Delivering coronial services

Report 6: 2018–19

Queensland Audit Office
Better public services

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Better public services

Your ref:
Our ref: 9177P

18 October 2018

The Honourable C Pitt MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Speaker

Report to parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Delivering coronial services (Report 6: 2018–19).

In accordance with s.67 of the Act, would you please arrange for the report to be tabled in the Legislative Assembly.

Yours sincerely

Brendan Worrall
Auditor-General

Contents

Audit objective and scope

In this audit, we assessed whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. We examined whether agencies:

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

The scope of the audit included three public sector agencies who have specific roles but are collectively responsible for providing coronial services:

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

Although not subject to this audit, we consulted with the Queensland State Coroner, Deputy-State Coroner and all other coroners and the Department of the Premier and Cabinet. The audit identified learnings and made recommendations that are relevant to whole of government.

Appendix B contains further details about the audit scope and our methods.

Reference to comments

In accordance with s. 64 of the *Auditor-General Act 2009*, we provided a copy of this report to relevant agencies. In reaching our conclusions, we considered their views and represented them to the extent we deemed relevant and warranted. Any formal responses from the agencies are at Appendix A.

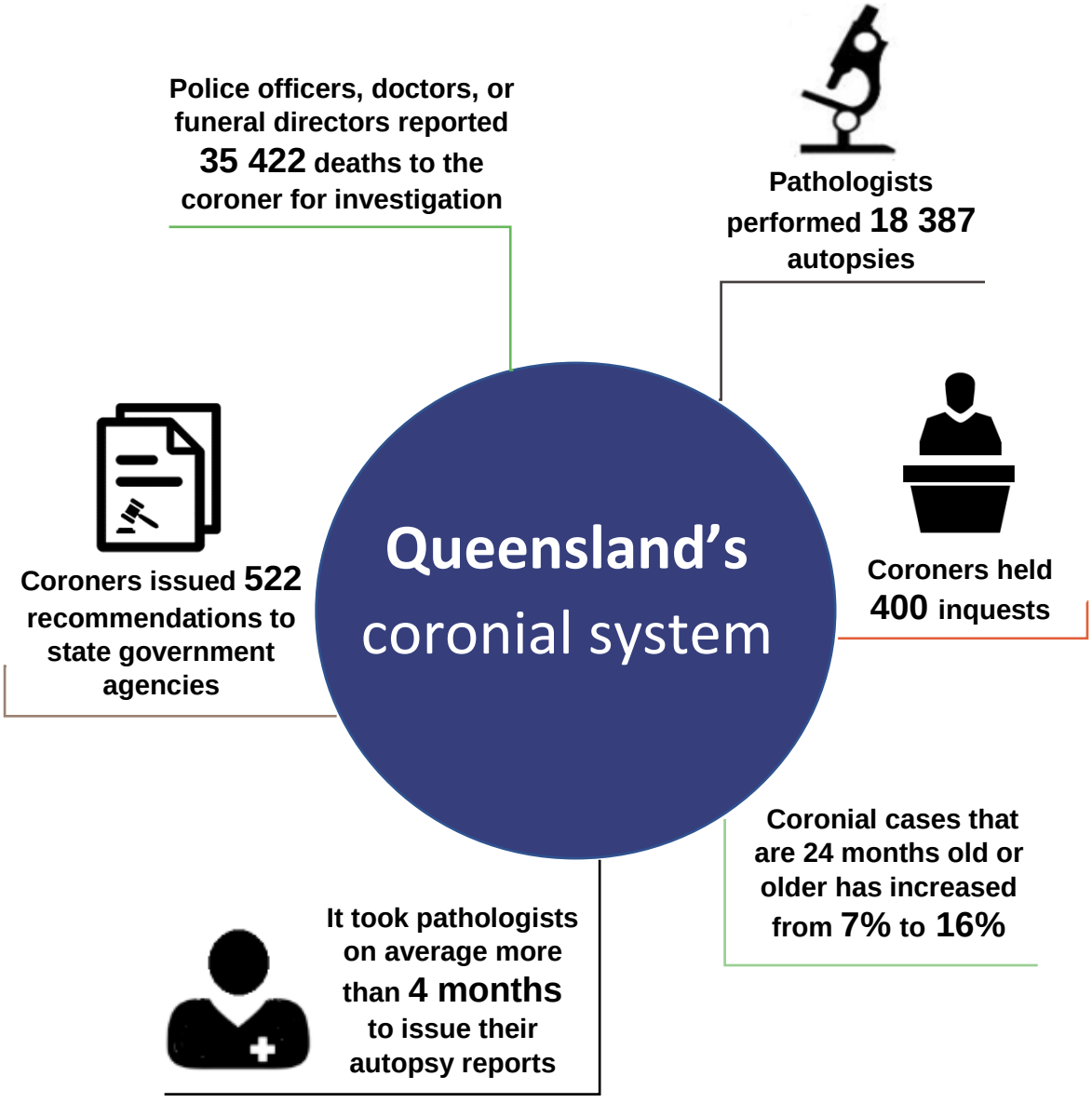
Glossary

Term	Definitions
Anatomical pathologists	According to the Royal College of Pathologists of Australasia anatomical pathologists are highly trained medical doctors who look at organs and tissues to determine the causes and effects of particular diseases.
Autopsy	This is the examination and dissection of a body after death for determination of the cause and circumstances of death. Also called a post-mortem examination.
Clearance rate	The clearance rate measures the number of coronial cases finalised by the Coroners Court of Queensland in a reporting period by the number reported (lodged) in the same period.
Conveyance	In the context of this report, this is the action or process of transporting a body from one place to another.
Coroner	According to the *Coroners Act 2003, Division 4, Section 82 (1),* a coroner is a magistrate who is responsible for investigating reportable deaths.
Coronial case	In the context of this report, a coronial case is an investigation into a death reported to the Coroners Court of Queensland.
Coroners Court	The Coroners Court is a court of record established under Part 4 Division 1 of the *Coroners Act 2003,* where coroners investigate, hear evidence and deliver findings about the causes and circumstances of reportable deaths.
Coroners Court of Queensland	This unit of the Department of Justice and Attorney-General supports the state coroner in administering and managing a coordinated state-wide coronial system in Queensland. It provides a central point of contact and publicly accessible information to families and the community about coronial matters.
Forensic medical officer	The Clinical Forensic Medicine Unit within the Department of Health employs forensic medical officers to provide expert clinical and medico-legal opinions in court and advice in healthcare-related death investigations.
Forensic Odontology	According to the Australian Medical Association forensic odontology is a discipline that involves the application of dental specific knowledge to legal and criminal issues. It primarily focuses on human identification, disaster victim identification, age assessment and examination of bite marks.
Forensic pathologist	According to the Royal College of Pathologists of Australasia, a forensic pathologist is a medical specialist with autopsy expertise who performs coronial autopsies and related tasks, forming opinions about causes and circumstances of death.
Histology	According to Black's Medical Dictionary, histology is the study of minute structure of tissues. Pathologists use a microscope to study tissue on a slide.

