Speech by

Jarrod Bleijie

MEMBER FOR KAWANA

Hansard Thursday, 20 August 2009

CORONERS AND OTHER ACTS AMENDMENT BILL

Mr BLEIJIE (Kawana—LNP) (3.36 pm): In the spirit of harmony, Madam Deputy Speaker O'Neill, I also acknowledge your mother in the gallery and wish her all the best. I note that my friend the member for Everton is in the chamber, so there is a strong chance, Madam Deputy Speaker, for you to show your strong protection for me from the member for Everton.

Mr WATT: Madam Deputy Speaker, I rise to a point of order. I find it staggering to be accused of being a threat. I take pride in being accused of being a threat. Being five foot eight or nine at best, I find it amazing that this man needs protection from me, but there you go.

Mr BLEIJIE: I thought the point of order might have been the friendly part. Anyway, I withdraw.

I rise to speak in general support of the Coroners and Other Acts Amendment Bill 2009, which has been introduced by the government. The bill will amend the Coroners Act 2003, the Births, Deaths and Marriages Registration Act 2003 and the Cremations Act 2003. The Coroners Act 2003 repealed the Coroners Act 1958. Since the Coroners Act was enacted in 2003, an Office of the State Coroner has been established, and we have seen a new coronial administration established to focus on discovering the cause of and the truth behind certain deaths in an effort to prevent similar deaths happening again. The scope of the previous act related mainly to deaths arising as a result of criminal liability. The new act expanded the scope beyond only criminal liability.

The bill before parliament clarifies the scope and operation of the Coroners Act and seeks to improve the operational efficiency of the coronial regime. The bill seeks to include amendments to address one of the coronial issues raised in the report of the Queensland Public Hospitals Commission of Inquiry, referred to as the Davies report. The Davies commission of inquiry arose as a result of complaints relating to one particular doctor at Bundaberg Base Hospital in 2004 and 2005, after the enactment of the Coroners Act. These complaints not only related to a doctor's judgement, competence and care but also the failure of Bundaberg Base Hospital administrators and officers of Queensland Health to address those complaints and concerns.

Part of the inquiry was to consider whether there was sufficient evidence to justify amendments to the Coroners Act 2003 in relation to appropriate reporting of deaths caused by or as a result of a health procedure. In the Davies report, the commissioner stated—

... thirteen people died in Bundaberg after an unacceptable level of care ... Extraordinarily, only two of these deaths were reported to the Coroner under the *Coroner's Act* 2003, which required reporting in any case in which death was not a reasonably expected outcome of a health procedure. It seems likely that none of these deaths were reasonably expected outcomes of the relevant procedure.

In the Davies report, the commissioner made several recommendations to deal with those health care related deaths that were not expressly required to be reported to the coroner as a result of the ambiguity or, rather, limited scope of the existing section 8(3)(d) of the act—that is, deaths that are 'not reasonably expected to be the outcome of a health procedure'. Whilst the amendment set out in this bill was not specifically recommended by the Davies report, the amendment does deal with the issue arising from the existing provision requiring the reporting of deaths that are 'not reasonably expected to be the outcome of a health procedure'. The bill will now require the reporting of all health care related deaths. The

definition of a 'health care related death' as set out in the bill is quite extensive. The definition of 'health care' itself is quite broad to mean—

(a) any health procedure; or

(b) any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health.

The definition of 'health care related death' covers those deaths that occur at any time after receiving health care that (a) either caused or contributed to or was likely to have caused or contributed to the death, and (b) immediately prior to receiving the health care an independent person—that is, a person who was qualified in the relevant area of health care and who has regard to all relevant matters—would not have reasonably expected that such health care would cause or contribute to the person's death.

I make note to the House that these recommendations by the commission of inquiry were made back in 2005 and many of those recommendations have not been incorporated into the amendments proposed by this bill. This government has a track record of not acting in a timely manner and bringing about reform on important issues such as these as well as doing the bare minimum so that the government can at least appear to be making changes.

The bill will extend the category of reportable deaths to those deaths that 'happened in the course of or as a result of police operations'. The Queensland Coroners Court has carried out a series of seven inquests in relation to police pursuit deaths that occurred between 5 June 2005 and 5 December 2006. The most recent inquest relates to the unfortunate death of Caitlin Hanrick, a 13-year-old grade 8 student who on 4 December 2006 was struck by a Holden Commodore as it sped through red lights at a crossing while being pursued by two police vehicles. Sadly, this young girl died the following day as a result of the injuries resulting from being hit by a stolen car involved in a police pursuit.

While this death is a tragedy and nothing can take away from the loss experienced by Caitlin's family, her family have been provided with some answers as a result of the coronial inquest. But one must ask how many other deaths have occurred in the course of or as a result of police operations that have not been reported to the coroner and how many other families did not and still do not have any answers. The amendment to include deaths that 'happened in the course of or as a result of police operations' as reportable deaths is welcome but long overdue.

The amendments set out in the bill now expand the definition of 'death in care' in relation to children to include all out-of-home placements. I refer to the *Child Death Case Review Committee Annual Report 2007-08: reviews of child deaths known to the Queensland child protection system*. During the period 1 July 2007 to 30 June 2008, 457 children and young people died in Queensland and, of these 457 children and young people, 63 were known to the department of child safety. Of these 63 deaths, four were in out-of-home care. Sadly, 16 of these 63 young deaths were caused by non-accidental trauma—nine as a result of a fatal assault and seven as a result of suspected suicide. Other causes of death were: disease and morbid conditions, SIDS or other undetermined cause, transport related, drowning, accidental or fire. The cause of death of 10 children during this time is still unknown, pending determination by the coroner.

The number of deaths of children known to the department of child safety has regrettably increased from the previous year, when there were 57 deaths of children and young people during the period 1 July 2006 and 30 June 2007. Of those 57 deaths, 11 were caused by non-accidental trauma—seven being fatal assault and four being suspected suicide.

The loss of such young lives is a sad and terrible reality that our community must stand against. As a community, we need to focus on the area of child safety and welfare. This government needs to look to reform its prevention programs in relation to child safety and welfare. While most of these deaths would have been reportable deaths and would most likely have been required to be reported to the coroner under some category of reportable deaths, the amendments set out in this bill will ensure that the death of any child who is in a placement out of home will be a death that must be reported to the coroner.

The amendment will extend the reportable child deaths from only those deaths of children who are placed in care under section 82 of the Child Protection Act 1999 to be those out-of-home placements where the child is: in the custody or guardianship of the chief executive of the department of child safety; or placed in care under an assessment care agreement; or the subject of a child protection order granting a member of the child's family, other than a parent of the child, custody of that child; or the subject of a child protection order granting long-term guardianship of the child to either a member of the child's family, other than a parent of the child, or a person who is not a member of the child's family but has been nominated by the chief executive.

Once again, I reiterate the importance of prevention in the area of child safety and welfare. The children of Queensland are depending on this government to stand up for their safety and their lives. I urge this government to take that seriously and seek to prevent any threat to our children's safety and welfare, to their lives. While the LNP will support the bill, the amendments proposed in the bill should have been brought before this parliament quite some time ago and they still do not deal with several issues and recommendations contained in the Davies report. I commend this bill to the House.