State Coroner’s Guidelines 2013

Chapter 10

Access to coronial information

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10.1 Introduction

Information generated by and obtained during a coronial investigation can be highly sensitive or distressing, yet timely and appropriate release of coronial information can be therapeutic for the deceased person’s family or important for other investigative, systemic review, legal or financial processes running concurrently in respect of the death. Coronial information can usefully inform medical, scientific or other research which in turn assists the coronial system to prevent future deaths. Carefully considered public release of coronial information can help protect public health and safety and can also properly inform fair and accurate reporting of inquest proceedings.

This Chapter sets out the considerations a coroner must take into account before releasing coronial information. It provides guidance about how to manage requests for access to sensitive and potentially distressing material. It deals with the process by which researcher applications are managed. It briefly explains other standing access arrangements established by the Act. It also clarifies the application of the Right to Information and Information Privacy schemes to coronial information.

In this guideline, the concept of coronial information encompasses both documentary items gathered during a coronial investigation and information derived from those documents.

Legislation

Coroners Act
Section 17(4) & (5), 38, 52-59, 62

Acts Interpretation Act
Section 36, definition of ‘document’

Recording of Evidence Act and Recording of Evidence Regulation
Sections 5B (Act) and sections .4, 6, 7 (Regulation)

Right to Information Act
Sections 4, 11, Schedule 1 (Documents to which this Act does not apply) s. 8

10.2 Access to investigation documents for other than research purposes

In principle

Determining whether access should be granted to investigation documents requires the consideration and balancing of competing interests - the privacy of the deceased and his or her family members; the openness and transparency of official processes; and the potential benefits to public health and safety.

Independence, openness and transparency are hallmark features of the coronial process. However, information coming to light during a coronial
investigation is often confidential, personal, highly sensitive or distressing. Coroners should conduct their investigations in a way that appropriately and sensitively manages the needs of those with a legitimate interest in the information arising from an investigation but carefully guards against exciting or satisfying mere personal or public curiosity.

The determination of whether someone has sufficient interest in a document requires consideration of their connection with the deceased person or the circumstances of the death, the particular purpose for which access is sought and the document’s relevance to that purpose. For example a deceased person’s spouse may need access to an autopsy report to process a life insurance claim and a person injured in the fatal event may also need it to assist their claim against the deceased person’s estate.

The deceased’s family will generally be entitled to access coronial information at appropriate stages during an investigation.

Other persons given or eligible for leave to appear at an inquest should be given access to coronial information during the investigation, subject to appropriate conditions, so they can participate effectively in the coroner’s investigation.

Access will generally be given to others deemed to have sufficient interest, during an investigation and subject to appropriate conditions, when it will facilitate other investigative, systemic review, or legal processes relating to the death that may in turn inform the coroner’s investigation, or will assist in administering the deceased’s personal affairs or alleviating hardship to the deceased’s family or other affected parties. In these cases, access will be limited to only those documents the coroner considers relevant to the particular purpose for which access is sought.

Otherwise access will generally not be given until an investigation is finalised.

Journalists and media organisations will generally not be given access to documents from investigations that do not proceed to inquest, but may be given to access documentary inquest exhibits where it is considered necessary to properly inform fair and accurate reporting or public scrutiny of inquest proceedings. Notwithstanding this, it may still be appropriate for a coroner to communicate limited information about a death by issuing a public statement.

Coroners should be proactive in releasing coronial information to public officials or entities with public health and safety responsibilities where to do so is in the public interest and would further the objects of the Act.

**In practice**

Part 3, Division 4 of the Act establishes criteria and processes for the release of documents prepared specifically for, or obtained during a coronial investigation (investigation documents). In general, coronial consent is required and may be given subject to appropriate conditions, or refused in the
public interest. Coroners are prevented from releasing certain types of highly sensitive information. The coroner must be satisfied that the person has “sufficient interest” in the document sought, unless it is released to a “genuine researcher”.

Documents other than those prepared specifically for a coronial investigation may still be accessible from the entity that created them under other access to information schemes such as Right to Information (RTI).

The access regime under Part 3, Division 4 of the Act applies to the management of requests to access investigation documents at any stage during a coronial investigation or inquest, and after an investigation or inquest has been finalised.