Term	Definitions
Inquest	An inquest is a court hearing conducted by a coroner to gather information about the cause and circumstances of a death. An inquest isn't a trial and there is no jury. It is not about deciding whether a person is guilty of an offence or civilly liable. Under the *Coroners Act 2003,* there are provisions that mandate when a coroner must hold an inquest, such as a death in custody.
Organ retention	According to the Royal College of Pathologists Australasia organs may be retained at autopsy for diagnosis and for other purposes. Under section 24 of the *Coroners Act 2003,* organs are defined as prescribed tissue which may only be retained if the coroner is satisfied that it is necessary, and the family has been appropriately consulted.
Forensic Neuropathology	Forensic neuropathology is concerned with the diagnosis of injury and disease of the brain, spinal cord, muscles and peripheral nerves in coroners' autopsies.
Registrar	The coroners are supported by a coronial registrar located in Brisbane. The registrar is responsible for determining whether a death referred to a coroner is reportable (see below) and authorising the issue of a death certificate for reportable deaths.
Reported death	In the context of this report, a death reported to the Coroner's Court of Queensland that may or may not be reportable under the *Coroners Act 2003.*
Reportable death	According to the *Coroners Act 2003, Part 2, Section 8(3),* a death is reportable if it occurred in Queensland and meets one or more of the criteria below: • it is not known who the deceased person is • it was a violent or otherwise unnatural death • the death happened in suspicious circumstances • it was a healthcare-related death • a cause of death certificate has not been issued and is not likely to be issued • it was a death in care or in custody • the death happened in the course of or as a result of police operations.
Royal College of Pathologists Australasia	This is a medical organisation that promotes the science and practice of pathology in Australasia. Their mission is to train and support pathologists and improve the use of pathology testing.
Triage	Triage means sorting coronial cases into categories (such as reportable and non-reportable deaths) that reflect whether an investigation is required, and the extent of autopsy needed (for example, external examination, partial autopsy, or full internal autopsy).

Key facts

Between 2011–12 and 2017–18:



Notes: The coronial statistics displayed above are based on data extracted from the Coroners Court of Queensland's case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland in 2017–18. The forensic pathology statistics are based on data extracted from the Forensic and Scientific Services Auslab database on 17 July 2018 and include all autopsies performed between 2011–12 and 2017–18.

Source: Queensland Audit Office, using data provided by the Department of Justice and Attorney-General's Coroners Court of Queensland and data provided by the Department of Health's Forensic and Scientific Services.

Introduction

The *Coroners Act 2003* (the Act) governs Queensland's coronial system. It requires coroners to investigate the circumstances of a reportable death and provides the broad criteria of the types of deaths which are reportable. This includes violent or unnatural deaths, deaths in custody and healthcare-related deaths (see glossary for more information on reportable deaths). For cases that proceed to inquest, coroners may make recommendations intended to prevent deaths from happening in similar circumstances in the future.

The Act recognises the needs and concerns of the family of the deceased. An effective and efficient coronial system will enable a coroner to provide timely and reliable answers to the family about their loved one's death. Noting the importance of an independent and robust investigation, it will also consider their views and provide adequate and timely information to them throughout coronial investigations.

Queensland's coronial system is complex, and coroners rely on the timely and reliable services of multiple public sector and contracted agencies across a geographically dispersed state.

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 are the public sector agencies responsible for supporting coroners.

Each agency plays a key role across the coronial process:

- The Coroners Court of Queensland provides legal and administrative support to coroners and the registrar.
- Forensic and Scientific Services provide clinical, advisory, scientific, counselling, and forensic pathology services, including autopsies.
- The Queensland Police Service provides investigative support and specialised forensic analysis.

Summary of audit findings

Supporting coroners

Structure, leadership, and accountability

The Coroners Court of Queensland, Forensic and Scientific Services, and the Queensland Police Service (the agencies) each play a key role in supporting coroners. However, none is accountable for managing Queensland's coronial system or coordinating the various activities across the system. Under the Act, the Queensland State Coroner (the state coroner) is legally accountable for the efficiency of Queensland's coronial system, but the role has little functional control over the resources needed to effectively fulfil this responsibility.

This void has resulted in a system that is under-resourced to meet existing and future demand. This is most acute in forensic pathology services. In March 2015, the state coroner raised concerns about the future sustainability of forensic pathology services, stating that '… the situation is fast becoming a critical vulnerability for Queensland's coronial system'. He also raised concerns about triaging practices and suggested amendments to the Act.

The agencies made some improvements to triage practices but not amendments to the Act. It also took the agencies more than two years to establish a multi-agency project reference group to identify and consider potential models for forensic pathology services. In July 2018, the project reference group recommended incrementally centralising forensic pathology services in Brisbane. However, the submission by the project reference group lacked robust assessment of the options and the merits of the recommended model.

The coronial system relies on the dedication of staff and agencies cooperate as best they can to support coroners in finalising their investigations with the resources they have. However, without adequate leadership, clearly defined accountabilities, and with demand increasing, their support is at times ineffective. As expected, agencies focus on the services they're responsible for delivering within the context of multiple competing priorities. This sometimes means they don't adequately consider the overall system effectiveness, coroners, and bereaved families.

For the three agencies delivering coronial services it is one of many functions they perform and is not necessarily considered their core business. This means that at times competing priorities can impact on the efficiency and effectiveness of the system. For example, Forensic and Scientific Services is a business unit within the Department of Health and as such, competes with many other divisions for funding.

A 2005 Ministerial Taskforce's report on the role and function of Forensic and Scientific Services recommended that an independent entity be established based on best practice models in other jurisdictions such as New Zealand and the United Kingdom. Victoria has also established a dedicated statutory body (the Victorian Institute of Forensic Medicine) to deliver forensic medical services to the coronial and justice systems, separate from the Department of Health. The separate entity model acknowledges the difference in priorities and needs of medical services for court outcomes to those intended for health outcomes. It provides a clear delineation for governance, resourcing and control of funding.

Since 2003, the Department of Justice and Attorney-General has had an interdepartmental working group to review and discuss statewide policy and operational issues for Queensland's coronial system. But it has no terms of reference, lacks purpose, and has not delivered system improvements.

The costs of delivering coronial services are not well known. This is because the costs are spread across the contributing agencies and are not captured well by the agencies. Even when agencies know what the costs are, they are not necessarily managing them well.

For example, the Department of Justice and Attorney-General needs to tighten its approval process for funeral assistance applications. Currently, court registry staff approve applications for assistance with funding funerals, but at times they do this without performing an adequate assessment of the deceased's estate. (This includes checking if the deceased has, for example, superannuation, a house, and bank accounts.) As such, the Coroners Court of Queensland is paying money to some families that do not require funeral assistance. It has also been unsuccessful in recovering outstanding money, in part because it is constrained by the *Burials Assistance Act 1965*.

Coronial processes and practices

The number of deaths reported to the coroner has been increasing since 2011–12, but because agencies have improved their triage practices, they have reduced the number of reported deaths proceeding to a full coronial investigation. Triage is the process of sorting cases into categories (such as reportable and non-reportable deaths) that reflect whether further investigation is required. It also determines the extent of investigation needed (for example, the type of autopsy: external examination, partial autopsy, or full internal autopsy).

Various individuals from each of the agencies contribute to this triage process, including the Coroners Court of Queensland's coronial registrar and the Forensic and Scientific Services' duty pathologist, forensic medical officers, counsellors and coronial nurses. But this work is, to some extent, uncoordinated, and agencies do not assess all deaths reported to the coroner to ensure they're reportable. The agencies need to implement a more coordinated and systematic statewide triage process if they are to realise efficiencies.

They also need to have an effective case management practice to ensure an investigation is finalised in a timely manner, while ensuring it is conducted in an independent and robust manner. No one agency is accountable for managing a coronial investigation from start to finish. The agencies' case management practices vary and tend to be reactive rather than proactive.

There are other aspects of Queensland's coronial process that are potentially inefficient. For example, there is no requirement for a pathologist or coronial nurse to undertake a preliminary investigation when a death is reported. (A preliminary investigation can involve reviewing medical records or obtaining a computed tomography (CT) scan.)

As a result, coroners sometimes have limited information available to them to inform their decisions about whether an autopsy is required, the type needed (external, partial or full autopsy) and the most appropriate location for the autopsy. This may result in unnecessary investigations and potentially invasive autopsies. In other jurisdictions, coroners have CT scans, blood samples, and toxicology results provided to them as input to their decisions.

Coronial system performance

Excessive delays and a declining clearance rate are leading to a growing backlog of coronial investigations. This indicates that Queensland's coronial system is under stress. The state coroner has reported these delays in successive annual reports since 2014–15. The percentage of coronial cases in Queensland that are 24 months or older has increased from seven per cent in 2011–12 to 16 per cent in 2017–18. This excludes coronial cases delayed due to criminal proceedings.

