Speech by

Lawrence Springborg

MEMBER FOR SOUTHERN DOWNS

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CORONERS AND OTHER ACTS AMENDMENT BILL

Mr SPRINGBORG (Southern Downs—LNP) (Deputy Leader of the Opposition) (12.39 pm): This bill amends three acts: the Coroners Act 2003, the Births, Deaths and Marriages Registration Act 2003 and the Cremations Act 2003. The amendments to the Coroners Act come after a review of the act, which has been in operation since 2003. The Coroners Act replaced the previous act that had been in operation since 1958. The explanatory notes claim that the intended amendment in no way shifts the fundamental policy of the original legislation.

One of the major amendments to the Coroners Act being proposed has come about as a result of the Davies inquiry into Queensland hospitals, which was also backed by the State Coroner who raised concerns about the language and interpretation of the term 'relating to a death not reasonably expected to be the outcome of a health procedure'. The new amendment proposes a more detailed 'health care related death'. The bill makes a number of other amendments to the Coroners Act which I will now speak to in some detail.

The bill redefines what is a death in care to remove any doubt that such deaths would go unreported because, as the bill states, there may be a misapprehension that a hospital has reported or will report the death. The next part of this amendment seeks to introduce a new type of reportable death and that is a death that 'happened in the course of, or as a result of, a police operation'. Furthermore, this government continues to deny the police in Queensland a helicopter, which I think is a real concern. A police helicopter would be crucial in reducing the number of pursuit related incidents.

Officers have no support if they call off a pursuit. They are damned if they do and damned if they do not. Since December of 2006, seven people have died in police chases in Queensland. Many have been criminals being pursued by police or passengers of stolen vehicles. Our brave police are operating under high pressure and are presented with split-second scenarios in which policy and procedure run through their heads when deciding how to pursue a vehicle. As I mentioned previously, the bill also changes the definition of 'death as a result of a health procedure'. But before I get into that, I want to go back to the issue of police pursuits and the need for a police helicopter.

If our police, as I indicated, pursue somebody and that person dies in custody or somebody else dies as a consequence of that pursuit, then of course there is going to be an investigation, and the officers involved and the service as a whole are often subjected to adverse media and community commentary. If they do not pursue that particular person or persons involved, then they are going to be subjected to adverse commentary in the media and by others because they have let somebody who has committed a criminal offence basically go free. Everyone needs to understand this. As a consequence of these particular changes, more deaths are going to become reportable and that is fair enough. However, it is going to draw those sorts of deaths more into the spotlight and place them under more scrutiny and make them the subject of more criticism. I say to the government that if it wants to actually do something about addressing the potentiality of those deaths, which nobody wants to see happen, then our police need to be resourced so they can perform their roles and obligations of protecting the community and apprehending those people who seek to do wrong in our community.

In referring to the Davies report, it is stated that the reference to 'reasonably expected' is unclear. It was never made clear as to whose expectation and to what standard. Despite coroners guidelines, the report found that there were still varying degrees of medical qualifications and independence. Over the past year in this House my colleagues in the LNP have proposed amendments to the Coroners Act based on Davies inquiry recommendations and both were rejected by the government. It was not that long ago that the member for Surfers Paradise, the Leader of the Opposition, introduced a suggested amendment into parliament which would enact certain recommendations of the Davies commission of inquiry.

The bill also amends what is a death in custody to include any death of a person in custody under any state or Commonwealth act. The Royal Commission into Aboriginal Deaths in Custody was established in October 1987 in response to a growing public concern that deaths in custody of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them. Further, the scope of the inquiry was expanded to inquire into the deaths in Australia between 1 January 1980 and 31 May 1989 of Aboriginal and Torres Strait Islander people while in police custody, prison or any other place of detention. Between 1 January 1980 and 31 May 1989, 99 Aboriginal or Torres Strait Islander people died in custody—in prison, or in police or juvenile detention institutions.

This bill makes amendments to ensure that definitions of death in care cover all aspects of circumstances where children are in out-of-home care. It was revealed during the estimates process that a record 79 children who were known to the department of child safety died. Whilst we have a Child Death Case Review Committee that examines these deaths, having the independent assessment and examination of the State Coroner into deaths of children in care is a vital tool of accountability that provides a truly independent assessment of what tragic circumstances led to the death of the child who was in care. Sadly, in the past we have seen that many of the reports of the so-called independent commission for children, which also heads up the Child Death Case Review Committee, have been vetted and watered down by interfering ministerial staff. So we are thankful for the role of the coroner in assessing and providing objective review of child deaths in care.

