

Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		New South Wal	es	
New South Wales	Coroners Act 2009 Coroners Regulation 2010	Any hearing conducted in a "coronial proceeding" is to be open to the public: s 47(1). Involve any proceeding which is the investigation of a death: s 46. "Coronial proceedings" are any proceedings conducted by a coroner concerning the investigation of a death: s 46. A coroner can direct that coronial proceedings be heard in a room or building that is not open to the public if the coroner is of the opinion that special circumstances make it necessary or desirable to do so: s 47(2). All witness testimony must be recorded" s 65(1). If a person requests a copy of a coronial file, and the coroner is satisfied it is appropriate to be granted access, the coroner must supply a copy of the file: s 65(2). Mitigating circumstances include: • Appropriateness; • Impact of release of information; • Applicant's connection to proceedings. A coroner can clear a court and prevent publication of evidence s 74 Relevant considerations to which the coroner may have regard include: • Principle that such proceedings should generally be public;	Most investigations are finalised without the need for an inquest. Coroner to regard the principle that proceedings should generally be open to the public. A coroner can direct file not to be supplied but must provide reasons: s 64(4) and (5)	Suicide deaths fall within the scope of "reportable deaths": s 6(1)a: unnatural death. The coroner has jurisdiction to hold an inquest in reportable death scenarios and must hold an inquest where, among others, the death occurred in custody or police operations: s 27.



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
New South Wales		 Integrity of evidence; National security; Personal security of the public or any person. NSW Coroners Act 2009 contains a provision specific to suicide deaths. Section 75 stipulates a coroner can issue a non – publication order if a death is suspected to be self-inflicted. If a coronial proceeding finds the cause of death to be self-inflicted contains then publication of the findings is prohibited unless an order permitting publication is made: s 75. A person must not publish a disallowed question or an answer given to such a question: s 76. Punishment for contravening a non-publication order or publishing findings where cause of death is self-inflicted is a fine of up to \$1,000 and 6 months imprisonment for an individual and \$5,500 for a corporation. In the cases of corporations, each director or person concerned with management, for example newspaper editors, is taken to have committed the offence. Persons contravening orders made by the coroner may be held in contempt and fined up to \$2,200 or a prison sentence: s 103. Offences against the Coroners Act 2009 may be dealt with in the Magistrates Court without a jury: s 106. 		



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Queensland		
Queensland	Coroners Act 2003	Coroners' inquests must be held in open court (unless ordered closed): s 31. Proceedings must be recorded, and copies can be obtained unless prohibited by s 41(6): s 38(2). A coroner may prohibit publication of information relating to an inquest if it appears that a person's death was self-inflicted. Penalties apply for disclosure: s 41(2). A person must not publish/or allow to publish information disallowed by the court: 41(3). A coroner also has the power to prohibit a person from recording (in any manner) in an around inquest venue: s 41(4)(a). A person may be excluded from an inquest if determined to be in the interest of justice. E.g breaching rules regarding non-publication: s 43. Persons breaching coronial orders may be held in contempt of court under and face up to 3 years imprisonment: Magistrates Court Act 1921, s 50. Coroner must provide written copies of inquest findings to a family of deceased, people of sufficient interest and persons appearing at inquest.	Coroner investigating a reportable death must produce a written report of findings and state: • Whether death happened • Identity of deceased • How they died • When, where and what caused death. Written copy of findings distributed to family of deceased, children's commissioner (if under 18) if a child and a state coroner if not conducted by state coroner. s.45(4)	Suicide deaths are "reportable deaths" in s.8(3)(b):unnatural death. An inquest must be held if death was in custody or care or during a police operation: s. 27; or if a reportable death and determined in public interest to hold an inquest: s. 28. In QLD journalists are more likely to gain access to information and coronial documents where the death is subject to an inquest rather than an investigation. Findings of investigations are only provided to family and government departments (if recommendations are made). If an inquest is held findings are published on the QLD coronial website.



Jurisdiction Key legislati	on Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
Queensland	Comprehensive prohibitions on granting access to investigation documents exist: s 52. Examples include: Confidential documents; Coronial documents; Police documents; Documents connected to the investigation; Likely to prejudice an investigation, prevent fair trial, reveal confidential sources, endanger personal safety or police methods investigating crime. Information regarding personal affairs or health. Disclosure for genuine research purposes is exempted (not media professionals or journalists): s 53. Access if generally prohibited and coroners may only consent if satisfied that the person seeking access has sufficient interest: s 54. Special rules apply if protected under another act e.g Child Protection Act 1999. A coroner may impose conditions when necessary to protect the interests of justice, the public or persons: s 55. A coroner may also refuse disclosure where it is not relevant to public interest when weighed against all other relevant interests: s 56. For example Documents containing defamatory information or unsubstantiated allegations of criminal conduct may be restricted.	Section 52 also includes several restrictions on granting access, including where the document: Is subject legal professional privilege; Prejudice a person's right to a fair trial; Reveal a confidential source; Contains information about a person's personal affairs or health.	



