Submission No 13

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Coroners Court of Queensland

Date Received: 29 June 2021

QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND – Chambers of State Coroner Terry Ryan

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29 June 2021

Hon Adam Searle MLC
Committee Chair
Select Committee into the coronial jurisdiction in NSW
Parliament House, Macquarie Street
Sydney NSW 2000

Dear Mr Searle

Thank you for your letter dated 13 May 2021 in relation to the inquiry into the coronial jurisdiction in New South Wales. I am pleased to provide a submission to the inquiry.

Queensland's coronial jurisdiction operates in accordance with the functions outlined in the *Coroners Act 2003* (Coroners Act). The Coroners Court is established as a court of record under the Coroners Act. The Act provides for the appointment of the State Coroner who is responsible for overseeing and coordinating the coronial system and ensuring that the coronial system is administered and operated efficiently. The Act specifies that it overrides the common law.

While coroners are appointed as magistrates, the Coroners Court operates independently of the Magistrates Court, subject to the requirement to consult with the Chief Magistrate in s 76 of the Coroners Act. In practice, magistrates who wish to specialise as coroners remain in the coronial jurisdiction. The Attorney-General has recently advertised to fill a vacancy within the court with a specialist coroner.

Queensland has seven specialist coroners located across the State in Southport, Brisbane, Mackay and Cairns. During 2019-20, the Chief Magistrate also allocated a part-time magistrate, and an acting magistrate, to work in the coronial jurisdiction.

At the commencement of the Coroners Act coronial work was undertaken by all magistrates. However, since 2012 coronial work is carried out by the seven specialist coroners and the coronial registrars. Two coronial registrars, located in Brisbane, assist coroners by triaging and investigating less complex matters, such as deaths from apparent natural causes.

The Coroners Court of Queensland (CCQ) registry is part of the Department of Justice and Attorney General and sits within the Magistrates Court Service. The CCQ provides registry, administrative, legal and research support to coroners and registrars across the State.

The CCQ Registry is led by a Director and comprises positions ranging from Administrative Officer level to Senior Officer level, as well as staff in the Professional Officer stream. The latter group is comprised of seven counsel assisting. The Court also engages external counsel for more complex inquests.

While most court staff are located within the Brisbane registry, staff in Southport, Mackay and Cairns work in team-based structures to support coronial investigations in the regions.

The coronial jurisdiction is multidisciplinary supported by our two key coronial partner agencies: Queensland Police Service (QPS) and Queensland Health (QH) Forensic and Scientific Services (QHFSS).

Coronial Family Services are part of QHFSS. In the early stages of a coronial investigation, skilled counsellors provide information and support to relatives and close friends of people whose deaths are being investigated by a coroner.

The sustainability of forensic pathology services continues to be a focus of the Court in conjunction with QHFSS to ensure Queensland has access to timely and quality forensic pathology services. The 'triaging' process and the introduction of the preliminary examination procedures are intended to divert cases from unnecessary autopsy.

In September 2019, the CCQ commenced trialling the establishment of a second coronial registrar and support team with positions within CCQ, QH and QPS. This cross-agency team has been 'triaging' all apparent natural cause (ANC) deaths reported to police. This represents a significant percentage of deaths reported to the Court for investigation.

The 'triaging' approach is a multidisciplinary one that engages forensic pathologists, clinical nurses, forensic medical officers, coronial nurses and counsellors to divert non-reportable deaths from the unnecessary application of full coronial resources by reviewing medical records and liaising with families to determine if there are any concerns and authorise a cause of death certificate.

The primary objectives of the trial were designed to:

- reduce demand pressures on agencies (including reducing the number of ANC deaths reported to police, and reducing the need for deceased persons to undergo autopsy examinations unless required);
- better support families by minimising unnecessary contact with the coronial system, ensuring these deaths do not enter the system unless they require review and investigation, use of less invasive autopsy procedures and increased case finalisation timeframes; and
- ensure coroners have increased capacity to focus on more complex investigations.

Queensland's coronial system has undergone significant reform across the Department of Justice and Attorney-General, Queensland Police Service and Queensland Health in response to the 2018 Queensland Audit Office (QAO) report: *Delivering coronial services*.

The QAO report recognised staff commitment to deliver services across agencies but identified service provision impeded by lack of governance and integration across system, insufficient resourcing, and inadequate case management practices.

Implementation of recommendations was overseen by the Coronial Services Governance Board. Members included the State Coroner, Deputy State Coroner and Chief Forensic Pathologist, senior representatives from the Department of Justice and Attorney-General, QPS, QH, Queensland Treasury and the Department of the Premier and Cabinet.

Future governance arrangements to continue the work of the Coronial Services Governance Board are presently being finalised.

The Coroners Court of Queensland (CCQ) has focused on addressing coronial backlogs. The CCQ has achieved a reduced backlog of coronial cases through:

- undertaking a comprehensive audit of cases greater than 24 months to better understand their status and factors delaying case finalisation
- introducing timeliness indicators on matters ready for findings, with cases greater than 24 months continuing to be proactively monitored and case managed on a regular basis.

A dashboard reporting system was rolled out in CCQ to enhance performance monitoring processes and identify possible blockages and support more effective case management.

Proactive case management procedures have also been rolled out, including ensuring CCQ appoints appropriately trained and supported case managers to proactively manage investigations and be the central point of information for families, and establishing processes to ensure families receive adequate and timely information throughout the coronial process.

As at 30 April 2021 the year to date clearance rate was 99.38%. This is just below national benchmark of 100%. The CCQ backlog indicator was 14.21%. This is below national benchmark of 5%. The Court is required to publish an annual report and more detailed information about the Court's performance can be found in the 2019/20 Annual Report.[1]

The Court has made limited progress in responding to the needs of culturally and linguistically diverse and First Nations families and communities. The Coroners Act contains provisions that respond to relevant RCIADIC recommendations such as mandating inquests into deaths in custody. In 2019 the Court published "Sorry Business" - A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people. The Court does not have a dedicated First Nations unit.

Where an individual requires an interpreter, the registry will engage an interpreter from an approved service provider.

Queensland Government responses to coronial recommendations are made within six months of the recommendation being handed down. Six-monthly implementation updates are provided. The responses are coordinated by the Legal Services Coordination Unit in the Department of Justice and Attorney-General and published on Coroners Court website next to the relevant inquest findings.

I trust this information is of assistance to the Select Committee. If you have any further questions, please call my office on

Yours sincerely

Terry Ryan
State Coroner

[1] https://www.courts.qld.gov.au/__data/assets/pdf_file/0020/670421/osc-ar-2019-2020.pdf