Speech By

Melissa McMahon

MEMBER FOR MACALISTER

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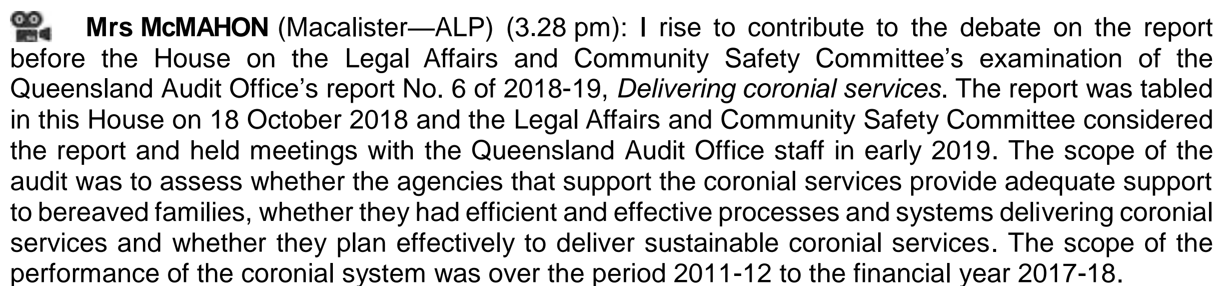
LEGAL AFFAIRS AND COMMUNITY SAFETY COMMITTEE

Report, Motion to Take Note



Mrs McMAHON (Macalister—ALP) (3.28 pm): I rise to contribute to the debate on the report before the House on the Legal Affairs and Community Safety Committee's examination of the Queensland Audit Office's report No. 6 of 2018-19, *Delivering coronial services*. The report was tabled in this House on 18 October 2018 and the Legal Affairs and Community Safety Committee considered the report and held meetings with the Queensland Audit Office staff in early 2019. The scope of the audit was to assess whether the agencies that support the coronial services provide adequate support to bereaved families, whether they had efficient and effective processes and systems delivering coronial services and whether they plan effectively to deliver sustainable coronial services. The scope of the performance of the coronial system was over the period 2011-12 to the financial year 2017-18.

Following the audit report, the Queensland Audit Office made the following seven recommendations: the establishment of effective governance arrangements across the coronial system; to evaluate the merits of establishing an independent statutory body to deliver effective medical services for Queensland's justice and coronial systems; to improve the systems and legislation supporting coronial services; to improve processes and practices across the coronial system; to assess more thoroughly the implications of centralising pathology services; to implement a strategy to address a growing backlog of coronial cases; and to improve performance monitoring and management of government undertakers. Tabled as part of the Audit Office's report was the response by the Department of Justice and Attorney-General and their response to these recommendations.

The director-general responded in October 2018 to the Audit Office outlining that all recommendations were agreed to and that the recommendations that were made aligned with work already underway. That work was informed by a 2017 independent organisational review of the Coroners Court of Queensland.

Further, in considering the report the committee wrote to the relevant agencies to receive an update on the process of implementing the recommendations. The committee received a combined response from the newly formed Coronial Services Governance Board. The board has been established to lead the implementation of all recommendations and is comprised of representatives from DJAG, Queensland Police, Queensland Health, the State Coroner and Deputy Coroner, the Chief Forensic Pathologist and senior advisers from Queensland Treasury and the Department of the Premier and Cabinet. The board reports to the Attorney-General every six months on the progress of implementing the recommendations.

To assist in implementing the recommendations from the Audit Office report, the government has invested $3.9 million over four years. This funding allocation in the last financial year allowed the appointment of additional staff across agencies including an additional coronial registrar and two coronial service officers within DJAG, an additional coronial nurse and forensic medical officer in Queensland Health and an additional senior constable within the Queensland Police Service.

An extra two coronial counsellors have been appointed this financial year. Queensland Health is also actively recruiting for additional forensic pathologists, noting the nature of the specialty and the global shortage in the profession. To help safeguard against this, two training placement positions have also been created so we can grow our forensic pathology capability into the future.

An additional part-time magistrate has been allocated to support the finalisation of cases within the benchmark time frame set within the report recommendations. When the board wrote to the committee, it provided a comprehensive update on the progress against the seven recommendations with the only exception being a review of the Coroners Act which, members may recall, we passed yesterday so we can now tick off that part of the recommendation as well.

The delivery of coronial services has not and has never been a static process and it has varied in its delivery throughout the state, but it has improved significantly over the years that I have worked within it. When I first started, every time a car caught fire we had to write a report to the Coroner which was very much an impost on time. The John Tonge Centre only had one computer in which all form 1s could be prepared as everybody had to be lodged by the investigating officer.

In 2010 the sealed body bag project alleviated the need for police to travel to the morgue, reducing the time it took to prepare paperwork and that time could be spent furthering the investigation. The recommendations contained within this report will see the coronial services delivered in Queensland improve even further. I commend the report to the House.