QUEENSLAND COURTS

Coroners Court of Queensland

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7 December 2017

The Honourable Adele Farina MLC
Chair
Standing Committee on Public Administration
Legislative Council Committee Office
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005

Email: lcco@parliament.wa.gov.au

Dear Ms Farina

Thank you for your letter dated 13 November 2017.

I understand that you are requesting information regarding the relationship between the Coroners Court and Workplace Health and Safety Queensland (WHSQ) in relation to the investigation of workplace deaths. I have reworded your questions accordingly, and my responses are set out below.

1. **Does WHSQ share copies of their investigation reports with the Coroner?**

WHSQ works with the Queensland Police Service to investigate deaths in the workplace. A memorandum of understanding exists in relation to the respective roles and responsibilities of those agencies. WHSQ reports are routinely provided to coroners to assist with coronial investigations.

2. **Are there any limitations on the information that the Coroner is able to access from WHSQ?**

No

3. **Not applicable**

4. **Does the Coroner undertake their investigation into a death concurrently with WHSQ?**

Coronial investigations will proceed in parallel with the WHSQ investigation. Section 29 of the *Coroners Act 2003* provides that where a person has been charged with an offence, in which the question of whether the accused caused the death may be an issue, an inquest cannot be commenced.

While s 29 does not prevent the coronial investigation from proceeding, coroners will generally wait for a decision to be made about a prosecution before finalising the coronial file by way of chamber findings.

5. Does WHSQ hamper or delay the Coroner's investigations in any way?

Delays in making a decision to commence a prosecution following a workplace death and issues with the quality of the investigation can both affect the finalisation of coronial investigations.

In 2015, the Queensland Ombudsman undertook a review into the adequacy of WHSQ's investigation work and processes, following complaints and critical commentary from specific coronial inquests about the quality of these processes.[1]

These issues have been considered more recently in the best practice review of Workplace Health and Safety Queensland in response the fatalities at Dreamworld and an Eagle Farm worksite in 2016, carried out by Mr Tim Lyons. [2] Mr Lyons concluded:

> *The review finds that there is a need for ongoing improvement in WHSQ's investigations performance. Undoubtedly, the quality of investigations significantly impacts, and in many cases determines the possibility of a successful prosecution. Historically, there have been significant problems with the quality, timeliness and consistency of investigations conducted by WHSQ. These were highlighted in the Ombudsman's review and in many ways reflect the broader perceptions of stakeholders involved in this review, including employers, unions and the Families Forum. While significant additional quality assurance mechanisms and governance measures have been introduced since the Ombudsman's review, it is currently too soon to confirm whether these business improvement strategies have resulted in an investigations system that is efficient, timely and thoroughly professional.*

The Queensland Government has accepted the bulk of the recommendations contained in Mr Lyons report, including those relating to enhancing the quality of WHSQ's investigations and prosecutions processes. It is expected that the separation of the investigation and prosecution functions within WHSQ will lead to more timely decisions about prosecutions.

WHSQ has also initiated a process in which interim reports are provided to Coroners to assist in the finalisation of less complex coronial investigations.

6. Does WHSQ publish any educational material containing Coroner's recommendations regarding a workplace death?

Examples of educational materials in response to specific inquests can be found at:

https://www.worksafe.qld.gov.au/news/2012/coroner-requests-a-review-of-journey-claim-rules

And

https://www.worksafe.qld.gov.au/rideready/resources

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[1] Queensland Ombudsman, The workplace death investigations report: An investigation into the quality of workplace death investigations conducted by the Office of Fair and Safe Work Queensland, September 2015

[2] https://www.worksafe.qld.gov.au/laws-and-compliance/best-practice-review-of-workplace-health-and-safety-queensland

Responses to coronial recommendations are developed through an Organisational Response Governance Group within the Office of Industrial Relations. This group considers inquest findings and coronial recommendations and develops an organisational response.

Responses are then published on the Coroners Court of Queensland website and updated. These responses are reported through a whole-of-government process administered by the Department of Justice and Attorney-General. This process ensures that the Queensland Government departments respond to each coronial recommendation and that these responses are publicly accessible.

7. Does the Coroners Court have a strong working relationship with WHSQ and is there an efficient sharing of information between the two offices?

The Coroners Court has a strong relationship with WHSQ and continues to improve processes and procedures through regular meetings. The Office of Industrial Relations within Queensland Treasury has several positions dedicated to coronial liaison. WHSQ regularly appears as an interested party in inquests involving workplace deaths.

A consultative committee for work related fatalities and serious incidents (the Committee) has been established to ensure there is an ongoing consultative forum for injured workers and families affected by a workplace death. The Committee has recently been given statutory recognition under the *Work Health and Safety Act 2011*.[3] There is also ongoing engagement between the Committee and the Coroners Court.

https://www.worksafe.qld.gov.au/about-us/interim-consultative-committee

The Coroners Court notifies all families whose next of kin have died as a result of a work-place incident about the Committee and provides contact information for the Committee.

I trust that this information is of assistance to the Committee. Should you have any further queries do not hesitate to contact me directly.

Yours sincerely

Terry Ryan
State Coroner

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[3] The relevant amendments were contained in the *Workers' Compensation and Rehabilitation (Coal Workers' Pneumoconiosis) and Other Legislation Amendment Act 2017*