The Commonwealth Government's Report on Government Services (which has data up to 2016–17) reports that since 2011–12 Victoria has reduced its backlog, despite having slightly higher numbers of reported deaths. In 2016–17, 10 per cent of their coronial cases were 24 months or older, compared to Queensland's 16 per cent. Excessive delays and a declining clearance rate reflect a coronial system that is underperforming.

Government undertakers

The Coroners Court of Queensland is responsible for the ongoing management of government undertakers. Although it documents the performance expectations for government undertakers in their contracts, it does not actively monitor their performance. As such the performance of some government undertakers is variable and there are instances of inappropriate conduct being reported. These instances are small when compared to the overall number of transportation services provided over this period. But they reflect breaches in performance and can have negative impacts on families.

Informing and supporting bereaved families

Despite the intent of the Act to support families during a coronial investigation and the best efforts of those that work within the coronial system, the communication and support provided to families is inadequate. The lack of clearly defined leadership and accountability across Queensland's coronial system, inadequate case management practices, and a lack of integration between agencies' systems contribute to this breakdown.

We found that 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. In some instances, agencies have provided families with no additional communication despite the coronial investigation taking more than four years to finalise. The lack of dedicated case managers with the appropriate experience, training and authority, has at times meant families have received inconsistent or inadequate information during an investigation.

The Queensland Police Service and the Coroners Court of Queensland refer families to the Forensic and Scientific Services' coronial counsellors at the beginning of a coronial investigation. However, there are only five counsellors, and they often only provide information and support to families at the beginning of a coronial investigation. Similarly, witnesses at inquests can often require support. While agencies provide witnesses with some support it is limited. As a result, the agencies have, at times, overlooked the needs of some families and witnesses. The agencies require a more coordinated approach to ensure families and witnesses receive adequate support throughout a coronial investigation, including counselling services.

Audit conclusions

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.

Senior people across the system described to us a system that is failing. The coronial system relies on the dedication of staff and good will 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:

- a lack of coordination and accountability
- regional disparity
- a lack of support and information to 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.

To improve coronial services now and into the future, agencies must take a more integrated approach to managing and operating the system. This can best be achieved by working together to address a number of significant, system-wide structural and process issues. Only then are they likely to improve their support to coroners and families.

Recommendations

Department of Justice and Attorney-General, Department of Health, Queensland Police Service, and the Department of Premier and Cabinet

We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners:

1. establish effective governance arrangements across the coronial system by:
    - creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist
    - more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services
    - establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.
2. evaluate the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.

Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service

We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners:

3. improve the systems and legislation supporting coronial service delivery by:
    - identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports
    - reviewing the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process
    - reviewing the *Burials Assistance Act 1965* and the burials assistance scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.

4. improve processes and practices across the coronial system by:
    - ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators
    - ensuring there is a coordinated, statewide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy
    - establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process
    - ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.
5. assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.

Department of Justice and Attorney-General

We recommend the Department of Justice and Attorney-General:

6. implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners
7. improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.

1. Context

The *Coroners Act 1958* governed Queensland's coronial system from 1958 to 2003, when it was replaced by the *Coroners Act 2003* (the Act). This change was made to address a range of problems with Queensland's existing coronial system, including a lack of coordination and accountability, regional disparity, and lack of support and information to families.

Under the Act, coroners (who are magistrates) are responsible for investigating deaths that occur in Queensland under certain circumstances. These are called 'reportable deaths'. A coroner may also be required to investigate deaths that occur outside of Queensland, for example, if the person lived in Queensland at the time of their death.

The coroner's primary responsibility is to make formal findings in respect of the death, including the circumstances and cause of the death. For matters that proceed to inquest, a coroner may make recommendations about public health, safety, or the administration of justice to prevent similar deaths occurring in future.

The Act explicitly recognises the rights and needs of the family of the deceased person during the coronial process. Timely resolution of an investigation is crucial in helping families obtain closure and in not compounding their grief.

Who delivers coronial services?

Coroners lead Queensland's coronial system. They rely on timely and effective services from a range of public sector agencies across the coronial process, including the:

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

Coroners

There are seven coroners across the state: the state coroner, the deputy coroner, two Brisbane-based coroners, and three regional coroners located in Southport, Cairns, and Mackay. A coronial registrar supports the coroners by investigating less complex deaths.

In accordance with section 71 of the Act, the state coroner is responsible for overseeing the coronial system to ensure coronial investigations are conducted appropriately and efficiently.

Coroners are independent judicial officers who, subject to the requirements of the Act and State Coroner's guidelines and directions, exercise their individual judgement and discretion. Therefore, there will always be some variability in how individual coroners lead and manage aspects of coronial investigations. This variability can pose challenges for public sector agencies and heightens the need for their effective leadership across the coronial system.

Queensland Police Service

The Queensland Police Service is often the first point of contact when a person dies, and its officers are responsible for investigating the death on behalf of the coroner. Its officers:

- gather evidence for the coronial investigation and identify the deceased person
- liaise with doctors about issuing a cause of death certificate for apparent natural causes deaths
- record details about the deceased and the incident on a 'police report of death' (form 1) and submit it to the relevant coroner
- contact next of kin and ask family members if they have concerns about autopsies.

The officer attending the scene arranges for the contracted government undertaker to collect the body from the scene and transport it to the nearest mortuary.

The Queensland Police Service's Coronial Support Unit coordinates the management of coronial processes across the state and provides direct support to coroners throughout a coronial investigation. Its staff—located in Brisbane, Southport, Cairns, and Mackay—prepare documents, such as identification statements, attend autopsies, and liaise with investigators, pathologists, counsellors, and mortuary staff.

The Queensland Police Service also provide a range of specialised forensic services that may be used in a coronial investigation, such as ballistics, fingerprint analysis and forensic scene examination.

The Department of Health

The Department of Health's Health Support Queensland provides health support services to a range of stakeholders, including government agencies. Its Forensic and Scientific Services unit provides a range of coronial services, including:

- forensic pathology and mortuary services
- toxicology and scientific services
- coronial nursing services
- counselling services
- clinical advisory services.

Forensic pathology and mortuary services

Autopsies are performed by forensic pathologists with assistance from mortuary staff and radiographers and are a critical aspect of coronial investigations. They can assist in identifying the deceased and help establish the cause, mode and circumstances of the death. Depending on the nature of the death and the type of examination ordered by the coroner, a pathologist may undertake an:

- external examination
- external and partial internal autopsy
- external and full internal autopsy.

Pathologists record their preliminary findings from an autopsy on a form (form 3) in the Forensic and Scientific Services Auslab database and send their preliminary findings to the coroner. A pathologist will issue an autopsy notice or certificate (form 29 or form 30) once they have determined the cause of death.

Led by the Chief Forensic Pathologist, Forensic and Scientific Services have nine forensic pathologists located at Coopers Plains, two on the Gold Coast, and one in Cairns. All perform coronial autopsies.

There are an additional five fee-for-service forensic pathologists who undertake coronial autopsies in Rockhampton, Toowoomba, Townsville, Cairns, and the Gold Coast. These fee-for-service pathologists are completely independent from Forensic and Scientific Services and the Department of Justice and Attorney-General pays for their services.

Pathologists are supported by 18 full-time equivalent mortuary staff employed across the state.

Toxicology and scientific services

In some instances, coroners will order a forensic pathologist to perform additional tests to determine the cause of death. The Act allows forensic pathologists discretion to conduct any tests the pathologist considers necessary, so long as the tests are consistent with the type of examination ordered by the coroner.

Forensic and Scientific Services provide a range of scientific services, such as forensic toxicology, odontology, neuropathology, histology and post-mortem radiography. Forensic toxicology analysis may be needed to detect drug, alcohol, poisons, and other substances in the deceased. Histology examination may be needed to identify microscopic changes in the deceased's tissue resulting from natural disease, trauma or lifestyle habits. The pathologist will complete the final autopsy report (form 8) and send it to the coroner once all tests have been completed. In many cases, the coroner cannot finalise his or her investigation and issue findings until the final autopsy report is received.