With regard to the Child Death Case Review Committee, since 1 August 2004 the department of child safety has been required to review its involvement with a child if the child dies and the department was aware of the alleged harm or risk of harm to the child or took action in relation to the child up to three years before the child's death. The department must give a copy of the report to the Child Death Case Review Committee within six months of becoming aware of the child's death. The committee is responsible for reviewing the departmental review; making relevant recommendations to the department, including whether disciplinary action should be taken against departmental officers; and monitoring implementation of the recommendations.

The Child Death Case Review Committee produces an annual report that includes details of the number of Aboriginal or Torres Strait Islander children and young people known to the child protection system who died during the reporting period. Twelve such deaths were reported in 2004-05, 14 were reported in 2005-06 and 16 were reported in 2006-07, making a total of 42 deaths. That means that in just three years the number of Indigenous children who have died who were known to the department is exactly half the number of Indigenous deaths in custody over 10 years that brought about the royal commission. More children have died who were known to the department of child safety since 2006 than those in police pursuits. The bill also will allow people who are dissatisfied with the decision of a coroner as to whether a death is reportable to have the matter revisited.

The bill also clarifies certain powers that the coroner can exercise when conducting an inquest. The bill also clarifies who may attend an autopsy and breaks it down into three distinct regimes—coroner, police and anyone the coroner considers for vocational and clinical education or training. The bill makes amendments to the act in line with the Ombudsman's Coronial Recommendations Project. These amendments relate to the publishing of preinquest information. The bill proposes major amendments that will allow the coroner who held an inquest or the State Coroner to reopen an inquest or hold a new inquest on their own initiative. They must be satisfied there is new evidence that would cast doubt on a previous finding.

The amendments to the Births, Deaths and Marriages Registration Act 2003 are consequential amendments to allow for the amending of the death register where the cause of death is different from that of the coroner's finding. The amendments to the Cremations Act 2003 are to update references to other pieces of legislation.

So, by and large, the LNP is very supportive of the legislation which has been introduced into parliament by way of amendment. We are, of course, concerned that this government in its previous manifestation chose to reject significant legislative proposals in this parliament which could have enhanced the role of the coroner insofar as reportable deaths to make sure that we did not have a repeat of what we saw with regard to the Bundaberg Hospital disaster a number of years ago.

It is also unfortunate that we have a government that is so churlish in that it is always calling for bipartisanship from this side of the parliament—which is actually offered in spades if we look at the number of pieces of legislation that are passed through this parliament without opposition by the opposition, the alternative government; some eight out of 10 pieces of legislation—yet we put forward legislative amendments on many occasions which are rejected by the government. So the government does not practise the bipartisanship which it actually proffers that the opposition should. Then the government will often reject the opposition's proposition and bring it back in many cases absolutely unchanged and claim it to be its own. We see that on a regular basis. Only recently we saw the government embarrassed when it had to suspend the sessional orders of parliament to allow something to be reintroduced into the parliament that it had voted down. It put its own monicker on it and brought it back into the place.

With regard to what this bill seeks to do arising from the recommendations of the Davies commission of inquiry, those poor people should never have been put through the alleged medical misadventure—the hardship and the pain that they were put through—and then to be doubly interfered with and doubly neglected by a government of the day that sought, first of all, to deny the problem and then establish a commission of inquiry which then brought down certain recommendations.

The government has been somewhat tardy. It is unfortunate that it has taken this government so long to bring these particular amendments before the parliament. But they are necessary amendments because there have been circumstances, in the particular case that I mentioned and others, in Queensland where deaths that should have been investigated by the coroner were not investigated and were not reported because of the procedures that were put in place that did not bring them to the attention of the suitable authorities. Therefore, a chain of medical malpractice, misadventure and resultant death and injury and mayhem happened for those particular people. Therefore, to have a process which ensures a greater degree of scrutiny and a greater legislative obligation to investigate and report should hopefully lead to a whole range of people having better outcomes not only in our health system but also in custody and in care throughout Queensland in the future.

Therefore, we will support the legislative changes. There may need to be more made at some future time. I am not sure if this actually goes as far as Commissioner Davies alluded to in his particular recommendations. But, as with any piece of legislation in this parliament that becomes an act, we should all keep a close watching brief on it because it does need to be amended and enhanced from time to time to benefit those people in the community who rely upon this scrutiny and transparency to ensure their protection.