Because the regime applies specifically to access requests, it is not considered to limit the coroner’s ability to release investigation documents, on his or her initiative, for example, for the purpose of an investigation or inquest. The coroner may consider it necessary to provide investigation documents to an independent expert for review and opinion1 or for response by a person whose actions may have caused or contributed to the death. In preparation for inquest, the coroner will routinely release investigation documents to persons given or eligible for leave to appear as part of the inquest brief of evidence.

The release of documents for purposes connected with the investigation or inquest should always be made subject to the condition that they can only be used for coronial purposes and may not be disseminated for any other purpose without the coroner’s authorisation.

The Act was amended in August 2013 to expand coroners’ powers to release investigation documents and non-inquest findings in the public interest – see ss. 46A and 54(3)(b)2 These changes support proactive information release which furthers the general death prevention objectives of the Act, for example, immediate release of information to the Office of Fair Trading about a death resulting from a product defect may prevent future deaths by prompting an urgent product recall or ban. The changes recognise the family’s right to have their views considered whenever practicable when the coroner is contemplating a public interest release.

**What are ‘investigation documents’?**

The Acts Interpretation Act definition of ‘document’ is such that documentary material captured by Part 3, Division 4 includes not only written documents but also audio-visual or other electronic data from which sounds, images, writing or messages are capable of being produced or reproduced.

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1 The coroner may make, or arrange for, any examination, inspection, report or test that the coroner considers is necessary for the investigation – s13(2) of the Act
2 See Chapter 8 – Findings for a discussion (section 8.11) about the publication of non-inquest or “chamber” findings
Part 3, Division 4 of the Act distinguishes between documents prepared specifically for a coronial investigation ("coronial document") and other documents generated for a purpose other than the coronial investigation but obtained under the Act to inform the coronial investigation (other types of "investigation document").

It is important that coroners properly characterise documents for release purposes as specific release considerations apply to different document types, as explained below.

**Coronial documents**

These are documents prepared specifically for a coroner's investigation or inquest. Coronial documents commonly include the pathologist’s preliminary advice to the coroner, autopsy reports and toxicology certificates, police photographs of the death scene, police reports to the coroner, witness statements, independent reports commissioned by the coroner or on behalf of another person specifically to inform a coronial investigation or inquest, and the coroner’s findings.

The recording or transcript of an inquest is not a coronial document. Access to records of coronial proceedings is dealt with in section 10.6 below.

The significance of this characterisation is that:

- coronial documents can generally only be released under Part 3, Division 4 of the Act and not under the Right to Information scheme while an investigation is on foot
- coronial consent is not required if access is necessary for a police investigation or prosecution of an offence relating to a death
- coroners may postpone giving access to coronial documents if disclosure of the information they contain would not be in the public interest.

**Investigation documents**

The broader concept of ‘investigation document’ includes:

- documents obtained by a coroner under section 17 of the Act (confidential document) by virtue of other statutory provisions which permit disclosure to a court of information otherwise protected by a statutory duty of confidentiality, for example, a document kept under the Child Protection Act 1999 containing information that would otherwise identify or identify a person as a notifier of harm or risk of harm. This category of investigation documents also includes documents containing confidential information that was disclosed to the coroner under the Child Protection Act 1999, s.159P and the Public Health Act 2005, ss.56 (environmental health events) or 86 (notifiable conditions).
The significance of this characterisation is that these documents, to the extent they contain confidential information, cannot be released by the coroner under Part 3, Division 4 of the Act. Instead, the coroner must make his or her release decision having regard to the constraints of the statutory provision under which the confidential information was disclosed to the coroner. For example, section 17(4) of the Act limits the coroner to disclosing confidential information obtained under section 17 only for a purpose connected with the coroner’s investigation, for example, to obtain an independent expert opinion or to enable persons given leave to appear at an inquest to prepare for the inquest. The coroner could not release the document to a person’s legal representative for use in non-coronial proceedings.

- documents prepared or obtained by a police officer for the investigation of an offence relating to the death (police document). Coroners routinely obtain a brief of evidence from QPS or the Director of Public Prosecutions (DPP) where a person has been charged with, or consideration was given to charging a person with, or prosecuting a person for, an offence relating to the death. The significance of this characterisation is relevant to release by the State Coroner of these documents for research purposes or to the Family and Child Commissioner.

