The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

13 February 2026

Committee Secretariat
Justice Committee
Parliament Buildings
WELLINGTON

By email: ju@parliament.govt.nz

Tēnā koe,

The Royal New Zealand College of General Practitioners Submission on the proposed Arms Bill

1. Introduction

The College welcomes the opportunity to comment on the proposed Arms Bill. We acknowledge and support the Bill's intent to modernise firearms legislation, streamline regulatory functions, and enhance public safety. Our submission focuses specifically on the implications for the General Practice and the role of specialist GPs within firearms licensing and monitoring.

Our feedback draws on both the proposals in the Arms Bill explanation document and the existing clinical obligations under Section 92 of the Arms Act 1983 [1], as well as current Te Tari Pūreke guidance for health practitioners[2].

2. Existing Clinical Framework Must Be Retained and Clarified

2.1 Section 92 obligations remain the foundation for health practitioner engagement; however, further clarification is required

While Section 92 of the current Act gives health practitioners a legally defined role in notifying concerns, in practice this role is not as clear or well understood as often assumed. Although Te Tari Pūreke provides guidance on clinicians' responsibilities[2], many practitioners report uncertainty about when they should notify and how to interpret the expectation that they "consider notifying" when they believe a patient may no longer be fit and proper to possess firearms.

This ambiguity can result in conflicted and delicate decision-making. Practitioners must weigh the potential risk of harm that could arise from not notifying against the risk of damaging the relationship with their patient—something that can have significant health consequences. The pressure is even more pronounced in small or isolated communities, where it may be readily apparent which clinician has made the notification. This can expose practitioners to personal or professional risk and may create hesitancy to act, even where concerns are present.

Greater clarity, protections, and practical support for health practitioners would help ensure that frameworks such as the current Section 92 operates as intended, without creating undue burden or risk for those expected to give effect to it.

2.2 The new legislation must explicitly preserve this pathway

The Bill introduces new mechanisms, such as an independent regulator and a formalised red flag system but does not clearly articulate how these will interact with Section 92 processes.

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The College recommends that:

- The current health practitioner notification pathway is explicitly carried forward in legislation.
- Health reporting remains separate from generalised red-flag or inter-agency reporting systems.
- Any expansion of reporting expectations must be clearly defined and developed in collaboration with specialist GPs.

3. Health Related Licence Suspensions

3.1 Extension from 3 to 12 months

The proposal to extend health related suspensions from three months to twelve months can create sufficient time for medical assessment and mitigation planning. It is essential that responsibilities under the new framework remain clearly allocated. A longer suspension period increases the likelihood that licence holders will experience changes in health status, personal circumstances, or place of enrolment — all of which require careful consideration when determining where clinical and regulatory duties sit.

In addition, the College notes that many licence holders with complex mental health needs may move between practices or experience periods without enrolment. The regulator must recognise that general practice cannot maintain continuous oversight during a 12-month suspension period.

3.2 GP responsibilities must remain limited to clinical assessment

A specialist GP's role is to:

- Provide factual medical information already known to them;
- Offer clinical opinion within the limits of normal patient care;
- Document concerns in the patient's clinical record.

Specialist GPs must not be expected to:

- Proactively monitor suspended individuals;
- Track patient movements or reengagement;

Because general practice operates within a dynamic and patient-led enrolment system, it is not feasible for GPs or practices to maintain oversight of licence holders throughout the extended suspension period. Patients may relocate, unenroll, fail to update contact details, or move between practices with incompatible Patient Management Systems (PMS). These realities create significant risks if the regulator assumes that GPs hold continuous visibility of an individual's health or access to firearms.

GPs cannot safely or appropriately undertake regulatory supervision functions. Their role must remain focused on providing patient care and, where feasible, reporting any relevant medical concerns to the regulator through the established health practitioner notification pathway.

The College also seeks clarity regarding liability expectations. While Section 361(5) provides immunity from criminal, civil, or disciplinary proceedings when a health practitioner discloses information in good faith, the Bill does not address liability in situations where a clinician reasonably judges that notification is not clinically indicated. Clinicians therefore require explicit confirmation that they will not be held responsible for adverse events that occur despite acting reasonably, exercising clinical judgement, and meeting their obligations under Section 361.

3.4 Clarity needed on how medical assessments will occur within the 12month period

The College seeks clarification on how the regulator intends to request, use, and update clinical information during a twelve-month suspension. Specifically:

- Will the regulator seek one medical assessment, or multiple assessments over time?
- How will the regulator identify the correct current GP, given enrolment changes and PMS variability?

