comprehensive information relevant to genetic disorder research) are approved for destruction 10 years after the death of the patient if no longer required for any other purpose (see DA262).

Retention and disposal recommendation

Destroy 50 years after file closure.

Schedule sub-class 1.4 – COR10 Cases where a finding is issued when an inquiry will not be opened/resumed because the inquiry has been dealt with by another agency

Description

These prosecuting authorities for these files are those excluding the New Zealand Police such as the Civil Aviation Authority, Worksafe NZ and the Health and Disability Commissioner.

COR 10 files use the same tabs as specified in the agency and system information section above with the exception of inquest documentation.

Value statement

Most of the documents contained in these files are generated by other agencies (excluding Police). While these files contain Coroners findings they do not contain inquest reports for which the Coroner is accountable.

Records from this class are regularly requested for research purposes by:

1. Families (and lawyers representing family) of the deceased for information concerning

the family members death
2. Other individuals including friends and the media with an interest in an individual's cause of death
3. Mortality Review Committees who study the circumstances of children and youth deaths and recommend changes to health case based on research results. An example is the issue of co-sleeping and Sudden Unexpected Deaths in Infancy (SUDI's)
4. Non-Government organisations (NGO's) involved in research
5. Medical professionals such as doctors with patient with conditions similar to a deceased relative researching links with family history illnesses and genetic disorders

The type of research identified above will be completed within the recommended 50 year retention period.

There is a potential exception for research into genetic disorders. It is however, difficult to justify the permanent retention of large quantities of records on the basis of a theoretical future use. In this context it is also worth noting that District Health Board patient files (which presumably would have more comprehensive information relevant to genetic disorder research) are approved for destruction 10 years after the death of the patient if no longer required for any other purpose (DA262).

Retention and disposal recommendation

Destroy 50 years after file closure.

CLASS 2 – Coroners Court records created prior to the Coroners Act 2006

Schedule sub-class 2.1 – Coronial inquest files prior to the Coroners Act 2006

Description

These files document the activities of Coroners, specifically individual inquests as set out in the *Coroners Act 1988* and earlier legislation.

The files record the Coroners work in establishing the cause of death in specified instances i.e. violent or unnatural death, death in prison, care psychiatric hospitals or children's home, suicide and death under certain medical procedures, i.e. anaesthetic.

Typical documentation includes standard forms i.e. Coronial notification of decisions and related correspondence, a hospital post-mortem reports, a certificate of death, sworn statements, any other evidence and information documenting the coronial process.

These files are typically alpha annual single-number files followed by the name i.e. COR 80/29, Name. Most are split pin files, occasionally accompanied by videos or other miscellaneous items used in the inquest.

See agency information and system section above for more information.

Value statement

Inquest files constitute a record of a public enquiry into deaths that occur in specific circumstances (outlined in the Descriptions field above).

Permanent retention is justified as these records represent an invaluable primary resource for a broad range of mortality based research including changes in patterns of preventable deaths. This in turn, informs a wide range of health research initiatives.

More broadly, they document one of the most intrusive and direct state interventions in individual's lives (and deaths) and represent the most detailed accountability record of the circumstances surrounding deaths as described above.

Coronial records also contribute substantially to knowledge about how New Zealanders live their lives both at an individual and community level. Research using coronial records contributes to the knowledge in a broad spectrum of subjects ranging from work place accidents through to patterns of suicide. Coronial records are also commonly used as a primary genealogical resource by family members of the deceased.

Owing to the ongoing use of these files following closure, retention for 50 years prior to transfer to Archives New Zealand is recommended.

Retention and disposal recommendation

Transfer to Archives New Zealand 25 years after file closure.

Schedule sub-class 2.2 – Coronial non-inquest files prior to the Coroners Act 2006

Description

Inquest unnecessary files record the decision not to proceed with an inquest. Typical documentation includes standard forms i.e. `Notification of Decision that Inquest Unnecessary or to be Discontinued'. Occasionally there are additional papers such as a hospital post-mortem report, a certificate of death, and a sworn statement. Records date from approximately 1988 until the present day for deaths investigated by coroners prior to the 1 July 2007 introduction of the *Coroners Act 2006*. Note that there is a separate class for the comparable records produced pursuant to the *Coroners Act 2006*.

These case files were identified for destruction after 5 years in both the 2001 schedule (OP 2001/0074) and the 2009 ad-hoc disposal authority (DA373).

Under the expired schedule (OP 2001/0074) coroners unnecessary case files were approved for destruction 5 years after closure. However, the practice was to transfer these records to the custody of the Ministry of Health dating from 1979 to current for deaths investigated by coroners prior to 1 July 2007, i.e. introduction of the *Coroners Act 2006*.

The Ministry of Health accepted custody of these records as they support the Ministry's role in

reporting and monitoring the number, demographics and causes of death in terms of New Zealand's international obligations to the World Health Organisation. The records also support the Ministry's own research and policy development for reducing preventable morbidity and mortality in New Zealand.

The transfer was formalised in a Memorandum of Understanding (MOU) between the Ministry of Health, the Ministry of Justice and the Chief Coroner signed in October 2014. Under the terms of the MOU, the Ministry of Health provides a service to the Coronial Services Unit which includes **"archiving of coronial non inquest files received at the Coronial Services Unit in the years 1979 to the present day for deaths investigated by coroners prior to the 1 July 2007 introduction of the *Coroners Act 2006*".**

In practice the Ministry of Health is responsible for storage of these records but the Ministry of Justice maintains effective control of these records including implementation of disposal. Consequently, a disposal authority pursuant to section 20 (1) (a) of the *Public Records Act 2005* (transfer of control of public records to another agency) was not requested when the MOU was drafted.