- any other documents connected with the investigation obtained by the coroner under the Act – in practice, these are documents generated for a purpose other than the coronial investigation but which have been obtained by the coroner under the Act. Given the breadth of the coroner’s power to inquire into a person’s death, this category can cover an exceedingly wide range of documentary material. Common examples include suicide notes, CCTV footage, SMS or email messages, telephone recordings, medical records, Medicare and prescription history records, departmental records, internal policy and procedure documents and the outcomes of internal incident reporting and review processes (e.g. clinical incident reviews or safety analyses) or other investigative processes (e.g. workplace health and safety, health regulatory authority, ATSB investigation reports)

- child death case review reports prepared under Chapter 7A of the Child Protection Act 1999 and given to the State Coroner under s.246H of that Act

- a report prepared by the Ombudsman relating to a person’s death and given to the State Coroner under s.57A of the Ombudsman’s Act 2001.

The latter three categories of investigation documents are subject only to the general coronial consent requirement discussed below.
Documents that can not be accessed

Section 52 of the Act prevents a coroner from giving access to investigation documents to the extent they contain certain types of highly sensitive information. Broadly this prohibition relates to information:

- subject to legal professional privilege – in practice, this really only relates to counsel assisting’s legal advice to the coroner as legal professional privilege in respect of external documents obtained under the Act will generally have been waived by the act of providing the document to the coroner for the investigation or inquest. (It is a reasonable excuse not to comply with a coroner’s information requirement under s.16 of the Act if the document sought is subject to a valid claim of legal professional privilege.)

- likely to prejudice a fair trial, the investigation of an alleged offence or the effectiveness of law enforcement or public security measures

- likely to lead to the identification of a confidential source of information for law enforcement purposes or to endanger a person’s life or safety

- likely to facilitate a person’s escape from custody

- about a living or dead person’s personal affairs except where the information is relevant to a matter about which a coroner can make findings, whether or not the coroner has made the findings.

The breadth of the coroner’s power to inquire into a person’s death can result in the coroner receiving all sorts of sensitive information about a person’s private life, for example, their sexual orientation, personal proclivities, infectious disease status, criminal history or events leading to a relationship breakdown or loss of employment. The extent to which this information is relevant to a finding about the death will depend on the circumstances of the death, for example, it may explain a person’s state of mind immediately before they took their own life but may have little bearing on a person’s death as a passenger in a motor vehicle accident.

This general prohibition does not prevent a coroner releasing test results to the person who applied for infectious or notifiable condition testing under s.23A of the Act.

- compelled under another Act, for example, under the Crime and Corruption Commission Act 2001, Coal Mining Safety and Health Act 1999.
Interviews given by police officers under direction by the Commissioner of Police under section 4.9 of the *Police Service Administration Act 1990* are not caught by this prohibition.\(^3\)

- that is restricted information connected with an investigation or inquiry conducted under the *Transport (Rail Safety) Act 2010* given to the coroner under s.238 of that Act or its predecessor provision, the repealed s.239AC of the *Transport Infrastructure Act 1994*.

It is important that coroners carefully consider whether a document contains information caught by this prohibition, and if persuaded to grant access to the document in part, must ensure the document is appropriately redacted to obliterate this information.

It is possible for documents safeguarded from release under s.52 to still be accessible from the entity that prepared them through other access to information schemes such as Right to Information. For this reason, coroners are to pass on any access request denied under s.52 to the relevant entity and alert it to any concerns the coroner has about how release of the document could affect the coronial investigation.

The interplay between ss.17 and 52 was considered by the Deputy Chief Magistrate in the third inquest into death of Mulrunji,\(^4\) who found there was nothing in either section to exclude the operation of s52 in relation to section 17. Rather, he considered section 52 qualified the access the coroner may give to confidential information under s17(4). However, the more general issue of whether s52 impacts on the release of investigation documents for investigation and inquest purposes was not addressed in this case, as it was held the documents to which access was sought did not fall within the prohibition under s52(1)(d).

I consider section 52 should not be construed to prevent a coroner, on his or her initiative, releasing investigation documents for a purpose connected with an investigation or inquest, especially as part of an inquest brief of evidence. The rationale for this interpretation is as follows:

- an Act should be interpreted so as to give effect to its purpose wherever possible
- the Act requires coroners to investigate or hold an inquest in certain circumstances\(^5\)
- coroners are obliged to give procedural fairness\(^6\)
- to withhold information in his or her possession from a person directly interested in a coronial investigation or who is given or eligible for leave to appear at an inquest risks denying procedural fairness\(^7\)

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\(^3\) Ruling of Deputy Chief Magistrate Hine in the third inquest into the death of Mulrunji, 26 February 2010

