Speech by

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CORONERS (REPORTING ARRANGEMENTS) AMENDMENT BILL

Mr LANGBROEK (Surfers Paradise—Lib) (7.47 pm): It is my pleasure to rise to speak to the Coroners (Reporting Arrangements) Amendment Bill. It is not surprising that the Attorney has indicated that the government will not be supporting this bill, and once again I have to express my disappointment at this. I want to congratulate my colleague the honourable member for Caloundra for bringing this bill to the House. It is something that he and I have discussed in our various roles—he as shadow Attorney and I as shadow minister for health. I kept seeing these coroners reports coming through that involved health matters and I thought, 'These recommendations seem to have a lot of merit.' It all seemed pretty obvious to me.

I was surprised to find that there is no compunction on agencies to implement recommendations, or even indicate that they had received them, or to state whether they were going to do anything about them at all. In fact, in many of the reports I have read—and that is 71 coroners reports since I became the shadow health minister in September 2006—there have been many times when there has been no response from the agencies at all. I think that is interesting because the Attorney mentioned that agencies supposedly respond and they are often there noted in the coroners reports, which may give some succour to people who have suffered loss. In fact the executive summary of the report of the Queensland Ombudsman from December 2006 states—

... it was apparent that the relevant agencies had neither sought nor received a copy of the recommendations in question from the coroner and, in some instances, were unaware that recommendations had been made that concerned legislation they administered.

That is quite remarkable considering that the Attorney told us this evening that they do have to respond and that some sort of administrative measure has been put in to make sure they do it. The Ombudsman also went on to say—

... there was no formal monitoring of the implementation of those recommendations by any independent entity.

I had a look at some of these coroner's reports. I always noted there were lots of recommendations and I looked at some specific ones because I thought there was merit in what the bill is seeking to do, which is amending the Coroners Act 2003 by establishing mandatory reporting requirements for chief executive officers or chief executives where coronial comments or findings have been made that relate to a government entity under their control or to the investigation of a death in care or in custody. The proposed bill establishes a legislative framework by which government agencies, both local and state, must comply with when they receive relevant coronial recommendations.

I note, too, that only recently after the Auditor-General brought out a rather damning report about annual reports which departments are putting out that Premier Bligh advised the parliament that the government would explore new ways to improve performance management. I would have thought that using the recommendations of the coroner, who has considered these recommendations very seriously in the light of these deaths, would make a lot of sense. I note in one of the coroner's reports that the coroner says—

A coroner may comment on anything connected with a death investigated that relates to public safety or the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

To my mind, that makes a lot of sense. As I say, the coroner has thought through these recommendations a lot. To me it is almost like the ministers in various departments having a policy adviser to give policy advice. They could quite easily say, 'It has been well considered and is something we should probably be considering doing,' and it is something the Premier could consider instead of going down to the equivalent of a dinner party in Canberra at the 2020 Summit and coming back with a big idea that we heard—the opt-out policy. That was a policy that suddenly the Premier said we might consider. That is overriding a 238-page report brought out by the health ministers only a year ago. There are some great ideas in here. I suggest that maybe the coroner needed to go to the 2020 Summit and put some of his ideas there. Then maybe the government would have considered them as possibly good ideas.

Mr Nicholls: It is the only way they will listen to him.

Mr LANGBROEK: That is the only way it will listen to him. I take that interjection, because it clearly does not listen to the coroner now when we see that his reports are unread and that over 40 per cent of his recommendations are not acted on.

The inquiry that the coroner did in 2006 examined 79 deaths. There were recommendations made about 23 agencies. As I said, the Ombudsman found that about 40 per cent of recommendations made to government agencies following unexpected or unusual deaths were never acted on. As I say, I think that is an indictment. I can understand that the coroner at times seems frustrated in some of his responses, and I will come to that later.

I want to note another one of the coroner's reports into the deaths of Charles Edward Barlow, Patrick Douglas Lusk and Emily Jane Baggott. The findings were delivered on 15 December 2006. The conclusion of the coroner at page 46 of the report is—

Good policy itself is clearly not enough; and for so long as priority is not given to active implementation of policy, adequate resourcing and single point accountability, nothing will change for those people in our community who suffer mental illness.

It is very clear that it is all very good to have good policy, but obviously the coroner is proposing changes to policy that government agencies should be considering. One of the issues that he mentions is mental illness, which is one of the things that the coroner deals with a lot. Clearly, there are a number of reports that I have seen that deal with patients who have suffered mental health issues, and there have been a number of recommendations that have been made that the government has said that it is following in some ways but the coroner does not concur with.

I want to have a look at 'Frequently Asked Questions' about the Ombudsman's *The coronial recommendations project*. I note on this sheet that came from the coroner it says—

What are some of the key recommendations of the Coronial Recommendations Project?

The Ombudsman made two recommendations in respect of public sector agencies and one recommendation about an extended role for his office. He also identified a number of possible amendments to the Coroners Act 2003 including that there should be a monitoring role of these public sector agencies; that coronial liaison officers be appointed in public sector agencies; and that the Coroners Act 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, its reasons for doing so.

That is exactly what this bill is doing. I think families would like to know from agencies why, if there are recommendations, the government is not acting on them and the agencies are not implementing them. Finally, the recommendation was that the Coroners Act 2003 be amended to require public sector agencies to provide details of coronial recommendations and their response in their annual reports. We have already heard criticisms from the Auditor-General about annual reports. The government is not accepting this anyway, but once again there would be an issue as to whether it would be included in their annual reports because the Auditor-General has doubts about the quality of annual reports.

Finally, I want to talk about one of the inquest findings from this year, and that is a case that I am particularly aware of. Before I do that, I want to come to one of the things that was mentioned in the coroner's report on 8 December 2006: recommendations are not mandatory in terms of compliance but are nonetheless evidence based, which obviously indicates that the coroner has looked at a lot of evidence, has considered it, has made recommendations and it would make sense that, under section 46 of the Coroners Act, a coroner may comment on anything connected with these deaths and can make recommendations. That is clearly what the coroner has been doing.

I want to refer to a case, as I mentioned before, that was delivered on 17 March 2008. It is an inquest into the death of a young fellow called James Henry Jacobs, who was another mental health patient. There was an inquest into four mental health patients, but James Jacobs was a patient of mine and a young fellow whom I had known from when he was a very young boy. He was shot, and that is what the coroner's inquest was into. He was a dual diagnosis patient. In a section of the coroner's report responding to dual diagnosis, the coroner says—

Since 1996, the National Standards for Mental Health Services have stipulated that 'The mental health service is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.'

He goes on to state that the mental health service should ensure 'access to a comprehensive range of treatment'. The coroner further states—

I am yet to be persuaded that Queensland Health has implemented these philosophies.

He then says—

However, in view of all the activities being undertaken by the department in relation to these problems a recommendation by a mere coroner to that effect is unlikely to have any impact.

So there the coroner is saying that he does not even regard his own recommendations are going to be considered, because he calls himself 'a mere coroner'. That is obviously how the coroner sees himself. This government needs to take this more seriously. I commend the bill to the House. I congratulate the member for Caloundra.