Parliamentary Committees



Examination of Queensland Audit Office Report 6: 2018-19

Delivering coronial services

Report No. 50, 56th Parliament

Legal Affairs and Community Safety Committee

September 2019

Legal Affairs and Community Safety Committee

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Acknowledgements

The committee acknowledges the assistance provided by the Queensland Audit Office, the Queensland Police Service, the Department of Justice and Attorney-General, Queensland Health, and the Coronial Services Governance Board.

Contents

Abbreviations

Auditor-General	Queensland Auditor-General
Board	Coronial Services Governance Board
committee	Legal Affairs and Community Safety Committee
QAO	Queensland Audit Office
QAO report	Queensland Audit Office Report 6: 2018-19 *Delivering coronial services*
this report	Legal Affairs and Community Safety Committee, Report No. 50, 56th Parliament, Examination of Queensland Audit Office Report 6: 2018-19 Delivering coronial services

Chair's foreword

This report presents a summary of the Legal Affairs and Community Safety Committee's examination of the Queensland Audit Office Report 6: 2018-19 *Delivering coronial services*.

On behalf of the committee, I thank the Queensland Audit Office, the Coronial Services Governance Board, 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.

I commend this report to the House.

Peter Russo MP

Chair

Recommendation

Recommendation **6**

The Legal Affairs and Community Safety Committee recommends that the Legislative Assembly notes the contents of this report.

1 Introduction

1.1 Role of the committee

The Legal Affairs and Community Safety Committee (committee) is a portfolio committee of the Legislative Assembly.[1] The committee's primary areas of responsibility are:

- Justice and Attorney-General
- Police and Corrective Services
- Fire and Emergency Services.[2]

One of the committee's roles is to consider the reports of the Queensland Auditor-General (Auditor-General) that fall within its portfolio area.[3] The committee may examine and inquire into the reports, and make recommendations and report on them to the Legislative Assembly.[4]

1.2 Role of the Auditor-General

The Auditor-General conducts independent audits—financial audits and performance audits—of the Queensland public sector and certain other entities.[5] In the reports to Parliament on the audits, the Auditor-General makes recommendations to improve service delivery, accountability and transparency.[6] The Queensland Audit Office (QAO) supports the Auditor-General.[7]

1.3 Referral of Queensland Audit Office Report 6: 2018-19 *Delivering coronial services*

The Queensland Audit Office Report 6: 2018-19 *Delivering coronial services* (QAO report) was tabled on 18 October 2018. It was referred to the committee on the same day.

1.4 Committee's inquiry process

The committee held a private meeting on 1 April 2019 with Ms Daniele Bird, then Acting Auditor-General, and Mr Darren Brown, then Director Performance Audit, QAO, to discuss the QAO report in detail.

On 29 April 2019, the committee wrote to the following agencies seeking an update on the progress of the implementation of the recommendations in the QAO report:

- Department of Justice and Attorney-General
- Department of Health
- Queensland Police Service.

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1 *Parliament of Queensland Act 2001*, s 88; Standing Rules and Orders of the Legislative Assembly, standing order 194. The committee commenced on 15 February 2018.

2 Standing Rules and Orders of the Legislative Assembly, schedule 6.

3 *Parliament of Queensland Act 2001*, s 94(1); standing order 194B.

4 *Parliament of Queensland Act 2001*, ss 79, 92.

5 *Auditor-General Act 2009*, s 3. A financial audit assesses the financial statements of a public sector entity: *Auditor-General Act 2009*, ss 40, 58. A performance audit evaluates whether any or all of a public sector entity's activities are achieving their objectives economically, efficiently and effectively, and are compliant with relevant legislation. It does not question the merits of government policy: *Auditor-General Act 2009*, s 37A.

6 Queensland Audit Office, 'The Queensland Audit Office', https://www.qao.qld.gov.au/.

7 *Auditor-General Act 2009*, s 6.

The committee received a response from the newly established Coronial Services Governance Board (Board) whose members include the Department of Justice and Attorney-General, Queensland Police Service and Queensland Health. The correspondence is available on the committee's website.

2 Examination of the Queensland Audit Office report

2.1 Audit objective and scope

The *Delivering coronial services* performance audit assessed whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths.

The agencies subject to the audit were:

- Department of Justice and Attorney-General, Coroners Court of Queensland
- Department of Health, Forensic and Scientific Services
- Queensland Police Service.

The audit examined whether the agencies:

- have efficient and effective processes and systems for delivering coronial services
- provide adequate support to bereaved families
- plan effectively to deliver sustainable coronial services.[8]

2.2 Background

Under the *Coroners Act 2003*, coroners are responsible for investigating deaths that occur in Queensland under certain circumstances. The primary responsibility of coroners is to make formal findings in respect of the death, including the circumstances and cause of the death.[9]

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. The QAO report further advised that since 2005-6, the number of deaths reported to the coroner has increased by 81 per cent.[10]

The QAO report advised that '[d]emand for Queensland's coronial services is likely to increase with the state's growing and ageing population'.[11]

2.3 Audit findings

The QAO found:

- *a lack of governance across Queensland's coronial system. The State Coroner has legislative responsibility for the efficiency of the system but has little function control to fulfil this responsibility. None of the public sector agencies have overall responsibility for leadership, accountability, planning, and reporting across the system*
- *delivering coronial services is not necessarily considered core business for the three agencies and at times their competing priorities can impact on the efficiency and effectiveness of the system. …*
- *no one agency is accountable for managing a coronial investigation from start to finish and their case management practices tend to be reactive rather than proactive.*

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8 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, pp 1, 63.

9 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 12.

10 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 16.

11 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 16.