Counselling services

Forensic and Scientific Services has five coronial counsellors located in Brisbane who provide advice to families of the deceased about the coronial process and information about autopsy findings. The counsellors also assist with obtaining the views of families and working through objections to autopsy or to retention of prescribed tissue, such as whole organs.

Clinical advisory services

Forensic and Scientific Services' Clinical Forensic Medicine Unit staff are located in Brisbane, Southport, and Cairns. Its staff provide coroners with independent clinical advice about a wide range of issues, primarily regarding healthcare-related deaths. The unit also provides a range of non-coronial services.

Department of Justice and Attorney-General

Coroners Court of Queensland

The Department of Justice and Attorney-General's Coroners Court of Queensland, (formerly referred to as the Office of the State Coroner) began operations in 2003. It provides legal and administrative support to coroners across the state and publicly accessible information to families of the deceased about coronial matters. The Coroners Court of Queensland provides a range of other services, including managing the performance of government undertakers who collect and transport the body of the deceased to the local mortuary and overseeing the burials assistance scheme.

The Coroners Court of Queensland also has a dedicated unit that supports the Domestic and Family Violence Death Review and Advisory Board.

The Act requires the board to review domestic and family violence deaths in Queensland. The unit provides advice to coroners in their investigations of domestic and family violence related homicides and suicides and child protection related deaths. The Queensland Police Service provides support to this unit.

The Coroners Court of Queensland is divided into four regions:

- North Queensland
- Central Queensland
- Greater Brisbane
- South East Queensland.

It has staff located in Brisbane, Southport, Mackay, and Cairns. Staff record all information related to a death in the Coroners Case Management System. The Coroners Court of Queensland also provides coronial data to the National Coronial Information System which contains information about deaths reported to a coroner in Australia and New Zealand.

Monitoring coronial recommendations

The Department of Justice and Attorney-General's Legal Services Coordination Unit coordinates state government responses to coronial recommendations.

Government departments are required to respond to coronial recommendations within six months of notification and provide an update to the Legal Services Coordination Unit until the recommendation is implemented. All government responses are published on the Coroners Court of Queensland's website.

Interdepartmental working group

An interdepartmental working group was established in 2003 to review and discuss statewide policy and operational issues for Queensland's coronial system. The group meets quarterly and is chaired by the state coroner.

Its membership is made up of representatives from:

- the Queensland Police Service's Coronial Support Unit
- The Department of Health's Forensic and Scientific Services and other sections of the department as needed (for example, mental health)
- the Coroners Court of Queensland.

It provides a forum for the agencies delivering coronial services to discuss issues.

What happens when a death is reported?

In most cases, a police officer notifies the coroner of a reportable death by submitting a 'form 1 police report of death'. For healthcare related deaths and mechanical fall related deaths, a medical officer is required to submit a 'form 1a medical practitioner report of a death' to the registrar. In some instances, a funeral director may also notify the coroner of a deceased person in their care whose death they believe is reportable.

For form 1s the coroner considers the initial report of death and may ask police or a coronial nurse to obtain additional information, such as medical records and statements from witnesses.

Not all deaths reported to the coroner are found to be reportable after further investigation.

In some cases, agencies may seek additional information and/or discuss the circumstances with the deceased's doctor, enabling the coroner to obtain a death certificate (not having a cause of death certificate is one of the criteria for reportable deaths). These triaging practices can help avoid unnecessary coronial investigations and autopsies.

For form 1a's the registrar will consider the initial report for the healthcare or mechanical fall related death and may seek independent clinical advice from FSS's Clinical Forensic Medicine Unit. The registrar will determine whether the case requires an autopsy to determine the cause of death and warrants a full coronial investigation. In many of these cases, the registrar will authorise the issue of a cause of death certificate diverting the death out of the coronial system.

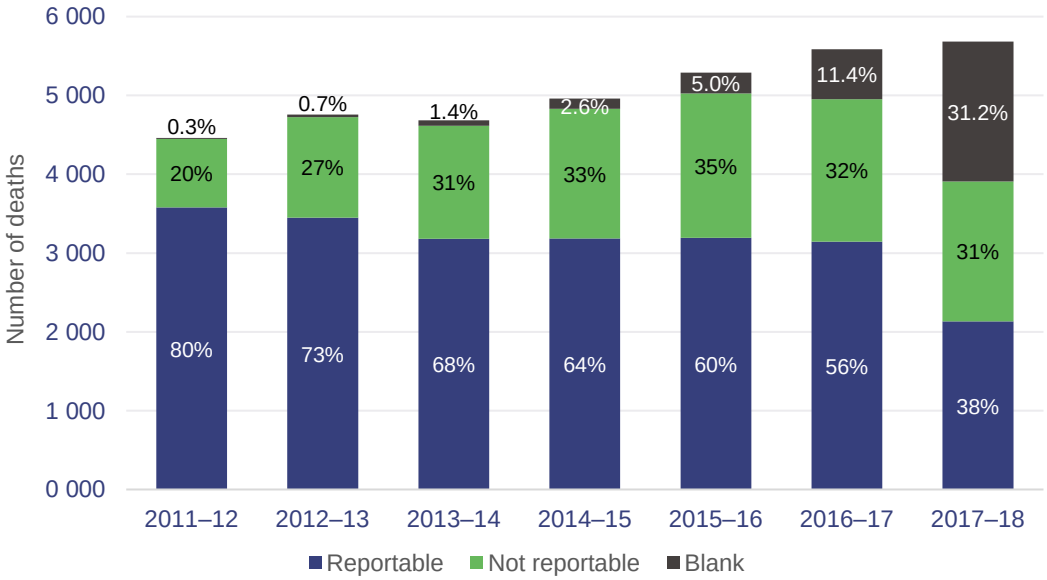
How many deaths are reported?

Between 2011–12 and 2016–17, 29 739 deaths were reported to the coroner. This represented 17 per cent of all deaths in Queensland. As at 21 June 2018, 5 683 deaths had been reported to the coroner for the 2017–18 financial year.

The number of deaths reported to the coroner each year for investigation increased by 27 per cent between 2011–12 and 2017–18, (from 4 461 to 5 683). Since 2005–06, the number of deaths reported to the coroner has increased by 81 per cent. Demand for Queensland's coronial services is likely to increase with the state's growing and ageing population.

Figure 1A displays the total number of deaths reported to the coroner between 2011–12 and 2017–18, including whether the deaths were reportable, not reportable or blank.

Figure 1A
Number of deaths reported between 2011–12 to 2017–18 by category as at 21 June 2018.



Notes: 2 914 deaths recorded in the Coroners Court of Queensland case management system were blank and did not have a reportable or not reportable status. It is possible that CCQ populates the status for these deaths when it finalises the investigations, rather than when it commences them.

Source: Queensland Audit Office, using data recorded in the Coroners Court of Queensland's case management system. The data displayed in this graph was extracted from the case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland and their classification in 2017–18.

Of the 35 422 deaths reported between 2011–12 and 2017–18, 62 per cent (21 867) were found to be reportable and 30 per cent (10 641) not reportable. The Coroners Court of Queensland determined that the remaining eight per cent (2 914) of deaths were reportable but they had not recorded this in their system. It is not mandatory for staff to record whether a death is reportable or not reportable when its first reported.

Autopsies

If a coroner decides they need an autopsy to determine the cause of death, they issue an order for autopsy (form 2). Between 2011–12 and 2017–18, pathologists performed 18 387 autopsies. Of these:

- 49 per cent (9 092) had an external and full internal autopsy
- 27 per cent (4 884) had only an external examination
- 24 per cent (4 411) had an external and partial internal autopsy.

The total number of autopsies decreased from 2 742 in 2011–12 to 2 572 in 2017–18. Once a pathologist completes an autopsy and all associated tests, they give the coroner their post-mortem report (form 8). The coroner considers the autopsy results and, if necessary, other relevant records or expert reports, prior to making their findings.