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Victoria		
Victoria	Coroners Act 2008 Coroners Regulations 2009 Coroners Court Rules 2009	Section 8 Stipulates factors which a coroner should consider in exercising statutory powers, such as the balance of public interest in protecting personal information. This is not mandatory. A coroner may hold an inquest into any death that the coroner is investigating: s 52(1) but must if the death occurred in care or custody: s52(2). Section 55 establishes coronial powers at inquest, which includes excluding a person or class of persons. A coroner may give any direction necessary for inquest purposes: s. 55(2)(e). Must publish date, time, place & subject of inquest 14 days prior to hearing online or printed. All evidence must be recorded: s.63. Upon investigating a coroner must make findings on identity and cause of death of deceased, unless there is no public interest in making finding: s 67. Findings, comments and recommendations made following an inquest must be published online when practicable (if not under suppression order): s 73(1).	A coroner must investigate reportable deaths: s 15. Unless there is no public interest, the coroner must make findings on identity and cause of death: s 67. Coroners Court Rules 2009: findings and recommendations made by a coroner without an inquest may be published online. Coroner may release investigation documents if satisfied a person has sufficient interest. S.115 (2).	Suicide deaths fall within the "unexpected, unnatural or violent accident or injury" category of reportable deaths: s 4(2)(a). A coroner must investigate reportable deaths: s 15. A coroner must hold an inquest if the death occurred in care or custody: s 52(2). While a coroner must investigate reportable deaths, there is no requirement that the coroner make a finding if there is no public interest served. This may impact on a coroner's decision to make a formal determination that the cause of death was suicide.



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Failure to comply with coronial order involves contempt charges under section 103(1) and incurs fines and/or imprisonment. Unless otherwise ordered by the coroner the registrar must provide the deceased person's senior next of kin with reports: s 115. The Coroners Regulations 2009 requires a register of orders restricting publication: s.23.		
Victoria		Section 62A confers a power to suppress a finding in respect of death. Findings, comments and recommendations made by the coroner to be published online (unless the coroner orders otherwise): s 64.		



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Western Austra	lia	
Western Australia	Coroners Act 1996 Coroners Regulation 1997	Coroner must give 14 days' notice of an inquest by print in a newspaper: s 39. A coroner may make statements available to those of sufficient interest: s 42. A coroner has the power to exclude any or all persons from attending the hearings in the interests of any person, the public or justice: s 45. A coroner has an unfettered power to give any direction or do anything the coroner believes is necessary for the purpose of an inquest: s 46. All evidence given at an inquest must be recorded: s 48. Coroner must order that the inquest report or any part of the proceedings or evidence cannot be published where it would be likely to prejudice a fair trial or be contrary to the public interest: s 49. After the completion of an inquest into a death, the coroner's record of the investigation is to be open to public access unless the coroner orders otherwise. <i>Coroners Regulation 1997</i> s 19(2).	A coroner must investigate reportable deaths: s 19. A coroner must make findings on identity and cause of death: s 67; and any particulars to register death under the <i>Births, Deaths and Marriages Registration Act 1998:</i> section 25. Senior kin may ask for access to evidence. access must be granted unless determined it is not desirable or practicable to do so: s 26A.	Suicide deaths fall within the "unexpected, unnatural or violent" category of reportable deaths: s 3. An inquest must be held if the deceased was in care immediately before the death or the death was caused by or contributed to by an action of a member of the police force. An inquest must also be held if the Attorney General or State Coroner directs: s. 22.



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide		
	South Australia					
South Australia	Coroners Act 2003 Coroners Regulations 2005	Inquests held by the Coroner's Court must be open to the public: s 19(1). This is subject to exceptions, namely those contained in the <i>Evidence Act 1929</i> . Primarily, these exceptions relate to suppression orders or where it is in the interests of the administration of justice to close the inquest. A suppression order may only be granted: • to prevent prejudice to the proper administration of justice or prevent undue hardship to a victim of crime, a witness or to a child; • after recognising that open justice and the consequential right of the news media to publish information is a primary objective of the administration of justice: s 69A(1). If an inquest is held into a death, the coroner's court must give its findings in writing. Findings into inquests are usually published on the South Australian court's website. The State Coroner must, on application by a member of the public, allow a person to inspect or obtain a copy of any records of the Coroner's Court: s 37(1). A member of the public may only inspect or obtain a copy of material that was not received in open court or was suppressed with the consent of the State Coroner: s 37(2). Section 37(4) provides that the decision of the State Coroner on an application under this section is final and not subject to review.	Following a report of a death to the coroner, a finding as to the cause of death must be made: s 29. The deceased person's next of kin can ask for a copy of the coroner's records.	Suicide deaths fall within the "unexpected, unnatural, unusual, violent or unknown cause" category of reportable deaths: s 3. An inquest must be held if a death occurs in custody or if the State Coroner considers it necessary or desirable to do so: s 21.		



