

Justice and Other Legislation Amendment Bill 2026

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19 March 2026

Committee Secretary
Justice, Integrity and Community Safety Committee
Parliament House
George Street
BRISBANE 4000

Only by email: jicsc@parliament.qld.gov.au

Dear Committee Secretary,

Justice and other Legislation Amendment Bill 2026

Thank you for the opportunity to provide feedback on the Justice and Other Legislation Amendment Bill 2026 (**Bill**).

Authors

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The authors are able to appear remotely at any hearing should the Committee wish to take evidence from them and consent to the publication of this submission.

Queensland Coronial Legal Service

The Queensland Coronial Legal Service is a statewide service provided by Caxton Community Legal Centre and Townsville Community Law Inc.¹ The Queensland Coronial Legal Service. The Queensland Coronial Legal Service provides legal advice, representation and social support to bereaved families engaged in coronial processes including providing representation at inquests.

Scope of this submission

This submission addresses only the amendments in the Bill relating to the *Coroners Act 2003 (Act)*.

General support for amendments

We are generally supportive of the proposed amendments, particularly those directed at improving efficiencies within the coronial system. Delays in the finalisation of coronial investigations and inquests can cause significant and ongoing harm to bereaved families. Measures that support more timely resolution of matters are therefore important and welcome.

We also support the proposed amendments to sections 45 and 46, which clarify that coroners may include in their findings and comments that a referral has been, or will be, made under section 48. These amendments promote transparency and ensure that families are informed about what further action may follow an inquest. This is an important reform that strengthens confidence in the coronial process.

Effect of the proposed amendments to section 11

The current framework requires that all deaths in custody, and deaths in the course of police operations, be investigated by the State Coroner, a Deputy State Coroner, or an appropriately approved coroner. This ensures that these deaths are subject to specialist and consistent oversight.

The proposed amendments alter that position by drawing a distinction between deaths characterised as “natural” and those characterised as “unnatural”. Only deaths classified as “unnatural” may be investigated by the State Coroner, Deputy State Coroner, or an approved coroner. Other deaths may be investigated by any coroner.

While the explanatory materials indicate that the intent is to allow straightforward natural cause deaths to be dealt with more efficiently, this distinction does not reflect the realities of deaths in custody.

¹ Townsville Community Law provides services in the Far Northern, Northern and Central Coronial Areas, whereas Caxton Community Legal Centre provides services within the Brisbane and Southeastern Coronial Areas.

The distinction between “natural” and “unnatural” deaths

In custodial settings, the classification of a death as “natural” does not determine whether issues of public importance arise.

Deaths that are medically described as natural frequently involve complex and significant questions about:

- the adequacy of health care provided;
- access to timely and appropriate treatment;
- the suitability of custodial environments for people with serious illness;
- supervision and monitoring; and
- substitute decision-making and consent.

These issues go directly to the State’s responsibility for the care of people deprived of their liberty and are often systemic in nature.

Right to life and the requirement for effective investigation

Deaths in custody engage the State’s fundamental obligation to protect the right to life under section 16 of the *Human Rights Act 2019*.

That obligation includes a requirement to ensure that deaths occurring in circumstances where the State exercises control over a person are subject to effective, independent and rigorous investigation. The coronial system is central to the discharge of that obligation.

Where a person is in custody, the State assumes responsibility for all aspects of their care, including access to health services and support for decision-making. People in custody are entitled to a standard of health care equivalent to that available in the community.

This obligation requires more than a determination of the medical cause of death. It requires an investigation capable of examining whether the systems responsible for the person’s care operated appropriately and whether any failures contributed to the death.

Importance of specialist and consistent oversight

Specialist oversight by the State Coroner or Deputy State Coroner is critical in this context.

Deaths in custody frequently involve complex intersections between health care, custodial management and decision-making. These matters require a consistent, expert and system-focused approach.

Centralised investigation within the State Coroner’s jurisdiction promotes:

- consistency in the approach to similar deaths;
- the development of specialised expertise in custodial health and systemic issues; and
- the ability to identify patterns and recurring failures across cases.

Absent that centralised oversight, there is a real risk that similar deaths will be approached differently, that systemic issues will be considered in isolation, and that opportunities for broader reform will be diminished.

Illustration: Inquest into the death of Barry Haynes

The inquest into the death of Barry Haynes² illustrates why this level of scrutiny is necessary. Mr Haynes died from cancer while in custody. Although his death was medically described as natural, the inquest identified significant issues relating to his care. These included concerns about the suitability of the custodial environment for a person requiring palliative care, delays in facilitating access to appropriate care, and the absence of effective substitute decision-making arrangements despite evidence that he lacked capacity.

The inquest also examined broader systemic issues, including coordination between corrective services and health providers and barriers affecting Mr Haynes' ability to make decisions about his care and applying for bail.

These issues arose not from the medical cause of death, but from the circumstances of custody and the systems responsible for his care. They demonstrate that deaths characterised as "natural" may nonetheless raise serious questions of public importance and State accountability.

Risks arising from the proposed amendments

By permitting deaths in custody characterised as "natural" to be investigated by any coroner, the proposed amendments introduce a risk of:

- variability in the level of scrutiny applied to deaths;
- fragmentation in the investigation of systemic issues; and
- reduced capacity to identify patterns across deaths in custody.

These risks are particularly acute in cases involving vulnerable people and complex care needs.

Recommendation

We recommend that all deaths in custody, and all deaths in the course of police operations, continue to be investigated by:

- the State Coroner;
- a Deputy State Coroner; or
- a coroner approved by the Governor in Council on the recommendation of the Chief Magistrate in consultation with the State Coroner.

² Inquest into the death of Barry Haynes (COR 2017/1416) accessed at https://www.coronerscourt.qld.gov.au/_data/assets/pdf_file/0006/659607/cif-haynes-b-20201116.pdf

While the objective of improving efficiency is supported, deaths in custody require the highest level of scrutiny and consistency.

The distinction between “natural” and “unnatural” deaths does not adequately reflect the nature of custodial deaths or the State’s responsibilities. All deaths in custody should continue to be subject to specialist coronial oversight to ensure accountability, consistency and public confidence in the coronial system.

Yours faithfully

A solid black rectangular box used to redact the signature of the sender.

Klaire Coles
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