Speech By

Corrine McMillan

MEMBER FOR MANSFIELD

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LEGAL AFFAIRS AND COMMUNITY SAFETY COMMITTEE

Report, Motion to Take Note

Ms McMILLAN (Mansfield—ALP) (3.38 pm): The Queensland Audit Office forms a key part of the Palaszczuk government's integrity and accountability agenda. Report No. 50 of the Legal Affairs and Community Safety Committee captures the Queensland Audit Office's report titled *Delivering coronial services*. The report reflects the dutiful work of the Queensland Audit Office.

The delivery of coronial services performance audit addresses whether agencies are effective and efficient in supporting the Coroner in investigating and helping to prevent deaths. The agencies subject to the audit were the Department of Justice and Attorney-General, the Coroners Court of Queensland, the Department of Health's Forensic and Scientific Services and the Queensland Police Service. The audit examined whether agencies have efficient and effective processes and systems for delivering coronial services and whether they provide adequate support to bereaved families and also whether they plan effectively to deliver sustainable coronial services.

The QAO report advised that between 2011-12 and 2017-18 the number of deaths reported to the Coroner each year for investigation increased by 27 per cent from 4,461 to 5,683. Since 2005-06 the number of deaths reported to the Coroner has increased by 81 per cent. The QAO report advised that the demand for Queensland's coronial services is likely to increase with the state's growing and ageing population. Of course, these statistics make absolute sense in light of the population increase in our state.

The QAO also found that agencies have improved their triaging practices—as we would expect of our great Public Service—reducing the number of deaths leading to proceeding to full investigation unnecessarily. This triage process could be expanded and applied more consistently across the state. The communication provided to the families at the beginning of a coronial investigation is sufficient, but agencies again could provide more support to families throughout the investigation. The Coroners Court of Queensland does not actively monitor the performance of government undertakers. As such, the performance of some government undertakers is variable across the state. Agencies could more effectively plan for the ongoing delivery of these forensic pathology services.

As we have heard today, the QAO made seven recommendations in its report and provided a summary of its recommendations to the relevant agencies. I have no doubt that our Public Service will accept these seven recommendations and that they will act in a systematic way to put in place procedures to rectify some of these suggestions. I thank Queensland's coronial services—the many men and women across our Public Service—who deliver these difficult services often in very difficult contexts. I also appreciate that, when one takes the opportunity to read the statistics in the way that they have been presented, one can identify the reasons some of the reports and some of the investigations take a little longer. A growing population in Queensland requires a growing Public Service.