Inquests

In some cases, the coroner may hold an inquest into a death. Between 2011–12 and 2017–18, only one per cent of deaths reported proceeded to an inquest. An inquest is unlike criminal and civil court cases. It is not a trial, with a prosecutor and a defendant, but an inquiry led by a coroner that seeks to find out why the death occurred. Coroners have more flexibility than other court jurisdictions with the type of evidence they can accept. They cannot, however, attribute blame to any person for the death.

Reviews of Queensland's coronial system

Queensland's coronial system has not been reviewed since the enactment of the *Coroners Act* in 2003. Reviews undertaken have either focused solely on individual agency structures, or service delivery models, or just on part of the coronial process.

In 2013, the Department of Justice and Attorney-General reviewed the former Office of the State Coroner's organisational structure and service delivery model. It commenced this review due to the increasing demand, limited resources and need for greater managerial support for staff in the regions. The review made 14 recommendations and concluded that the office could be more efficient by centralising its coronial services.

In May 2017, Forensic and Scientific Services, the Coroners Court of Queensland, and the Queensland Police Service began a project to review the statewide management of coronial autopsies. The agencies formed a project reference group to review Queensland's existing model and assess other models for the delivery of forensic pathology services. In July 2018, the project recommended centralising the delivery of forensic pathology services.

In late 2017, the Coroners Court of Queensland commissioned a private firm to review its organisational structure and workforce culture and identify opportunities to improve the office's effectiveness and efficiency. The review made 42 recommendations. The Coroners Court of Queensland has implemented 15 recommendations and commenced implementing another 21 recommendations. It has delayed implementing the remaining six recommendations due to funding.

2. Supporting coroners and bereaved families

Introduction

Through the Coroners Court of Queensland, the Department of Justice and Attorney-General provides support services to coroners. The Department of Health's Forensic and Scientific Services and the Queensland Police Service also provide crucial pathology, scientific, and investigative services in support of coroners. We refer to them collectively in this report as 'the agencies'.

We examined whether these agencies effectively and efficiently support coroners in investigating and helping to prevent deaths.

We assessed whether the system's structure and processes support the delivery of appropriate outcomes for coroners and for families of the deceased. We also assessed whether agencies adequately keep families informed throughout the coronial process.

How well is the system structured?

We expected to find a structure that effectively and efficiently integrates and coordinates agencies' services across the system and that is sustainable. Specifically, we expected to find that the structure provides:

- clear leadership, responsibilities, and accountability
- effective coordination across the system
- sufficient and appropriate resources across the system to ensure it is effective and efficient
- effective planning to meet current and future demands.

We found that Queensland's coronial system is struggling to keep up with demand and is not consistently providing timely and effective support to coroners.

We also found there is a lack of governance across the system. No agency has overall responsibility for leadership, accountability, planning, and reporting across the system.

This is contributing to:

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

As a result, there are excessive delays and a declining clearance rate, leading to a growing backlog of coronial investigations that are 24 months old or older. The system is under stress, to the extent some senior people believe the system is failing.

This accords with issues raised by the Queensland State Coroner (the state coroner) in 2015 about the sustainability of key aspects of the system. In March 2015, the state coroner sent a letter to the Attorney-General raising concerns about the shortage of forensic pathologists, the need to strengthen triaging practices, and the need to amend the *Coroners Act 2003* (the Act).

The agencies have made some changes. But after three years they haven't completely addressed these issues despite their significance and the long lead time needed. Actions they have taken were largely piecemeal, reactive, and focused on specific issues, without considering fundamental system-wide structural and process causes and implications. We detail these in the following sections.

Leadership across Queensland's coronial system

In accordance with Section 71 of the Act, the state coroner is responsible for overseeing and coordinating the coronial system and for ensuring it is administered and operated efficiently. The state coroner also has powers under section 14 of the Act to direct and guide coroners about the performance of their functions. While he has legal accountability for the efficiency of the system, he has little functional control over the resources needed to effectively fulfil these responsibilities. For example, he has little control over the:

- number, level, mix, and placing of the staff of the Coroners Court of Queensland, or of staff from other agencies
- allocation or expenditure of funding to deliver the various functions necessary to provide coronial services across the system
- prioritisation of coronial matters over competing functions within the supporting agencies.

This limits his ability to drive efficiencies across the system and means he relies on effective governance arrangements within and across the three supporting agencies. But none of these agencies nor the interdepartmental working group has taken responsibility for managing the system or coordinating the workload across it. As a result, the leadership, accountability, and planning across the system for the delivery of coronial services has been largely ineffective.

Unsurprisingly, agencies focus on the services they're responsible for delivering. The fragmented responsibilities, and at times competing priorities, can impact on the efficiency and effectiveness of the system. For the Queensland Police Service, the Department of Justice and Attorney-General and the Department of Health, delivering coronial services is one of many functions they perform and is not necessarily considered as their core business. Forensic and Scientific Services is a business unit within the Department of Health and as such, competes with other divisions for funding.

A 2005 Ministerial Taskforce's report on the role and function of Forensic and Scientific Services stated that Forensic and Scientific Services has no organisational alignment with Queensland Health, whose mission is to promote a 'healthier Queensland'. It recommended that Forensic and Scientific Services be established as an independent entity. The recommendation was based on two best practice organisations in New Zealand and the United Kingdom that were independent statutory entities that provided forensic and other related scientific services to government on a fee for services basis.

Other jurisdictions have different models. For example, Victoria has a dedicated institute, the Victorian Institute of Forensic Medicine, which delivers forensic medical services to the Coroners Court of Victoria. It is a statutory body independent of the Department of Health, with its own board, chief executive officer, and funding. The medical services it provides are for coronial and justice outcomes, not health outcomes. Victoria also has a clearer delineation of funding and administration between the agencies that deliver coronial services.

The agencies in Queensland cooperate to support coroners and the registrar in finalising their investigations. But this is often reliant on individual relationships and practices rather than design and management.

The agencies have made attempts to achieve better coordination and relationships. In 2003, the Department of Justice and Attorney-General established an interdepartmental working group to review and discuss statewide policy and operational issues for Queensland's coronial system.

Since its establishment, coroners and key representatives across the coronial process have attended quarterly meetings. The working group provides opportunities to share information and discuss key issues. But it does not have a defined terms of reference or mandate which limits its ability to drive reform.

Resourcing the coronial system

Staffing at the Coroners Court of Queensland

Effective staffing involves having suitable people, in sufficient numbers, in the necessary locations, performing appropriate functions.

Staffing at the Coroners Court of Queensland is inadequate for the volume and nature of work its staff perform across the state.

Over the past five years, the Coroners Court of Queensland has made efforts to improve the planning and management of its workforce and has engaged consultants to conduct workforce reviews. Despite this, its workforce planning and management has been inadequate. The reviews it has commissioned have been narrow and have had significant limitations, failing to adequately consider the broader coronial system implications.

For example, a 2013 review recommended the Coroners Court of Queensland move staff from regional areas and pool them in Brisbane. The recommendation to centralise resources intended to gain efficiencies and enable the office to better cope with future demand. However, the Coroners Court of Queensland implemented this recommendation and others, without appropriate consideration and assessment of the effects for its workforce, stakeholders, and the broader coronial system. It also failed to recognise the need for appropriate change management processes. Some of the changes it implemented had negative impacts on staff and work practices.

Following a subsequent review in late 2017, the Coroners Court of Queensland is now adding staff back into the regions. The review recommended that staff be re-located to the regions to provide appropriate support to coroners. The Coroners Court of Queensland has commenced implementing this recommendation and has relocated staff to the south eastern and central region. However, it is waiting for full-time equivalent positions to become available before relocating staff to the Northern region. As it stands, the northern coroner only has a lawyer located in the Cairns office assisting with coronial investigations. Given that the northern region has the highest case load and backlog of outstanding coronial cases this strategy is untenable both in the short and long term.

