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Coroners Act Reform Team
Strategic Policy and Legislation
Department of Justice

Via email: xxxx@justice.qld.gov.au

Dear Coroners Ac*t* Reform Team

The Queensland Family and Child Commission (the Commission) welcomes this review as an opportunity to strengthen Queensland's coronial system so that it continues to promote prevention, accountability and public confidence. A modern coronial system should not only determine the circumstances of a person's death but also ensure that lessons identified are translated into meaningful improvements that reduce the likelihood of future harm.

Queenslanders rightly expect that people are safe in their homes, communities and in their interactions with government and service systems. When this is not the case—particularly where a child's death may have been preventable—there is an expectation that the circumstances are independently examined, systemic issues are identified, and government agencies respond with lasting improvements. Public confidence depends not only on the quality of investigations but also on transparency about what has been learned and what has changed as a result.

Queensland already has complementary statutory mechanisms that support these objectives. Under the Queensland *Family and Child Commission Act 2014*, the Commission is responsible for Queensland's child death monitoring and review functions. Part 3 requires the Commission to establish and maintain the Child Death Register, providing a comprehensive evidence base for monitoring child deaths, identifying trends and emerging issues, and informing prevention strategies.

Part 3A establishes the Child Death Review Board, an independent expert board supported by the Commission. The Board reviews the deaths of children to identify systemic issues, undertakes thematic reviews and inquiries, and makes recommendations to improve legislation, policy, practice and service delivery. Its focus is not on attributing responsibility for individual deaths, but on identifying recurring risks and opportunities for systemic improvement. These functions complement, rather than duplicate, the role of the Coroners Court.

A coronial investigation is an independent judicial process that examines the circumstances of an individual death and, where appropriate, makes recommendations to prevent similar deaths. The Child Death Review Board, by contrast, examines patterns across multiple child deaths over time, particularly where children had contact with the child protection system, enabling broader assessment of system performance and emerging risks. Together, these functions provide both case-specific scrutiny and longitudinal system learning. Recent reviews have demonstrated that these parallel processes can be mutually reinforcing, with each informing a more comprehensive

understanding of the issues than either process could achieve alone.

While the current framework is fundamentally sound, the Commission considers there are opportunities to further strengthen the coronial system. First, greater transparency regarding coronial recommendation outcomes would enhance public accountability. While coronial findings often result in important recommendations, there is limited visibility of how agencies respond, whether recommendations are accepted, and most importantly what progress has been made in implementation. Consideration could be given to legislative mechanisms that improve public reporting on agency responses and implementation, similar to existing approaches used elsewhere in government to monitor recommendations arising from independent reviews. As one of many oversight bodies the QFCC produces an annual *'Recommendation Monitoring Report'* and it may be feasible for the Coroners Court to be resourced to similarly provide system and policy guidance.

Secondly, the timeliness of coronial investigations is critical to maximising their preventative value. Delays can postpone important system improvements, reduce the practical relevance of findings, and prolong uncertainty for families and agencies. The Commission's experience illustrates this challenge. In July 2025, I gave evidence at the inquest into the death of a 14-year-old child who died in Cairns in February 2022. The inquest considered significant issues relating to child protection services, residential care and police responses. While the Commission recognises that coronial investigations are often complex and that procedural fairness must remain paramount, lengthy delays can defer important reforms and limit opportunities for earlier system improvement. During the four-year period following the death, the child protection system may form the view that progress has been made, and consequently that the value of the learnings from an old case are diminished. There is merit in considering legislative amendments or case management mechanisms that support the timely completion of coronial investigations, particularly where matters involve the death of a child or raise significant issues of public safety.

The Commission therefore encourages consideration of reforms that: support the timely completion of coronial investigations, particularly those involving children or significant public interest issues; and strengthen transparency regarding coronial recommendations, agency responses and implementation progress.

These reforms would build on an already strong framework by improving transparency, timeliness and accountability, while ensuring that Queensland continues to learn from deaths and translate those lessons into safer outcomes for children, families and the broader community. If you would like to meet to discuss this matter further, please don't hesitate to contact me directly on xxxx xxx xxx or via email at xxxx@qfcc.qld.gov.au.

Yours sincerely

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

July 2026