\(^4\) ibid

\(^5\) ss.11 (Deaths to be investigated), 12 (Deaths not to be investigated or further investigated), 27 (When an inquest must be held), 28 (When an inquest may be held)

\(^6\) Annetts v McCann [1990] HCA 57; (1990) 170 CLR 596 (20 December 1990)

\(^7\) Musumeci v Attorney General of NSW & Anor [2003] NSWCA 77 (8 May 2003)
• s52 is contained in a division of Part 3 that is separate to those relating to investigations and inquests
• the purpose of the Act can be achieved while affording interested persons procedural fairness if s52 is contrasted so as not to related to dissemination of investigation documents to interested persons for use in an investigation or inquest.

**Coronial consent**

An investigation document can only be accessed for non-research purposes with a coroner’s consent – s.54(2). The only exception relates to access by or through a police officer to a coronial document for the purpose of a police investigation or prosecution of an offence relating to a death.

Before giving consent, a coroner must turn his or her mind to matters including whether the applicant has sufficient interest in the document or whether it is in the public interest for the document to be accessed, the extent to which the document contains information that cannot be released, the desirability of placing conditions on access and whether it is in the public interest for the document not to be released at that time or indeed at all.

Consent is generally given by the investigating coroner, but can be given by another coroner or the registrar acting under the State Coroner’s delegation, if the investigating coroner is not available.

**Who has sufficient interest in an investigation document?**

A coroner can only authorise access if he or she is satisfied the person seeking to access to a document has sufficient interest in it – s54(3).

The Act does not define sufficient interest. However, relevant case law suggests following matters can be relevant to the determination of sufficient interest, having regard to the circumstances of the death:

• the applicant’s connection with the deceased person - in practice, this involves an assessment of any familial, personal or other relationship that may have existed between the applicant and the deceased person and the directness of that relationship.

• the nature of the applicant’s involvement in the events leading to the death

• the purpose for which access is sought and the relevance of the document to that particular purpose - the authorities are clear that the applicant’s interest in the document must be more substantial than mere curiosity, newsworthiness or some other trivial interest. Sufficient interest is something more particular than a general public interest.

Applying these considerations, the following categories of applicant will generally be regarded as having sufficient interest in an investigation document:
• the deceased’s family members – as discussed in Chapter 2 *The rights and interests of families*, Parliament clearly intended that families be given access to a broader range of coronial information under the Act than was made available to them under the previous system. This is why family members are specifically recognised as having sufficient interest under s.54. The family is generally entitled to know as much as possible about the circumstances of their loved one’s death. Quite apart from meeting a family’s emotional needs, timely release of coronial information to family members can alleviate hardship by helping to expedite financial or other legal processes running concurrently in respect of the death, for example life insurance or superannuation claims and estate administration.

Coroners must also give careful consideration to the impact of information release on known family tensions, for example, between a current and former spouse or between estranged parents. While coroners should be vigilant about a family’s desire to prevent another family member from accessing information about the death, the coroner is not bound by those views. For example, it can be entirely appropriate for the surviving parent of the deceased’s non-adult children from a previous relationship to be given access to cause of death information. In most cases, it is reasonable and appropriate for the coroner to give multiple family members the same degree of access to routine coronial information such as cause of death, autopsy reports and findings. Coronial counsellors can provide valuable assistance to coroners in working with family members to resolve these tensions in difficult family dynamics.

• any person or entity whose actions may have caused or contributed to the death, particularly when it is possible the coroner may make an adverse finding about that person

• a person who was materially involved in the events leading to the death

• any person given or eligible for leave to appear at an inquest

• an investigative entity whose statutory function enables or requires it to inquire into the death, for example, Office of Fair and Safe Work Queensland, ATSB, health regulatory authority, Crime and Corruption Commission, Office of Aged Care and Quality Compliance

• an entity responsible for service provision to the deceased person during life seeking access to coronial information to inform internal quality assurance processes, for example, a hospital seeking a copy of the autopsy report to inform a clinical incident or mortality review

• the deceased’s personal representative
• an insurer, superannuation fund or workers compensation entity considering a claim in respect of the death or the incident in which the death occurred - coroners should only give access to those documents considered relevant to the particular claim and are encouraged to require these applicants to demonstrate the relevance of the information they seek to the matters to be assessed when considering the claim.