4. Health Practitioner Definition and Nomination Issues

4.1 The current nomination model allows loopholes

Te Tari Pūreke guidance acknowledges that applicants may nominate *any* qualifying health practitioner. This results in:

- Inconsistent availability of clinical information,
- Reduced ability to assess long-term risk,
- Applicants intentionally nominating practitioners with limited knowledge of their health status.

4.2 The Bill should require the applicant's usual GP or practice

To strengthen clinical relevance and public safety, the College recommends that:

- Applicants must nominate their usual GP or usual practice.
- If a different practitioner is nominated, Te Tari Pūreke must verify a legitimate clinical relationship.
- Notifications from the regulator should go to the practice, not an individual practitioner, to prevent information loss.

5. Information Sharing Provisions

5.1 Protecting health data

The Bill enables information sharing between Police and the regulator. The College supports this for administrative and public safety purposes but seeks explicit exclusion of general health information from automatic sharing.

In line with WAI 2575 [3]and the Tiriti principle of active protection, the College is concerned about how Māori data will be managed within expanded cross-system information-sharing arrangements. Māori are disproportionately impacted by justice and regulatory systems, and any movement of personal or health information between the regulator and Police carries a heightened risk of reinforcing systemic bias. Active protection in this context requires assurance that Māori data will be handled with explicit safeguards, culturally informed protocols, and strict limits on its use, so that firearms-related processes do not further compromise Māori trust or wellbeing.

The College also notes the operational implications for practices. Regulator notifications will require prominent, enduring PMS flags to ensure any clinician interacting with the patient is aware of the licence status. The processes of receiving notifications, applying and maintaining flags, and managing related correspondence introduce administrative time, legal exposure, and workflow impacts that must be recognised.

5.2 Protocols for clinician engagement

Operational guidance must specify:

- What information can be requested;
- How requests should be structured;
- Secure communication channels.

These should be co-designed with RNZCGP.

6. Equity Considerations

6.1 Acknowledging systemic bias

The College acknowledges the well-documented systemic bias experienced by Māori across both the health and justice sectors. In this context, Māori are at increased risk of having their information used in ways that

reinforce existing disparities, including disproportionate scrutiny, misinterpretation of health issues as risk factors, and reduced willingness to seek care due to fear of agency involvement.

6.2 Data sharing risks for Māori

Given these inequities, the College is concerned that expanded information sharing powers between Police and the regulator may disproportionately impact Māori firearms licence holders. Any process that increases the flow of personal or health information between agencies must be approached cautiously, with strong privacy protections and a clear, narrowly defined purpose.

6.3 Importance of the GP–patient relationship for Māori

Trust in the GP–patient relationship is crucial for Māori, particularly where interactions involve state agencies. If patients perceive that engaging with their GP may result in unintended or disproportionate regulatory consequences, this could undermine healthcare engagement and worsen existing inequities in access to primary care.

This risk is heightened for Māori due to longstanding and disproportionate negative experiences when engaging with Crown systems — highlighted again during the COVID19 response, when Māori communities raised significant concerns about data use, surveillance, and inconsistent access to culturally safe services. The College therefore emphasises that any firearms related health processes must protect patient trust, ensure culturally safe engagement, and avoid exacerbating inequitable outcomes and impacts on Māori.

Conclusion

The College supports legislation that strengthens public safety while protecting clinical ethics and patient trust. We support the intention of this Bill and wish to engage with Te Tari Pūreke after this Bill has passed to re-establish clear expectations of specialist GPs.

The College also notes that the proposed system introduces new costs for general practice, including preparation of medical reports, secure communication and record-management processes, and participation in independent assessment pathways. These functions must be formally recognised and appropriately funded to avoid imposing an unfunded mandate on community care.

The College requests structured engagement with the regulator following enactment, specifically to:

- Co-develop clear clinical guidance, including confidential notification pathways;
- Clarify expectations around 12-month suspensions and confirm liability protections for clinicians acting in good faith;
- Ensure strong privacy and Māori data safeguards;
- Align operations with general practice realities — including PMS flags, practice-level notifications, enrolment requirements — and ensure appropriate funding for the associated clinical, administrative, and medico-legal workload.

Nāku noa, nā

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[1] Section 92, Arms Act 1983. Available at: https://www.legislation.govt.nz/act/public/1983/0044/latest/LMS440519.html

[2] Te Tari Pūreke (Firearms Safety Authority), Information for Health Practitioners. Available at: https://www.firearmssafetyauthority.govt.nz/manage-and-apply/health-and-wellbeing/information-health-practitioners

[3] WAI 2575, Health Service and Outcomes, Waitangi Tribunal. Available at: https://waitangitribunal.govt.nz/en/inquiries/kaupapa-inquiries/health-services-and-outcomes