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Tasmania		
Tasmania	Coroners Act 1995 Coroners Rules 2006	A coroner may make available any statements the coroner intends to consider at the inquest available to any person who has a sufficient interest: s 52. A coroner may give any direction or do anything else if the coroner reasonably believes that it is necessary for the purposes of the inquest: s 53. Inquests are to be held in open court: s 56(1). A person may be excluded from the inquest or the court closed if the coroner considers that it is in the interests of the administration of justice, national security or personal security: s 56(2). A report may not be published if likely to prejudice a trial or contrary to administration of justice, national security or personal security: s 57(1). At the conclusion of an investigation into a death, the coroner must give a copy of their findings to the deceased person's next of kin. The <i>Coroners Rules 2006</i> , s 25. A coronial authority may give a person access to a coronial record or prohibit access to coronial records: s 26. Relevant considerations are: the applicant's personal or professional interest in the investigation, likelihood to unfairly prejudice the interests or reputation of another person, and any other matters the authority sees fit: s 26(4).	The coroner must determine: who the deceased person is, when and where the death occurred, and how and why the death occurred: s 28. Section 25 of the Coroners Rules 2006 must provide a copy of their findings to the deceased person's senior next of kin.	A coroner has jurisdiction to investigate any 'reportable deaths': s 21. "Reportable death" includes deaths that are unexpected, unnatural, or resulted from an accident or injury: s 3. An inquest must be held in some circumstances, such as if the death occurred while the person was in care or custody: s 24(1), or if it is desirable to do so.



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Northern Territo	ory	
Northern Territory	Coroners Act Coroners Regulations	Details of the inquest must be published at least 14 days before the inquest is held: s 37. A coroner's inquests must be held in an open court: s 42(1). A coroner may give directions and do anything the coroner thinks fit: s 41. A coroner may make a seclusion order and must give reasons for making the order if asked to do so: s 42(2). Evidence must not be published if likely to prejudice a fair trial be contrary to the administration of justice, national security or personal security, or involve the disclosure of sensitive personal matters: s 43. A coroner may direct that a person or class of persons may inspect or copy the coroner's file: s 13(1) <i>Coroners Regulations</i> .	A coroner must determine who the deceased person is, when and where the death occurred, and how and why the death occurred: s 34. A coroner must record of all findings, evidence and comments in relation to investigation: s 11. A person, or class of persons can be directed to inspect investigation file: s 13(1) Coroners Regulations. A coroner may order that the record and file of an investigation is not to be open to inspection by any person other than a party to the proceedings or a member of the deceased persons' family: s13(3) Coroners Regulations.	A coroner to whom a death is reported must investigate the death if it is a reportable death: s 14. Reportable deaths extend to cover 'unexpected, unnatural or violent' and therefore would include suicide: s.12(1). Deaths in care of custody or from injuries sustained while in custody must be subject to an inquest: s 15(1). A coroner may also hold an inquest if he or she considers it appropriate: s 15(2).



Jurisdiction	Key legislation	Restrictions on reporting Coronial Inquests	Restrictions on reporting Coronial Investigations	Comments re: suicide
		Australian Capital Te	erritory	
Australian Capital Territory	Coroners Act 1997 Coroners Regulation 1994	Details of the inquest must be published at least 14 days before the inquest is held: s 38. Coroner's inquests must be held in an open court: s 40(1). A coroner may order a hearing to take place in private, close hearing or directions regarding the prohibition of disclosure of evidence when desirable: s 40(2). Hearings before the Coroners Court must be recorded: s 49. Copies can be obtained if a person has a good reason for applying for the copy: s 315 Magistrates Court Act 1930. A coroner may make documents and evidence available to a person with a "sufficient interest" in an inquest or inquiry: s 51. Coroners must make available a copy of the coroner's findings to members of the immediate family of the deceased or their representative if asked: s 54. A person who contravenes an order of the court is in contempt of court: s 99A.	A coroner may decide not to conduct a coronial hearing into a death if the coroner is satisfied that the manner and cause of death are sufficiently disclosed and a hearing is unnecessary: s 14. A coroner must determine the Identity of the deceased person, when and where the death happened, and the manner and cause of death: s 52(1). A coroner must record their findings in writing: s 52(3). A copy of the coroner's report must be supplied to family or representative if asked: s 54.	

Information contained in this document was accurate as of January 2012.