• a person’s legal representative in respect of criminal or civil proceedings relating to the death

• a health practitioner or health service advising a family member about possible genetic predisposition to the condition that caused the death

• a public official or regulatory entity with public health or safety responsibilities, for example, Chief Health Officer, Therapeutic Goods Administration, Australian Health Safety and Quality Commission, Office of Fair Trading, Civil Aviation Safety Authority.

Journalists and media organisations

Some reportable deaths and inquests attract considerable media attention.

Coroners frequently receive media requests for information about a death. When a request is made regarding a named deceased person, then provided the deceased has been formally identified and the family notified of the death, it is appropriate for the coroner to release information confirming the deceased person’s name, that the death has been reported to the coroner for investigation and when the death was reported.

Journalists and media organisations are not considered to have sufficient interest in investigation documents arising from an investigation that does not proceed to inquest.8

The issue of media access to inquest exhibits is discussed below.

Authors, television producers, film makers etc

From time to time, coroners will receive requests for access to investigation documents to inform the development of, or be used in a feature article, book, television show or other film production about the deceased person or the incident in which the death occurred. When considering these applications, coroners should carefully consider the objective of the proposed publication or production – is the objective to raise public awareness about preventable death or merely to provide public entertainment?

The coroner should seek the family’s views whenever practicable, and consult the State Coroner before consenting to release of investigation documents in these cases.

8 Mirror Newspapers Ltd v Waller (1985) 1 NSWLR 1
Proof of applicant’s identity

Documents can be released to family members nominated or mentioned in the Form 1 Police Report of Death to a Coroner or Form 1A Medical Practitioner Report of Death to Coroner, without requiring further proof of identity.

Otherwise, the applicant should be required to provide proof of identity, for example a driver’s licence and if relevant, proof of their relationship to the deceased person, for example birth or marriage certificate. It is acceptable for this documentation to be submitted electronically.

When can access be given in the public interest?

Consistent with the general death prevention objective of the Act, the Act was amended in August 2013 to enable coroners to give access to investigation documents in the public interest – see s.54(3)(b). This change allows coroners to release information proactively, including by way of a public statement, or in response to an application under s.54.

Circumstances in which it would be appropriate for a coroner to make proactive public interest release include where the information will inform death prevention initiatives, raise public awareness, correct public misinformation or inform profession or industry-specific regulators. For example, where a product defect or adverse medication reaction has been proven to have caused the death, or conversely was initially thought to have caused the death but subsequent investigations have confirmed this was not the case. Another example would be to clarify the cause of death where autopsy has confirmed a natural causes death in a case initially reported by the media as suspicious.

Applicants may satisfy the public interest criterion by demonstrating how use of the information sought will contribute to the various objectives outlined above.

It is well established that satisfying mere public curiosity or prurient interest does not equate to public interest.

Coroners are required to consider the family’s views whenever practicable when considering a public interest release and should consult the State Coroner before issuing any public statement in these cases.

When should conditions be placed on access?

Coroners have power to place conditions on a person’s access to an investigation document if considered necessary to protect the interests of justice, the public or a particular person. Failure to comply with these conditions is an offence under the Act – s55.

Given the confidential, sensitive and often distressing nature of coronial information, it is highly desirable that coroners always consider placing
reasonable limitations on the use a person can make of a document released to them under the Act.

Coroners are encouraged to make any document released for the purpose of enabling effective participation in an investigation or inquest subject to the standard condition that the documents may only be used for coronial purposes (i.e. to obtain advice, opinion or instructions for participation in the investigation or inquest) and may not be disseminated to anyone for any other purpose without the coroner’s authorisation. Unless there are specific statutory confidentiality obligations attaching to information contained in those documents, then documents released as part of an inquest brief of evidence will generally not be redacted or otherwise de-identified.

When crafting appropriate release conditions, coroners should turn their minds to matters including the nature of the document itself, the specific purpose for which access is sought, who is likely to gain access to it when used for that purpose, and the extent to which its contents could cause distress to either the applicant or another person, and appropriate strategies to minimise that distress. For example, the coroner may consent to a family member having access to an autopsy report or a suicide note if they agree to receive the document through a treating doctor or counsellor who can explain the document to them and support their reaction to it. A further example is where a person seeks access to a document in order to produce it in evidence in a non-coronial proceeding and the coroner allows a copy of the document to be provided directly to the relevant court or tribunal.