Given the proposed length of retention of these records, the Ministry of Health was consulted with a particular focus on the proposed retention period before destruction.

Value statement

The 2001 appraisal identified these records to be of purely ephemeral value according to the criteria for conducting a Coroner's Inquest as set out in the *Coroners Act 1988*. Destruction was approved 5 years after file closure. No further analysis of the potential archival value of these records or the 5 year retention period was included in the appraisal report.

Typical file content increased substantially in the years following the 2001 appraisal report with many of the document types specified in the tab structure outlined in the Agency and System Information section of the report above.

Due to this change and the view that the records substantial long-term research value, a detailed assessment was made of the research use of these records.

Access requests for these records indicate:

Requestor	2013	2014	2015
Ministry of Justice	55	24	28
Ministry of Health	17	7	3

Records from this class are regularly requested for research purposes by:

1. Families (and lawyers representing family) of the deceased for information concerning the family members death
2. Other individuals including friends and the media with an interest in an individual's cause of death
3. Mortality Review Committees who study the circumstances of children and youth deaths and recommend changes to health case based on research results. An example is the issue of co-sleeping and Sudden Unexpected Deaths in Infancy
4. Non-Government organisations (NGO's) involved in research

5. Medical professionals such as doctors with patient with conditions similar to a deceased relative researching links with family history illnesses and genetic disorders
6. Insurance companies and banks identifying causes/circumstances of deaths as part of investigations into insurance claims

The Appraisal Statement Criterion 6 Knowledge which includes scientific/technical/engineering is most applicable to this class. As indicated above, research using information extracted from these files has been used for research in such substantive areas as Sudden Unexpected Deaths in Infancy. In addition, the use of medical information in the context of genetic disorders may increase over time though these files are unlikely to be the best source for such information.

This class is similar to the later COR 2 class (cases where the findings are issued by the Coroner when an inquiry is not opened) with COR 2 files recommended for destruction 50 years after file closure. Given similarities between the 2 record classes a common minimum retention period of 50 years after closure is recommended.

The key question is whether the demonstrated research value of these records is sufficient to justify transfer to Archives New Zealand in terms of criterion 6. A review of the research uses indicates that an extended retention period should be sufficient to meet most research needs. In this context a minimum retention period of 50 years is recommended. The Ministry of Health however, may choose to retain these records longer if required to support longer term research needs.

Retention and disposal recommendation

Destroy 50 years after file closure.

Schedule sub-class 2.3 – District Office Coronial files

Description

This class was in the ad-hoc disposal authority (DA373) which authorised destruction of all but a small number of District Office files. While most of these records were destroyed under DA373, this class is retained to allow destruction of remaining residue records.

These records generated under the former *Coroners Act 1988* and earlier, contain copies of head office documents with little original information. File content typically consists of:

- Notification of death

- COR2 form (if a decision was made not to hold a formal inquest)

OR

- COR 7 form (if a decision was made to hold a formal inquest)

OR

- COR 9 form (if a decision was made to cease the formal hearing)

Other documentation may include correspondence with Health Boards, Transport agencies, or family members. Photographs and reference material may also be included.

Value statement
The 2009 ad-hoc appraisals of coronial records (DA373) noted that most of these files were copies of head office records and consequently are appropriate for destruction. The previous 5 years retention period was adequate under DA373 and is recommended to be continued.
Retention and disposal recommendation
Destroy 5 years after file closure.

Schedule sub-class 2.4 – District Office Coronial files where the original head office record is permanently lost
Description
This class was in the ad-hoc disposal authority (DA373) and consists of files where the equivalent head office file was permanently lost, i.e. not sighted for a minimum of 5 years, or inadvertently destroyed.
Value statement
These files contain much of the same content as the head office record. It is proposed to retain the District Office file as a substitute record in cases where the Head Office file would otherwise be transferred to Archives New Zealand. Because the records in this sub-class will replace a missing head office file (sub-class 2.1), they assume the same value. They are the record of a public inquiry into a death; are an invaluable primary source for a broad range of mortality research; document the most intrusive and direct state interventions in individuals lives (and deaths); contribute substantially to knowledge about New Zealanders as individuals and as a community; and are a primary genealogical resource. Only a very small number of files will be subject to this class.
Retention and disposal recommendation
Transfer to Archives New Zealand 25 years after file closure.

Schedule sub-class 2.5 – Annual numerical/alphabetical registers and indexes to Coroners Court files

Description

These are hard bound numerical or alphabetical indexes and registers. The indexes provide access to the registers, and the registers provide access to the inquest files.

The registers contain a summary of the information on the files: file number, date, subject of the inquest, where the inquest was held, verdict, and reference (which government agency the death was referred to).

The indexes document all investigations begun by the coroner, including non-inquests.

Value statement

The registers and indexes are necessary access tools to coronial case files. They contain summary information from the inquest files.

Permanent retention is justified as they form part of the record of a public inquiry into deaths, and are an invaluable source for a broad range of mortality research. They contain information on the most intrusive and direct state interventions in individuals' lives (and deaths). These records contribute substantially to knowledge about New Zealanders as individuals and as a community, and are a genealogical resource.

Retention and disposal recommendation

Transfer to Archives New Zealand 25 years after last entry

Access Recommendations

[Removed]

Caveat

Refer to any sentencing guidelines accompanying this report for specific recommendations:

- **records must be kept for the minimum period specified**
- **records may be destroyed at any point once the minimum retention periods have passed. Records do not have to be destroyed; the agency may keep them for longer if required.**

This authority is valid for a period of 10 years from date of signing, unless previously agreed with the Chief Archivist.