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In the National Assembly
Tuesday 3rd December 2019

**SECOND READING DEBATE**

CORONER’S OFFICE BILL [H. B. 5, 2019]

**Report by Portfolio Committee on Justice, Legal and Parliamentary Affairs**

**Presented by Hon Mataranyika**

**INTRODUCTION**

The Coroner’s Office Bill was gazetted on the 21st June, 2019. Its purpose as set out in the memorandum is to provide for the establishment of an office responsible for investigating all deaths that come about as a result of unnatural causes. It also sets out the appointment, functions, and powers of the Coroner-General, Deputy Coroner-General and Coroners in relation to post-mortems, inquests and their findings.

The Bill repeals the Inquests Act [Chapter 7:07], and amends the Birth and Deaths Registration Act [Chapter 5:02] and the Burial and Cremation Act [Chapter 5:03].

Parliament has a role to enhance access to Parliament by the public as well as strengthen public participation in the legislative process, in line with Section 141 of the Constitution.

In this regard, the Portfolio Committee on Justice, Legal and Parliamentary Affairs conducted public consultations in Gweru, Bulawayo, Masvingo, Mutare and Harare, from the 14th - 17th of October 2019, to gather people’s views on the Bill.

**SUBMISSIONS FROM THE PUBLIC**

**Clause 1: Short title and commencement**

This is just a title clause which no members of the public had issues with.

**Clause 2: Interpretation**

‘Unnatural deaths’ is defined as primarily not caused by natural death and the one that appears to come in a sudden, suspicious or violent way.

Some members of the public submitted that this was a vague definition as it is in the negative.

**Clause 3**: **Establishment and constitution of Office**

The peremptory proviso on Clause 3(5) which states that the Minister ‘*may endeavour’* to establish branches at provincial, district and other administrative levels was found to be problematic.

Members of the public suggested that the law should make it mandatory, rather than discretionary, in line with the spirit of devolution and to enable better performance and accessibility of the Office.

**Clause 4: Functions of the Office**

No comments were raised on this Clause

**Clause 5**: **Appointment of Coroner- General, Deputy- Coroner General and Coroners**

The Clause makes provision for the appointment of the Coroner- General, Deputy- Coroner General and Coroners. The appointment of the Coroner- General and the Deputy will be made by the President, in consultation with the Minister.

The reservations on this Clause were made on the appointment process. Members of the public were of the view that appointment of the Coroner- General and the Deputy should be done by Parliament in the same manner as Independent Commissions. The general feeling from the public is that, the Coroner should not hold any political office or after appointment be actively involved with any other work.

The qualifications of a Coroner ranges from forensic pathology, forensic sciences, or medical jurisprudence or any prescribed discipline. In addition, the person must be a fit and proper person to be entrusted with responsibility of the position.

Members of the public felt that, ‘…any prescribed discipline’ should be removed from the Bill. It was submitted that the qualification for one to become a Coroner should be restricted to only forensic pathology, forensic sciences and medical jurisprudence.

**Clause 6**: **Funds and Accounting Status of Office**

The clause outlines the sources of Funding and accounting status of the Coroner’s Office in accordance with the Public Finance Management Act. The clause subjects the accounts of the Coroner’s Office to audit by the Auditor- General.

Members of the public welcomed this clause as it is in line with sound public finance management principles.

**Clause 7: Preservation of Medical Records and Duties of Medical Practitioners**

In terms of this Clause, where a person dies, while in any health institution for medical treatment or care or while in custody, the custodial officer shall preserve all medical records, health care records or any other documents pertaining to medical treatment of the deceased for a period of not less than five years.

It was raised that the provision is too broad, the Bill should identify a specific person who shall the Custodial Officer. It was further proposed that the Bill should be specific on how and where to keep the records.

**Clause 8: Reporting of Deaths**

No comments were raised on this Clause.

**Clause 9: Post-mortem Examinations**

No comments raised on this Clause.

**Clause 10**: **Review of decision not to hold inquest**

The clause provides for the review of a decision by a Coroner not to hold an inquest. It states that a person aggrieved by the decision not to hold an inquest can apply to the Coroner or Coroner-General for a reconsideration of the decision and that should be done within a period of 30 years from the date of the deceased concerned.

Some members of the public were of the view that there should not be a bar; in case of new leads there should be a room to apply for reconsideration of the Coroner’s decision.

**Clause 11: Inquests and Powers of Coroners in Relation thereto**

No comments were raised on this Clause.

**Clause 12: Procedure at Inquest**

No comments were raised on this Clause.