It is advisable that document release for non-coronial purposes always be made subject to a condition that the document’s use be limited to the particular purpose for it was sought.

**Redaction and de-identification**

Before a document is released, care must be taken to ensure it is appropriately redacted to obliterate:

- any information caught by s.52 of the Act
- confidential information
- information considered irrelevant to the scope of the applicant’s access request
- where considered necessary, identifying information.

**When can access be refused or postponed?**

To the extent that a document contains information captured by s. 52 of the Act, access will not be given to that information.

A person who is not considered to have sufficient interest in an investigation document will not be given access to it, unless the coroner is otherwise satisfied it is in the public interest to give access to the document.

Notwithstanding that a person may have sufficient interest, a coroner can still refuse to allow access to an investigation document if he or she considers it
would not be in the public interest for the information it contains to be disclosed. This requires the coroner weigh up all other relevant interests. The coroner also has power to postpone the release of coronial documents – s. 56 of the Act.

The determination of whether disclosure of coronial information would be inimical to the public interest should be made having regard to the particular circumstances of the death and the nature of the document to which access is sought and the information it contains. Relevant considerations could include but are not limited to:

- the interests of justice
- risks to public health and safety
- the risk of damage to a person’s personal or professional reputation.

In practice, it would be appropriate for a coroner to refuse access when to do so at that time, or at all could compromise the coroner’s investigation or another legal proceeding or investigative process relating to the death. A coroner may be similarly minded in relation to documents that contain defamatory information or unsubstantiated allegations of criminal behaviour or professional misconduct. A further example might be where the document contains information that could trigger copycat suicidal behaviour.

**Timing of access**

Coroners are encouraged to regularly keep families and others with a direct interest in the outcome of an investigation informed of the progress of the investigation, unless to do so risks compromising the investigation. This can prompt requests to access investigation documents as and when they become available to the coroner.

Careful consideration should be given to the timing of release of coronial documents during an investigation. Release of information at appropriate stages during an investigation enables effective participation in the investigation and often addresses family concerns much more effectively than if documents are released in piecemeal fashion. Impact on the coroner’s investigation strategy is also an appropriate consideration.

**Access to sensitive or distressing investigation documents**

Suicide notes and audio-visual footage of a death are amongst the most personal and distressing items obtained by coroners. However coroners should resist adopting an overly paternalistic attitude when assessing potential risk of psychological harm from exposure to these items.

**Suicide notes**

Suicide notes, electronic messages and other documents evidencing a person’s intention to take their own life are routinely seized by investigating police for the coroner’s consideration. Consequently they are both investigation documents and physical evidence under the Act.
These documents often contain final messages to family members, friends or other persons. These messages can range from expressions of love, friendship and gratitude to declarations of abject despair and hopelessness to outpourings of anger, accusation, blame and hate. They often canvass intensely personal information and sometimes contain admissions or denials of guilt.

A person to whom a suicide note or message is directed will generally be considered to have sufficient interest in the document. To the extent the document contains information about another person, that person may also be considered to have sufficient interest in that information.

The very nature of the content of these documents means they require careful scrutiny to identify information captured by s.52.

When giving access to these documents, coroners should consider the extent to which disclosure of information they contain may cause the distress to the applicant or to another person, and appropriate strategies to minimise this distress. These strategies may include partial release or conditions requiring release through a counsellor or treating doctor or the undertakings not to communicate the document’s contents to specified persons e.g. the deceased’s non-adult children. Coronial counsellors can provide valuable assistance to coroners considering these matters.

If the coroner refuses access to a note, he or she should consider whether instead a general description of its contents may satisfy the applicant’s needs. For example, a letter advising the note contains nothing more than a brief farewell and expression of thanks and love to a spouse may alleviate an applicant’s concern that the note contained an admission of guilt by the deceased about having sexually abused the applicant as a child.

Because these documents are also physical evidence, they must be dealt with under Part 3, Division 5 of the Act once the coroner is satisfied they are no longer required for coronial or other legal proceedings. The original documents will generally be returned to the person to whom the note was directed or it that is unclear, to the deceased’s personal representative, unless the coroner considers it would not be desirable to do so, for example if the note is contaminated by bodily fluids or a toxic substance.

