Inquest into the death of Marcia Anne Kathleen Maynard

Marcia Anne Kathleen Maynard died on 3 October 2015, her cause of death was consistent with insulin overdose. The coroner found Ms Maynard took her own life in the context of a number of stressors, most prominent was her anxiousness about having to give evidence in a mandatory death in custody inquest.

Deputy State Coroner John Lock delivered his findings of inquest on 5 September 2018.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

**Recommendation 1**
The Queensland Government facilitate and fund a program that provides counselling for families as well as witnesses or others who may be involved in and impacted by a coronial investigation and/or inquest, similar to the program currently being facilitated by the Office of Industrial Relations.

Response and action: implementation of the recommendation is under consideration.

Responsible agency: Department of Justice and Attorney-General

On 15 May 2019 the Attorney-General and Minister for Justice responded:

The department is currently considering the supports required by families and witnesses involved or impacted by a coronial investigation and/or inquest as part of a broader package of reforms associated with a recent performance audit of coronial services by the Queensland Auditor-General.

This includes ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.

**On 3 September 2019 the Attorney-General and Minister for Justice responded:**

In acknowledging that families and witnesses have a diversity of support needs, a series of consultation sessions will be held in 2019 to bring together those who play a role in supporting people bereaved or otherwise affected by a death reported to a coroner.

This will assist all stakeholders to develop a shared understanding of the differing roles and responsibilities of agencies in providing support to families and witnesses, identify opportunities for improvement, and discuss examples of new and emerging practice.

Agencies are also continuing their focus on improving the case management and legal assistance they provide to coroners and the counselling support provided to families, through the allocation of additional temporary staff within the Coroners Court of Queensland and additional coronial counsellors within Queensland Health.