The 2017 review has led to change within the Coroners Court of Queensland, including funding six new temporary positions to review processes and support operations and the change process. While some of these changes may address immediate issues, they will not necessarily address broader systemic issues across the system. The Coroners Court of Queensland needs to undertake more detailed long-term workforce planning, including adequate consideration of potential impacts across the system of various resourcing options.

Further inhibiting the effectiveness of the Coroners Court of Queensland has been a lack of consistency of leadership. Since 2015, it has had five different acting directors as the permanent director was on extended leave. In March 2018, it appointed a permanent director to lead the office. The director leads approximately 50 staff and has support from two managers across the state. More than 59 per cent of its staff are junior (A03 or lower), with the staff in the regions being managed from Brisbane.

The junior staff often manage high caseloads (some have more than 150 open coronial case files at a time) of complex coronial investigations. They also communicate with distressed families. The lack of management and operational staff means the Coroners Court of Queensland cannot effectively support the state coroner in administering and managing the coronial system.

The Coroners Court of Queensland has provided some training to its staff to perform the role they're required to do. Its coronial investigation officers have completed a certificate IV in government investigations, but this is an entry level course for public sector investigations. While this training may be appropriate for junior investigators, it is not appropriate training to case manage complex multi-agency coronial investigations. Further to this, they receive no training in communicating with and supporting families. With such a high staff to manager ratio (50:2) it is difficult for the managers to provide adequate support to staff. This is particularly the case for coronial investigation officers located in regional areas, as their managers are located in Brisbane and they are required to work directly with coroners.

Coroners also receive legal support from qualified lawyers provided by the Coroners Court of Queensland (referred to as counsel assisting). These lawyers provide specialised skills and experience and represent coroners at inquests. Some of the cases they manage are highly complex and highly sensitive. They have no paralegal support and at times appear at inquests where senior lawyers and legal teams represent parties to an inquest. The Coroners Court of Queensland has provided its counsel assisting with professional development opportunities, including supporting three lawyers to complete their Bar Practice Course. Although it's not mandatory to hold a practising certificate, all seven of its current counsel assisting expressed that competing the Bar Practice Course would better position them to fulfil the unique challenges of their role. Due to limited funding the Coroners Court of Queensland has not been able to support its additional counsel assisting to complete the Bar Practice Course.

Resourcing for forensic pathology services

The Department of Justice and Attorney-General and the Department of Health have not structured forensic pathology services efficiently and have not planned well for the future delivery of these services across the state.

Currently, there is a two-tiered system for delivering forensic pathology services, consisting of:

- five fee-for-service pathologists in regional areas. These are contracted by the Department of Justice and Attorney-General
- 13 forensic pathologists, who are employees of the Department of Health.

Both the fee-for-service and the Department of Health pathologists provide a valuable service, but the different employment arrangements create organisational, management, and communication issues. Consolidating the management structure for all pathology services to one agency (while still retaining regional services), regardless of whether they are employed as permanent employees or contractors, would address these issues and allow for better coordination and management.

Review into future model for pathology services

In March 2015, the state coroner wrote to government about the future sustainability of forensic pathology services. He highlighted the recent resignation of three forensic pathologists and the likely retirement of another two in the short to medium term, stating that *'… the situation is fast becoming a critical vulnerability for Queensland's coronial system'.*

Of the 18 forensic pathologists (including the five fee-for-service pathologists in the regions) currently performing autopsies, 12 are 55 years of age or older. This is most acute in the regions. The five fee-for-service pathologists performing autopsies in the regions are all above 60 years of age. As a result, the sustainability of delivering forensic pathology services in the regions is uncertain.

It wasn't until May 2017, more than two years after the state coroner raised concerns, that the Coroners Court of Queensland, Forensic and Scientific Services, and the Queensland Police Service met to discuss expectations, risks, and opportunities to improve the forensic pathology model. In September 2017, Forensic and Scientific Services and the Coroners Court of Queensland established a multi-agency project reference group to identify and consider other potential models for forensic pathology services.

In July 2018, the project reference group recommended the Chief Executive Officer of Heath Support Queensland centralise forensic pathology services in Queensland. It recommended that services be centralised incrementally as regional pathologists retire.

The submission and recommendation put forward by the project reference group lacks robust analysis and assessment to support this recommendation. This is because the project group did not adequately:

- assess each option identified
- conduct financial modelling for any of the options considered
- consider system-wide impacts
- consult with and consider the views of coroners and stakeholders
- consider the social and family impacts of the various options
- consider the logistics, such as transportation of bodies across the state.

The recommendation to centralise pathology services was premised on there being effective coordination between agencies, efficient and quality conveyancing (moving) of bodies, and clear and effective communication with families. These are all aspects of the services that the agencies have not been doing well. As a result, it fails to establish evidence to demonstrate that a centralised model would result in the best outcomes for the coronial system, coroners and families.

The coroners did not support removing regional forensic pathology services because of the potential for greater turnaround times, transportation and logistics issues, and the potential impact on families in regional areas.

An alternate option considered was to establish two centres for delivering pathology services—one in Brisbane and another in Townsville. The project team did not adequately assess the merits of this option despite the coroners being in favour of it.

The project concluded that attracting and retaining three forensic pathologists in Townsville is not viable. It based this on two unsuccessful attempts to recruit pathologists to the Sunshine Coast and the fact that none of its existing Brisbane-based pathologists would like to move to Townsville. Assessing the viability of attracting and retaining pathologists in Townsville on these grounds alone is inadequate.

Agencies must perform a more thorough assessment before they decide to centralise. Further to this, it would be premature of them to implement a new forensic services pathology model without firstly addressing the broader leadership, integration, legislative, and funding issues across Queensland's coronial system. Although the project's scope never intended to look at these broader system issues, it is necessary if Queensland's coronial system is to effectively and efficiently support coroners and the families of the deceased in future.

Government needs to better consider the implications of this model for regional areas. These include the loss of jobs and services in regions, which is contrary to the current government policy of creating regional jobs. While this should not necessarily be the deciding factor, it should be an element of the assessment. The Chief Executive Officer of Health Support Queensland has noted the project reference group's recommendation and has not yet made a decision on the preferred model. However, without agencies taking positive steps to address the sustainability of forensic pathology services, centralisation may eventuate out of necessity rather than by design.

Recruitment and training of forensic pathologists

Forensic and Scientific Services is an accredited training laboratory for forensic pathologists and delivers training program curriculum set by the Royal College of Pathologists Australasia. It provides five-year specialist training leading to a Fellowship in Forensic Pathology. It also provides a two-year Diploma of Forensic Pathology enabling anatomical pathologists (pathologists who study the cause of disease) to become qualified forensic pathologists.

Forensic and Scientific Services has sought to address the shortage of forensic pathologists in Queensland. Since 2011, it has undertaken eight recruitment campaigns and successfully appointed six pathologists. Three of these appointments were trainees who completed training at Forensic and Scientific Services laboratory. It has another three trainees preparing to undertake the Fellowship in Forensic Pathology.

Costing and funding coronial services

There is limited oversight of the overall costs to deliver coronial services in Queensland. Each agency captures their individual costs to some extent. But this is not complete, so agencies are not aware of the overall cost to the coronial system.

Based on the limited financial data we could obtain from the three agencies, we calculated the total cost of Queensland's coronial system at approximately $128 million between 2012–13 and 2016–17. Expenditure across the system has increased from approximately $24 million in 2012–13 to $27 million in 2016–17.

Conveyancing (transporting of bodies) is one of the major costs of Queensland's coronial system. The system can expect high conveyancing costs given the state's geographical diversity. Between 2012–13 and 2016–17, the cost of conveyancing services has increased by 32 per cent, from $1.9 million to $2.5 million. The agencies need to give more thought to the costs of conveyancing, given that they are considering centralising forensic pathology services, which is likely to increase conveyancing costs.

In 2010, the Queensland Police Service began using sealed body bags to transport bodies for coronial purposes, alleviating the need for the police to escort the body to a mortuary. This has resulted in cost savings, but the Queensland Police Service has not quantified the savings.