**Photographs and audio-visual footage**

The incident in which a person is fatally injured or dies is sometimes captured in audio-video footage e.g. telephone recording, CCTV footage, bystanders’ mobile phones or media coverage of an event. A person who commits suicide may film their own death. This footage is routinely seized by investigating police for the coroner’s consideration. The death scene is also routinely photographed and/or videoed by police and the photographs provided to the coroner.
This information will routinely form part of a brief of evidence for an inquest and consequently will be released to persons given or eligible for leave to appear.

It is appropriate for photographs and audio-visual footage of the death or death scene to be provided to an entity that is also investigating the death e.g. Office of Safe and Work Queensland, or for the purpose of other legal or financial processes concerning the death.

Given the highly distressing and graphic content of these items, a coroner who contemplates giving access to these items for purposes other than informing another investigative or legal process should seek advice from a coronial counsellor or treating doctor about the likelihood of psychological harm to the applicant or another person, and appropriate access strategies to minimise this risk.

10.3 Application of RTI to coronial information

Right to Information schemes provide a right to access government information, unless on balance, it is contrary to the public interest to release the information. Information Privacy schemes give individuals a right to access and amend their own personal information.

Right to Information, and to a much lesser extent Information Privacy schemes can provide an alternative means of access to investigation documents, particularly those held by a government agency.

Coronial documents are generally not accessible under Right to Information while an investigation is on foot. However, copies of coronial documents given to a government agency under the Coroners Act may be accessible under a Right to Information application directed to that agency before the coronial investigation is finalised.

It is not uncommon for investigation documents like the deceased’s medical or departmental records to be accessed through a Right to Information application to the source government agency.

Applications are often made under Right to Information for access to closed coronial investigation files. These applications can result in the release of documents other than investigation documents, for example, correspondence and file notes.

10.4 Access to non-documentary physical evidence

Physical evidence covers anything seized by police for a coronial investigation or inquest, any exhibits tendered at an inquest or any other property that comes into the possession of the coroner or investigating officer. Naturally this includes both documentary items and non-documentary items.

While access to documentary items is dealt with under Part 3, Division 4, the Act does not establish a corresponding access regime for non-documentary
items that have not been tendered as inquest exhibits. There is currently only a requirement that until physical evidence is dealt with under Part 3, Division 5, a coroner must allow the item’s owner to access it for inspection, or copying purposes unless it is impracticable or unreasonable to do so – s.62.

In practice, a coroner should provide reasonable access to non-documentary items, on request by persons given or eligible for leave to appear at an inquest into the death for purposes that will inform the efficient conduct of an investigation or inquest, for example, to enable a party’s expert to examine the item.

10.5 Access to inquest exhibits
The Act was amended in August 2013 to establish a specific access regime for inquest exhibits.

This regime ensures access to documentary exhibits is dealt with under Part 3, Division 4 and establishes a consistent approach to managing access to non-documentary exhibits (“physical evidence exhibits”), meaning the coroner’s consent is required and access may be given if the applicant demonstrates sufficient interest in the exhibit or that access to it would be in the public interest.

These changes recognise the family’s right to be consulted and have their views considered, to the extent practicable, when the coroner is contemplating giving access in the public interest.

The changes do not affect a police officer’s ability to access or give access to an exhibit without the coroner’s consent if the exhibit is necessary for the investigation or prosecution of an offence relating to the death.

When considering whether a person has sufficient interest in an inquest exhibit, regard must be had to the principle of open justice which does not create a right of access to court documents, but favours allowing a non-party to access any non-confidential document or thing that has been admitted into evidence in an open court proceeding, unless there is a good reason to refuse access. Further, there is authority that media organisations have an interest in accessing an exhibit if it is necessary to properly inform fair and accurate reporting and public scrutiny of court proceedings.

Circumstances in which it would be appropriate to refuse non-party access to an inquest exhibit could include where the exhibit relates to evidence given in closed court or contains information which would not otherwise be released under the Act e.g. under sections 17, 52 or 56 or the exhibit is contaminated by bodily fluids or toxic substances or is in some way inherently unsafe.

10.6 Access to records of pre-inquest conferences and inquests
Section 38 of the Act requires inquest proceedings to be recorded under the Recording of Evidence Act 1962 and the Recording of Evidence Regulation
2008. The recording of a pre-inquest conference is a matter for the presiding coroner’s discretion.

Access to records of coronial proceedings is regulated by section 38(3) of the Act and the Recording of Evidence Act and Regulation. In practice, to the extent the record is not subject to a non-publication order made under s.41 of the Act, the record is available either electronically or in transcribed form to anyone who requests and pays for access to it. Eligibility for fee waiver is dealt with in the Recording of Evidence Regulation. Only the Director-General’s delegate can waive fees on hardship grounds. Coroners have no power to waive fees or provide free copies of transcripts to persons given leave to appear at an inquest.

