Speech By

Peter Russo

MEMBER FOR TOOHEY

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LEGAL AFFAIRS AND COMMUNITY SAFETY COMMITTEE

Report, Motion to Take Note

Mr RUSSO (Toohey—ALP) (3.18 pm): I move—

That the House take note of the Legal Affairs and Community Safety Committee Report No. 50, 56th Parliament—*Examination of Queensland Audit Office Report 6: 2018-19: Delivering coronial services* tabled on 20 September 2019.

As we heard yesterday in the debate of the Justice and Other Legislation Bill, the amendments to the Coroners Act reflect, as I addressed, the issues raised by the audit. The key facts of the *Examination of Queensland Audit Office Report 6: 2018-19: Delivering coronial services* are from data extracted from the Coroners Court of Queensland's case management system on 21 June 2018. This data may not capture all deaths reported to the Coroners Court in 2017-18.

Between 2011-12 and 2017-18 in the Queensland coronial system, police officers, doctors or funeral directors reported 35,433 deaths to the Coroner for investigation. Coroners issued 522 recommendations to the state government agency. Pathologists performed 18,387 autopsies. It took pathologists, on average, more than four months to issue their autopsy reports and during that period coroners held 400 inquests. In that period, coronial cases 24 months old or older had increased from seven to 16 per cent.

On behalf of the committee, I thank the Coronial Services Governance Board, the Queensland Police Service, Queensland Health, the Department of Justice and Attorney-General, and the committee's secretariat for their assistance with the committee's examination of the Queensland Audit Office report. The object of the audit was to assess whether agencies are effective and efficient in supporting the Coroner in investigating and helping to prevent deaths.

The Coroners Act 2003 governs the Queensland coronial system. It requires coroners to investigate deaths that occur in Queensland under certain circumstances. The primary responsibility of coroners is to make formal findings in response to a death, including the circumstances and cause of the death. Indeed, the act contains a recognition of the needs and concerns of the families of the deceased. An effective and efficient coronial system enables a coroner to independently and robustly investigate, while providing timely and reliable answers to the family. That is complex and relies on the timely and reliable services of multiple public sector and contracted agencies across a geographically dispersed state. The public sector agencies responsible for supporting coroners are the Department of Justice and Attorney-General through its Coroners Court of Queensland, the Department of Health through its Forensic and Scientific Services and the Queensland Police Service.

The Queensland Audit Office report found that demand for Queensland's coronial service is likely to increase with the state's growing and ageing population. While identifying there are three key agencies that play a key role in supporting the coroners, the Queensland Audit Office report found that the Queensland State Coroner has little functionality control over the resources needed to effectively

fulfil their responsibility under the act. This has resulted in a system that is under-resourced to meet existing and future demand and is fast becoming a critical vulnerability for the Queensland coronial system.

For the three agencies delivering coronial services, those services are one of the many functions they can perform and are not necessarily considered their core business. An improvement of triage practices has seen a reduction in reported deaths proceeding to a full coronial investigation, despite the number of deaths being reported increasing during this time. Currently, in Queensland there is no requirement for a pathologist or a coronial nurse to undertake a preliminary investigation when a death is reported and, as I outlined, some of those issues were dealt with yesterday in the debate. I commend the report to the House.