Cost per coronial case

The cost of a coronial case often involves costs incurred by multiple agencies. Cost per case can provide a good indication of the efficiency of the services. But the agencies do not capture all the information necessary for an accurate and reliable assessment of the cost per case.

The Australian Government's *Report on Government Services* attempts to provide some insights into the cost of coronial cases using the limited data available. (It doesn't include crucial costs related to autopsies, forensic science, pathology tests, and conveyancing.) It calculates the average cost of a coronial case in Queensland between 2011–12 and 2016–17 as $2 218. This is marginally higher than the national average, which is $2 118.

The report states that, since 2011–12, the cost per coronial case in Queensland has decreased from $2 840 to $2 052. This is inconsistent with the increase in the overall cost during this period and does not take into account that at least one of the excluded costs (conveyancing) has increased. This casts doubt on the reliability of the reported costs per case.

Burial support costs

Under the *Burials Assistance Act 1965,* the Chief Executive of the Department of Justice and Attorney-General has a duty to arrange the burial or cremation of a deceased person (not just reportable deaths) if no suitable arrangements have been made. This could be because the estate of the deceased, relatives or friends are unable to pay for the funeral or because their unwilling to arrange it. If they cannot pay for the cost of a funeral they can apply to the Magistrates Courts Registry to organise a simple burial or cremation. In many cases, the registries approve funeral assistance on the basis that the estate of the deceased will repay the money when funds are released to them (such as life insurance). The registries approved 88 per cent (2 865) of the 3 263 applications for funeral assistance between 2011–12 and 2017–18. Since 2011–12, the Department of Justice and Attorney-General has paid $6.9 million for funeral assistance, but only recovered 35 per cent ($2.4 million). More than $4.5 million is outstanding.

The Department of Justice and Attorney-General needs to tighten the approval process for funeral assistance applications. At times, the court registry staff approve funeral assistance applications without performing an adequate assessment of the deceased's estate. This includes checking if the deceased has, for example, a house or bank accounts. As such, it is paying money on behalf of some families that are not eligible for funeral assistance.

Although the Department of Justice and Attorney-General could be doing more to recover the outstanding money, it is constrained by the *Burials Assistance Act 1965*. In accordance with the Act, it can only recover money from the estate of the deceased or a relative of the deceased. But it defines a relative as the 'person's spouse' or for a child, the 'person's parents' and thereby excludes adult children of a deceased parent. Further to this, it cannot search or recover superannuation or life insurance if the applicant has not included them on the application.

Systems supporting coronial services

The Queensland Police Services forensic register aids agencies sharing coronial information efficiently. In 2016, the Queensland Police Service provided Forensic and Scientific Services forensic pathologists access to the forensic register, enabling them to view scene photographs to prepare for an autopsy. This has improved collaboration and information sharing between the agencies.

However, the Coroners Court of Queensland, Forensic and Scientific Services, and the Queensland Police Service (the agencies) agree that the lack of integration between their core information technology (IT) systems is a barrier to efficient coronial investigations. The Coroners Court of Queensland has highlighted this issue in its past three annual reports. The outdated systems used by agencies to send directions from coroners and share information are inefficient and can result in delays, duplication of effort, and an increased likelihood of errors. Agencies rely on staff manually checking email inboxes and putting information into the system. For example, police officers manually enter a 'police report of death' (form 1) into the Queensland Police Reporting Information Management Exchange system. The Queensland Police Service's Coronial Support Unit forwards the form 1 to the Coroners Court of Queensland, which then manually enters this information into its case management system.

If the coroner orders an autopsy, it forwards the coroner's order to Forensic and Scientific Services, which receives the order and manually enters the information into its Auslab system. It then emails a copy of the autopsy report to the Coroners Court of Queensland; whose staff manually enter this information into the Coroners Case Management System.

We found some aspects of the coronial data captured by agencies to be poor. Limited validation controls and a lack of mandatory fields has contributed to this. Although these cases are few, they impact the analysis agencies can perform. For example, 23 per cent (7 611) of cases recorded in Auslab between 2011–12 and 2017–18 do not have a release date for the body. Similarly, there are data quality issues with the Coroners Court of Queensland's case management system. For example, eight per cent (2 914) of the deaths recorded in the Coroners Court of Queensland's case management system were blank and did not have a reportable or not reportable status because it's not mandatory for staff to record this when a death is reported.

Coroners Act 2003

In March 2015, the state coroner identified potential amendments to the *Coroners Act 2003* (the Act) regarding categories of reportable death. At present, two of the most commonly reported categories of reportable death are:

- fall-related deaths of elderly or infirm persons
- apparent natural causes deaths where the cause of death is known but the doctor refuses to issue a cause of death certificate.

Under the Act, these deaths are reportable even though the cause is already known (for example, a person dies from a fractured neck of femur in an aged care facility).

Similarly, the Act requires the state coroner and deputy state coroner to investigate all deaths in custody (where a person dies while in the custody of police or prison staff). The Act requires deaths in custody to be investigated by mandatory inquest regardless of whether the death is due to natural causes. Other jurisdictions have included provisions that enable coroners to choose not to investigate a death in custody if satisfied on the available evidence that the death is attributable to natural causes.

The Department of Justice and Attorney-General is yet to act on the State Coroner's suggested amendments to the Act. Any amendment to the Act should take into account related leadership, accountability, and system issues. Therefore, a full review of the Act may be necessary.

How well is the system performing?

We expected to find agencies using efficient and effective processes and practices to deliver coronial services. Specifically, we expected the processes and practices would include:

- triaging of reported deaths to avoid unnecessary investigations
- providing coroners with adequate information to inform their decisions about investigations
- managing of cases to ensure sharing and coordination between agencies, avoiding duplication and delay
- finalising of investigations to provide timely and accurate outcomes
- effective contracting of service providers, such as government undertakers
- monitoring and evaluating the implementation and effectiveness of coronial recommendations.

Triaging reportable deaths

As mentioned previously, under the Act, one of the reasons a death is reportable is because a cause of death certificate cannot be obtained, even if the death is due to natural causes. The Act requires a police officer to report a death when they are satisfied that the treating doctor is not likely to issue a cause of death certificate. At times, they may report it without sufficiently exploring why the doctor won't issue a cause of death certificate. Doctors might not issue a death certificate because they cannot form an opinion about the cause of death or to avoid the risk of issuing an incorrect cause of death certificate.

Triaging involves a coronial registrar or coronial nurse gathering information and assessing whether a death should be a reportable death. This can involve liaising with other parties (such as police and doctors) and can prevent non-reportable deaths from entering the coronial system. It also can enable a reportable death to be finalised quickly (without proceeding to a lengthy investigation) by:

- obtaining a cause of death certificate from a doctor for an otherwise not reportable natural cause death or authorising the issue of a cause of death certificate for a reportable death
- providing information (in conjunction with the pathologist) to inform the coroner on the level or type of investigation needed.

