



Speech by

**Jann Stuckey**

**MEMBER FOR CURRUMBIN**

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## **CORONERS (REPORTING ARRANGEMENTS) AMENDMENT BILL**

**Mrs STUCKEY** (Currumbin—Lib) (8.58 pm): I rise to support, along with members on this side of the House, the Coroners (Reporting Arrangements) Amendment Bill 2007 which was introduced into the House by my colleague the honourable member for Caloundra, who is the shadow Attorney-General and shadow minister for justice. The key objective of this bill is to amend the Coroners Act 2003 to establish a legislative framework with which both local and government agencies must comply when they receive relevant coronial recommendations. As members are aware, a coroner holds a very responsible position in the investigation of causes and circumstances surrounding deaths that appear not to have natural causes, deaths that occur in custody, as well as deaths that occur in care. To ignore the findings of these eminent persons highlights just how arrogant this Labor government has become.

Upon the completion of their investigation under the Coroners Act 2003, the coroner must pass the relevant findings and recommendations on to the relevant government agencies. However, there is presently no requirement for these agencies to respond to the coroner's comments, and herein lies the reason for this bill coming before the House.

I applaud the honourable member for Caloundra for bringing forward this bill, which recognises the years of experience and knowledge that are involved with the making of these coronial recommendations. To suggest that the honourable member is engaging in political point-scoring is not only preposterous but also offensive. The member for Kallangur stooped into the sewer here tonight, and I am very sorry to have heard it.

Recommendations such as these do suggest that certain actions be taken with a view to preventing a recurrence of the circumstances that led to the fatal incident and should not be ignored by the current Labor government. We in the opposition, unlike those opposite, believe in an open and transparent government process—one that does not attempt to hide the truth from the public who have every right to expect that findings or recommendations made by a person in the senior role of coroner will be taken seriously and action taken.

In 2005 the Queensland Ombudsman undertook an investigation into the responsive public sector agencies to workplace electrocutions in Queensland known as the Workplace Electrocution Project report. Whilst conducting this investigation the Ombudsman noted, 'There were cases where little or nothing had been done by public sector agencies to implement recommendations made by coroners to prevent similar deaths occurring.' This observation resulted in the Queensland Ombudsman report *The coronial recommendations project: an investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* in 2006. I recommend that members opposite read that document and then they might see why it is important to support this bill tonight.

This inquiry examines 79 deaths, with recommendations made against at least 23 local and state government agencies, of which about 40 per cent of these recommendations were never acted upon. In this report it was recommended that the Coroners Act 2003 be amended to require public sector agencies to respond to coronial recommendations within six months as to their intended implementation or if the

agency does not intend to take action. Under this bill, government agencies must acknowledge the coroner's comments in writing within 48 hours of receiving them. The coroner must then be given an interim written report stating the action taken within six months. If no action has been taken, then this report must state the reason for the inaction. A full written report must then be sent to the coroner within one year of passing on the coronial recommendations.

The government has commissioned a number of reports in recent years from independent bodies or persons as a result of crises that have been revealed under this Labor government's watch. For example, the Crime and Misconduct Commission inquiry report *Protecting children: an inquiry into abuse of children in foster care*, *Challenging behaviours and disability: a targeted response* by the Hon. WJ Carter and *Promoting balance in the forensic mental health system* by Brendan Butler AM SC. The government has stated that it would implement the majority of these recommendations in part due to public and media pressure, so why is it baulking on *The coronial recommendations report*? As the shadow minister for child safety and shadow minister for women, I am particularly concerned at the growing number of child deaths where a child was known to the department.

It is important to note that in the case of child deaths the Child Death Case Review Committee publishes an annual report detailing the key findings, comments and recommendations of cases referred to it. To date, only three annual reports have been published, which means that quite a number of investigations into child deaths are still ongoing—therefore yet to be reviewed and recommendations considered. However, in the 2006-07 Child Death Case Review Committee annual report it was reported that 57 children and young people who were known to the Department of Child Safety died in the 12-month period from 1 July 2006 to 30 June 2007. That is more than one child per week dying in the care of this department, with the majority of these children—some 70 per cent—aged four years or younger.

Whilst I acknowledge that not all child deaths result in a coronial inquiry, it is important that the recommendations of coronial inquiries are taken on board to ensure that we are practising preventative measures and to some degree offering a layer of closure for those bereaved citizens of Queensland. Without a doubt, several of the child death cases reviewed by the Child Death Case Review Committee would have been subject to a coronial inquiry.

At present there are several reports on horrific child deaths that are still to be released including the death of two young brothers in Toowoomba in July 2007, the death of a toddler in Redcliffe in September 2007, as well as the shocking events that stole the life of a young girl on Bribie Island on New Year's Eve 2006. It is imperative that government agencies consider and action the recommendations of these inquiries to actively reduce unnecessary deaths in our community. The Queensland Ombudsman stated in 2006, 'The ability of the Queensland coronial system to prevent death and injury would be substantially improved by a requirement that public sector agencies respond to coronial recommendations that relate to legislation they administer.' He continues, 'The arguments for this position are highly persuasive while arguments against are not consistent with a best practice accountability framework.'

Yet it would appear that those opposite are very keen to vote for something that is not consistent with a best practice accountability framework. In light of this argument, and those of others who have spoken on this side of the House, I strongly urge government members to do the right thing by the citizens of Queensland and support this bill. But, as usual, and despite a particularly lame excuse from the Attorney and members of the Labor government, they will vote against this principled private member's bill. By doing so, I want it noted that they support going against the recommendations of Queensland's very own Ombudsman, and doing so they put a break in the chain of accountability—something that they would know nothing about. I commend the bill to the House.