10.7 Responding to subpoenas
From time to time, coroners are served with subpoenas requiring them to provide their complete investigation file or specified documents. While there is a view that it is an abuse of process to issue a subpoena to a coroner, coroners are encouraged to co-operate with the conduct of other legal proceedings, having regard to the law under which the subpoena was issued and the operation of Part 3, Division 4.

10.8 Access for research purposes

In principle
The scholarly investigation of reportable deaths is vitally important to improving public health and safety. The coronial system is an important source of information for researchers and in turn research analyses are essential in assisting the coronial system to prevent future deaths.

In practice
Applications for access to investigation documents for research purposes are considered under s.53 of the Act. Access for research purposes can only be authorised by the State Coroner, who must be satisfied the applicant is a genuine researcher and the document sought is reasonably necessary for the research. There are limited circumstances in which this authorisation can be given while an investigation is on foot. The State Coroner’s authorisation can be given for specified types of documents for either a defined period or on an ongoing basis, and can be made subject to conditions.

The genuine research access regime does not permit release of confidential documents and is subject to the release prohibitions under s.52. The State Coroner can refuse access in the public interest.

Documents released under this mechanism must be de-identified unless the State Coroner considers the person’s identity is necessary for the research to be effective and the benefit of the research outweighs the need to protect an individual’s privacy.
The documents researchers frequently seek to access are Form 1s, police or other investigation reports, autopsy and toxicology reports, witness statements and coroners’ findings.

Who is a genuine researcher?
The Act recognises three categories of researcher, namely:

- public health researchers who have been given access to health information under the Public Health Act 2005
- members of quality assurance committees established under the Hospital and Health Boards Act 2011 e.g. Queensland Maternal and Perinatal Quality Council, Queensland Paediatric Quality Council
- another person conducting genuine research.

What is genuine research?
The Act does not define ‘genuine research’, so regard must be had to the usual meaning of the term. Indicators that the applicant is conducting genuine research will include the applicant’s qualifications, standing and reputation in the research community, whether the applicant has obtained relevant ethical approvals, the purpose of the research and how its outcomes are intended to be published and used.

Since the Act commenced, a wide range of individuals and organisations have been recognised as genuine researchers covering diverse research activities into suicide prevention, road safety, fire fatalities, drowning deaths, scuba diving deaths, SIDS, building standards and the efficacy of the coronial system.

When can investigation documents be released for research purposes?
Access can be given while an investigation is on foot only if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in permitting access before the investigation is finalised. Otherwise access will only be given to investigation documents from closed investigations.

10.9 Access for tissue banking purposes
Section 54AA of the Act enables the State Coroner to enter into arrangements with prescribed tissue banks to provide them with timely access to information from Form 1s coroner in order to inform the donor assessment process. This mechanism is designed to maximise opportunities for tissue retrieval and recognises the timeframes for retrieving tissue for transplantation is very short (within 24 hours of death).

To date, the State Coroner has entered into arrangements with the Queensland Bone Bank, the Queensland Eye Bank, the Queensland Heart Valve Bank and the Queensland Skin Bank.

These arrangements operate in place of the general access regime under s.54 and obviate the need for consent from the investigating coroner on a
case by case basis. The arrangements do not enable tissue banks to obtain a copy of the Form 1.

Chapter 4 *Dealing with bodies* explains how these arrangements work in practice.

### 10.10 Access by the Family and Child Commissioner

Section 54A of the Act enables the Director-General of the Department of Justice and Attorney-General to enter into an arrangement with the Family and Child Commissioner to give the Commissioner access to investigation documents to inform its child death research functions. An arrangement was entered into with the former Children's Commissioner under this provision in 2011 and has since been updated to recognise the transfer of the child death research function to the Family and Child Commission.

This arrangement operates in place of the general access regime under s.54 and obviates the need for consent from the investigating coroner on a case by case basis. Access is provided through the State Coroner and enables access while a coronial investigation is on foot. Access under this arrangement remains subject to the s.52 prohibition and the power under s.56 to refuse access in the public interest.

Documents released under this arrangement must be de-identified unless the person’s identity is considered necessary for the Commissioner’s child death research function.