As a result, the backlog of outstanding coronial cases 24 months or older continues to increase, investigations are being delayed and some families are poorly informed.[12]

The QAO also found:

- *agencies have improved their triaging practices, reducing the number of deaths proceeding to a full investigation unnecessarily, but this triage process could be expanded and applied more consistently across the state*
- *the communication provided to families at the beginning of a coronial investigation is sufficient, but agencies do not provide adequate 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 and there are instances of inappropriate conduct being reported*
- *agencies have not effectively planned for the ongoing delivery of forensic pathology services.*[13]

2.4 Audit conclusions

The QAO concluded that 'Queensland's coronial system is under stress and is not effectively and efficiently supporting coroners or families. If left unaddressed, structural and system issues will further erode its ability to provide services beyond the short-term'.[14] The QAO report further noted that 'some senior people believe the system is failing'.[15]

The QAO report continued:

The coronial system relies on the dedication of staff and goodwill amongst agencies but lacks system-wide cohesion, with no agency having responsibility for leadership, accountability, planning, and reporting across the system.

This is contributing to:

- *ineffective planning*
- *insufficient and inadequate resourcing and funding*
- *inadequate case management practices*
- *a lack of integration between agencies' priorities and systems.*

For years, agencies have made efforts to address specific issues that prevent them from effectively or efficiently delivering aspects of coronial services. Some of their efforts have provided efficiencies, such as the appointment of a coronial registrar to filter some non-reportable deaths from the system and divert some reportable deaths from unnecessary autopsy and a full coronial investigation. Overall, however, agencies' efforts have been fragmented, have lacked purpose and coordination, and have failed to address critical system-wide issues. Many of the system issues identified in a 2002 review of the previous Act (the Coroners Act 1958) still exist, including:

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[12] Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, podcast transcript, pp 1-2. See also, Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, pp 6-8.

[13] Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, podcast transcript, pp 1-2. See also, Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, pp 6-8.

[14] Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 9.

[15] Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 18. See also, Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 9.

- *a lack of coordination and accountability*
- *regional disparity*
- *a lack of support and information for families.*

As a result, the backlog of outstanding coronial cases 24 months or older continues to increase, investigations are being delayed, and some families are poorly informed.[16]

2.5 Audit recommendations

The QAO made 7 recommendations in its report. In summary, the QAO recommended that agencies:

- establish effective governance arrangements across the coronial system
- evaluate the merits of establishing an independent statutory body to deliver effective medical services for Queensland's justice and coronial systems
- improve the systems, legislation (including a review of the *Coroners Act 2003* and the *Burials Assistance Act 1965*), processes and practices supporting coronial service delivery
- assess more thoroughly the implication of centralising pathology services
- implement a strategy and timeframe to address the growing backlog of outstanding coronial cases
- improve the performance monitoring and management of government undertakers.[17]

2.6 Response from agencies to the recommendations

As required by the *Auditor-General Act 2009*, the QAO gave a copy of the QAO report with a request for comments to the Department of Justice and Attorney-General, Department of Health, the Queensland Police Service. A copy was also provided to the State Coroner. The departments and agencies agreed with the recommendations to the extent that the recommendations affected the department or agency concerned.[18]

In April 2019, the committee sought an update on the implementation of recommendations made in the QAO report from the relevant departments and agencies. The committee received a co-ordinated response dated 19 July 2019 from the Board.[19]

The Board provided the following overview of the progress in relation to the Auditor-General report recommendations:

The Board has been established for an initial three year term to lead implementation of all recommendations made by the Auditor-General, monitor system performance, and improve governance and accountability across the service system. …

Given the scope of recommendations made by the Auditor-General, a staged approach to implementation across three financial years is being taken. This approach recognises that initial changes to the coronial system will shape the way the services are delivered to coroners and

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16 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, p 9.

17 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, podcast transcript, p 2. For a complete list of the recommendations see Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, pp 10-11.

18 Queensland Audit Office, Report 6: 2018-19 *Delivering coronial services*, 2018, Appendix A.

19 Board members also include the State Coroner, the Deputy State Coroner, the Chief Forensic Pathologist and senior public servants from Queensland Treasury and the Department of Premier and Cabinet: Coronial Services Governance Board, correspondence dated 19 July 2019, p 1.

families in into the future. It also allows for the development of a dynamic service delivery model that is responsive to shifting demand pressures and the changing needs of Queenslanders.

During 2018-19 agencies have undertaken extensive system-wide planning as part of the first phase of implementation which includes the development of a Coronial Services Reform Framework*.*

This Framework outlines how agencies will work together to implement all recommendations made by the Auditor-General across four priority areas:

1. *enhancing triaging practices through the trial of a second coronial registrar to triage all apparent natural cause deaths reported by police;*
2. *strengthening case management, legal and counselling support to improve the assistance provided by agencies to coroners and families throughout an investigation;*
3. *enhancing structural supports through improving the management of government undertaker contracts and administration of the Burials Assistance Scheme; and*
4. *driving system innovation, through developing a sustainable state-wide model for forensic pathology services, and a service delivery framework to guide how agencies provide support to coroners and families.*

To support these important reforms, the Queensland Government has allocated a total of $3.9 million over four years, including $474,000 per annum ongoing, as part of the 2019-20 Budget.[20]

The Board also provided to the committee a detailed report setting out the progress concerning the recommendations made by the Auditor-General.[21] As noted above, the correspondence from the Board is available on the committee's website.

2.7 Committee recommendation

The committee recommends that the Legislative Assembly notes the contents of this report.

Recommendation

The Legal Affairs and Community Safety Committee recommends that the Legislative Assembly notes the contents of this report.

[20] Coronial Services Governance Board, correspondence dated 19 July 2019, pp 1-2.

[21] Coronial Services Governance Board, correspondence dated 19 July 2019, pp 1-2, attachment.