Speech By

Stephen Andrew

MEMBER FOR MIRANI

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LEGAL AFFAIRS AND COMMUNITY SAFETY COMMITTEE

Report, Motion to Take Note

Mr ANDREW (Mirani—PHON) (3.42 pm): I rise as a member of the Legal Affairs and Community Safety Committee to speak to Queensland Audit Office report No. 6, *Delivering coronial services*. Currently, Queensland's coronial system involves a number of different agencies, including the Coroners Court, Forensic and Scientific Services, undertakers and the Queensland Police Service. No one agency has oversight for the management of coronial investigations in Queensland from start to finish. This has meant that individual cases are increasingly falling through the cracks.

The Auditor-General's report described Queensland's coronial services as a 'failed system that is currently under severe stress'. Its overall service delivery model is plagued with backlogs, some two years or older, and the support provided to grieving families was judged to be woefully inadequate. Since 2006 the number of reportable deaths in Queensland has risen a staggering 81 per cent. This trend is forecast to continue given the state's growing and ageing population.

The backlog of outstanding coronial cases in the system went back two years and in some of the worst cases even more. Overall, the number of cases in the system two years or older rose from seven per cent in 2012 to 16 per cent in 2018. In some cases families were not spoken with again after the process began despite the investigation taking more than four years to finalise. The report also revealed a shocking case in March 2008 where, according to police reports, an undertaker showed such a lack of care and compassion in handling a body that extreme distress was caused to at least one of the grieving families.

The report's key findings identified a lack of cohesion, planning and accountability across all agencies of the service, together with insufficient integration or communication between these agencies as contributing factors to the system's breakdown. The investigation into the service also found that excessive delays and declining clearance rates were directly attributed to chronically low staffing and funding levels, which were judged to be woefully inadequate for the volume of work coronial officers and staff were being asked to perform. With cases skyrocketing across the state, overworked and under-resourced staff tried their best, but the demands being made on the system were impossible to keep up with.

The report made a number of recommendations directed towards the Department of Justice and Attorney-General, the Department of Health, the Queensland Police Service and the Department of the Premier and Cabinet in collaboration with the Coroner's office. Briefly, these recommendations reinforce the need for various agencies to coordinate their processes more efficiently, share coronial information, explore avenues for improvement and identify means by which unnecessary coronial investigations may be avoided.

The report proposed the creation of a governance board with the adequate authority to oversee the coordination of agencies and provide ongoing monitoring and management of the system's performance. I sincerely hope the government will consider the report's recommendations and move quickly to make the necessary changes needed to improve the efficiency of the service.