**Clause 13: Duties of Coroner at Conclusion of Inquest**

No comments were raised on this Clause

**Clause 14: Publication of Coroner’s Findings**

The clause provides for the publication of a Coroner’s findings and observations.

Members of the public proposed that the Bill should specify that results of an inquest should be published within 3 months.

**Clause 15**: **Reporting Offences, Corrupt Conduct or Misconduct**

The Clause makes it an obligation for the Coroner to report offences, corrupt conduct or misconduct to the National Prosecuting Authority.

Members of the public applauded the Bill on the provision that empowers the coroner to give information to the National Prosecuting Authority if he/she reasonably suspects that a person has committed an offence.

**Clause 16**: **Inquest on Deaths of Members of the Defence Forces**

The Clause makes provision for inquests on death of members of Defence Forces dispensed within certain cases.

Members of the public suggested that where an inquest of this nature is held, there is need for application to the Coroner General for a certificate that this matter is confidential to the security of the State.

**Clause 17: Minister May Give Policy Directions**

The clause provides that the Minister may give policy directions to the Coroner-General, to which the Coroner-General should comply.

Some people were of the view that this provision gives excess powers to the Minister which may be abused in the name of ‘policy direction’.

**Clause 18**: **Regulations**

The Clause provides that the Minister, in consultation with the Coroner-General, may prescribe regulations on the terms and conditions of service, vacation of office, dismissal of members and filling of vacancies in the coroner’s office, fees and charges payable for services and facilities provided by the office, among other matters relating to the Coroner’s Office.

Some members of the public were of the view that the Minister of Home Affairs is the defendant for those who die in police custody, while the Minister of Justice, Legal and Parliamentary Affairs is the defendant for those who die in prison, therefore they are compromised. They suggested that the Bill should create an independent body to make these regulations.

**Clause 19: Official Formal Electronic Communication Platform**

The Clause provides that the Coroner’s Office should; have an official formal electronic communication platform and publish a Coroner-General’s bulletin every three months.

Members of the public welcomed this clause as it allows dissemination of information on the work of the Office.

**COMMITTEE OBSERVATIONS AND RECOMMENDATIONS**

The Committee recommends that there should be a Coroner Board. A clause mandating compliance with the gender provisions and requirements for regional representation of the Constitution should also be included in the Bill in the set-up of the board.

The Committee takes note of the divergent opinions on the appointment of the Coroner- General and Deputy- Coroner General. It is the Committee’s view that the appointment of the Office bearers would then remain preserve of the Coroner Board.

It is the view of the Committee that there are certain minimum standards of qualification that are necessary for one to become a Coroner. The Committee recommends that qualifications of a Coroner should be restricted to only forensic pathology, forensic sciences, and medical jurisprudence.

Zimbabwe has challenges of human resources shortage partly due to the country’s lack of capacity to train forensic pathologists, the lack of uptake of Forensic Pathology by Zimbabwean medical doctors, rudimentary infrastructure and shortage of specialist institutions and facilities, like CT scan services, pathological laboratory test facilities as well as toxicology testing and analysis equipment. These challenges need to be addressed in order for the Coroner’s Office to be able to effectively carry out its functions.

The Coroner’s office should be decentralised and have offices outside Harare and overally, the system must be established in such a way that it is sustainable and financially viable. The Committee strongly recommends the government to take a bolder approach to put in place the coroner system, embodying in legislation an enhanced decentralisation mechanism. On the face of the Bill should be clarification on how the coroner system is intended to function in scattered and remote areas. This should be backed up with significant resources to produce a system which provides greater public benefit and value for money.

The safeguards of financial accountability should be tight enough to avoid a misappropriation of public funds and property. The Coroner Board should be responsible for the usage and distribution of obtained funds.

Given the paramount importance of records in death investigations, the proposed system needs to be adequate to ensure the preservation of medical records and other relevant evidence. It is recommended that the obligation to keep records of deaths should be placed on a specified person for example Chief Executive Officer of a Medical Institution. It is further recommended for computerisation of the records to enhance efficiency.

**CONCLUSION**

The Bill is a welcome development as it addresses the current challenge of a fragmented legal framework in inquests related matters. It is the Committee’s view that co-operation and collaboration of the three responsible Ministries, the Ministry of Justice, Legal and Parliamentary Affairs, Ministry of Health and Child Care and the Ministry of Home Affairs, is essential for the successful implementation of the Coroner’s Office. There is need therefore, for an explicit framework for consultation and active participation in the Coroner system by the three ministries.

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