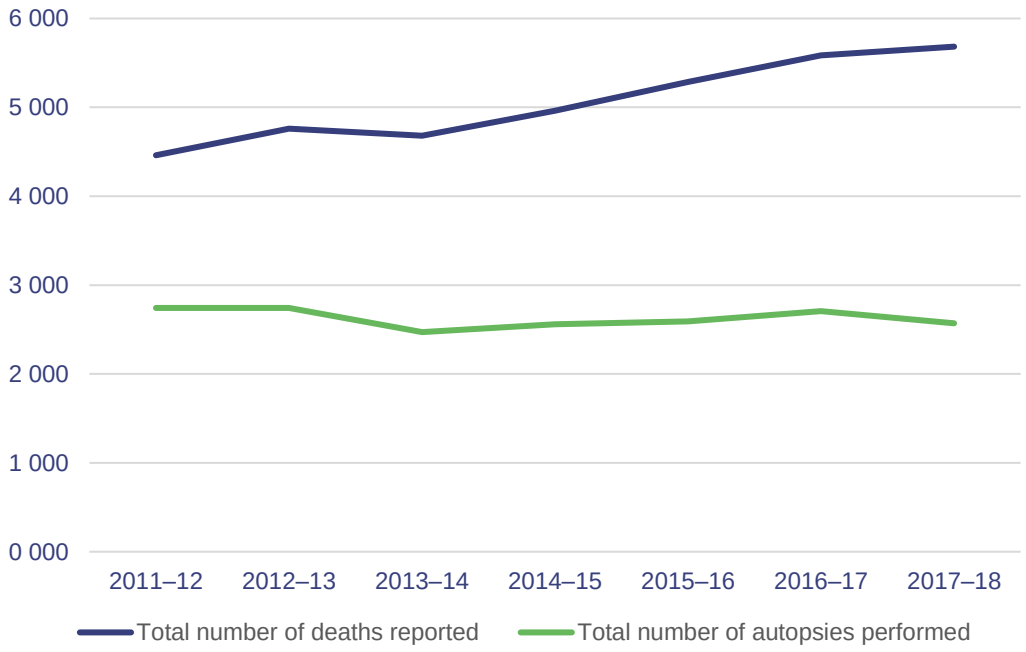
Although Queensland has some triage processes in place, there is no consistent and coordinated triage process for all cases entering the system. Some other Australian states have a dedicated unit with systematic processes for efficiently and effectively triaging all reported deaths.

In July 2013, after a trial period, the Coroners Court of Queensland appointed a permanent coronial registrar (lawyer) to triage coronial cases. The coronial registrar, with input from the duty pathologist and the coronial nurses, investigates whether a death is reportable. Where possible, the registrar authorises a doctor to issue a cause of death certificate.

The Coroners Court of Queensland reported in its annual report that the registrar finalised 55 per cent (8 269) of the 15 105 deaths reported to the office between 2012–13 and 2016–17. This represented 33 per cent of the 25 280 deaths reported across the state in this period. As a result, coroners did not need to investigate a third of the deaths reported to the Coroners Court of Queensland. The percentage finalised by the registrar has improved over the past five years. These triaging practices have reduced the number of deaths proceeding to an autopsy and a full coronial investigation.

Figure 2A shows the increase in deaths reported to the Coroners Court of Queensland and the reduction in autopsies performed between 2011–12 and 2017–18.

Figure 2A
Number of deaths reported, and the number of autopsies performed 2011–12 to 2017–18



Source: Queensland Audit Office, using data recorded in the Coroners Court of Queensland's case management system. The data displayed in this graph was extracted from the case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland in 2017–18.

The agencies could prevent even more unnecessary coronial investigations by better resourcing and expanding the triage process. Since 2013–14, the state coroner has raised the need for a second coronial registrar, highlighting that the existing registrar is at capacity, and another resource is required in order to triage all deaths reported to the coroner.

In January 2017, the registrar's role changed to focus solely on forms from medical practitioners reporting deaths (form 1a) to reduce the number of non-reportable hospital deaths entering the coronial system. The registrar's growing workload triggered this decision.

However, this has meant that there is now no coordinated statewide triage practice for deaths reported by the Queensland Police Service, which represent 62 per cent (22 034) of all cases reported between 2011–12 and 2017–18. By comparison, only 22 per cent (7 867) of all cases related to medically reported deaths (deaths that occur in the health system). Forensic and Scientific Services' coronial nurses undertake preliminary investigations to identify non-reportable deaths reported by the Queensland Police Service, but their involvement is after the death has entered the system.

Implementing a more coordinated statewide triage practice will also enable the agencies to better understand the key drivers for the increase in deaths reported to the coroner. It will help them identify strategies to reduce the number non-reportable deaths, for example, better education to doctors.

Making informed decisions

The coroner must determine whether an autopsy is required and, if so, whether an external, partial internal, or full internal autopsy is required. The decision to order an autopsy has time and cost implications and the coroner is also legally required to consider objections from family (such as for religious or cultural reasons) before making a decision. At times it can be difficult for the coroner to make an informed decision because there is limited information.

A coroner can request that a pathologist or coronial nurse undertake a preliminary investigation when they issue a form 2 'order for autopsy', but this is not mandatory under the Act. The pathologist or coronial nurse can review medical records and other relevant information, consult with the treating doctor, and take a computed tomography (CT) scan of the body. However, the Act prohibits them from taking blood from the deceased as part of their preliminary investigations.

We found coroners' practices varied when ordering an autopsy. Some specified the type of autopsy they require, whereas others left it to the pathologist to determine. Sometimes the pathologist would follow up with the coroner to determine the most appropriate type but not always.

Victoria has a more streamlined and consistent process. Pathologists at the Victorian Institute of Forensic Medicine take a CT scan, bloods, toxicology, and photographs of the deceased when a police officer or doctor reports a death to them. Based on this information, the pathologist meets with the coroner and makes a recommendation about what future action the coroner should take. The final decision still rests with the coroner, but they are more informed in making this decision. This practice is likely to result in more efficient practices and avoid unnecessary investigations and potentially invasive autopsies, which can be distressing for families.

Managing cases

Case manager

In Queensland, coroners have overall responsibility for an investigation, but they do not have administrative control of the resources required to undertake this work. Under the Act, they can compel information directly from agencies and specify timeframes for the receipt of information or direct the Queensland Police Service under the *Police Powers and Responsibilities Act 2000*, to compel information.

The three agencies support coroners to fulfil this responsibility, but no agency is accountable to manage a coronial investigation from start to finish. The Coroners Court of Queensland's coronial services teams assume operational responsibility for managing coronial investigations. Its coronial investigation officers and its coronial services officers perform this function, but they are junior staff with entry level investigations training, limited supervision and often juggling high caseloads. In 2013, the Coroners Court of Queensland recognised the power imbalance of junior staff liaising directly with Magistrates, doctors and senior police officers. It has not effectively addressed this power imbalance.

In 2017–18, the average number of cases per coronial services team was 247. The ratio varied considerably depending on the location of staff, with regional staff usually have higher caseloads.

The lack of dedicated case managers with the appropriate experience, training and authority can mean the agencies are not proactively following up outstanding cases. This contributes to delayed coronial investigations.

For example, if a coroner requires additional witness statements, the Queensland Police Service's Coronial Support Unit allocates responsibility to a police officer by entering a task in the Queensland Police Reporting Information Management Exchange database. If the officer has not completed the task by the deadline, the system automatically generates an overdue reminder. But the Coronial Support Unit does not actively follow up each outstanding task to ensure the officer completes it promptly. As at 29 June 2018, 213 tasks were overdue by 32 days or more. Of these, 74 per cent (158) were more than 60 days old. In some cases, agencies have only acted when families have made repeated requests for information or updates.

Finalising coronial investigations

Once a coronial case enters the system, the timely resolution of an investigation is critical to families seeking closure. The timeliness of the finalisation of coronial investigations depends on the complexity of the case, circumstances of the death, reliance on expert reports, and whether an inquest is held.

In some cases, coroners cannot close coronial investigations due to criminal proceedings. We excluded cases delayed due to criminal proceedings from our analysis because the delays are to a large extent dependent of criminal court processes outside the control of the coronial system.

In other cases, coroners have to wait on medical reports or other independent expert reports, such as a psychiatrist report or a structural engineer report. Depending on the complexity of the case, a coroner, counsel assisting, and other support staff can be required to invest a substantial amount of time reviewing high volumes of evidence.

The Coroners Court of Queensland publicly reports on two measures in the Department of Justice and Attorney-General service delivery statements:

- clearance rate
- backlog.

It calculates its clearance rate and its backlog based on the national Report of Government Services counting rules. It calculates its clearance rate by dividing the total number of coronial investigations it finalises in the financial year (regardless of when the coronial investigation was lodged) by the total number lodged in the financial year.

It calculates its backlog indicator by dividing the number of coronial investigations that are 24 months or older by the total number of coronial investigations outstanding. The national target is zero coronial investigations that are older than 24 months.

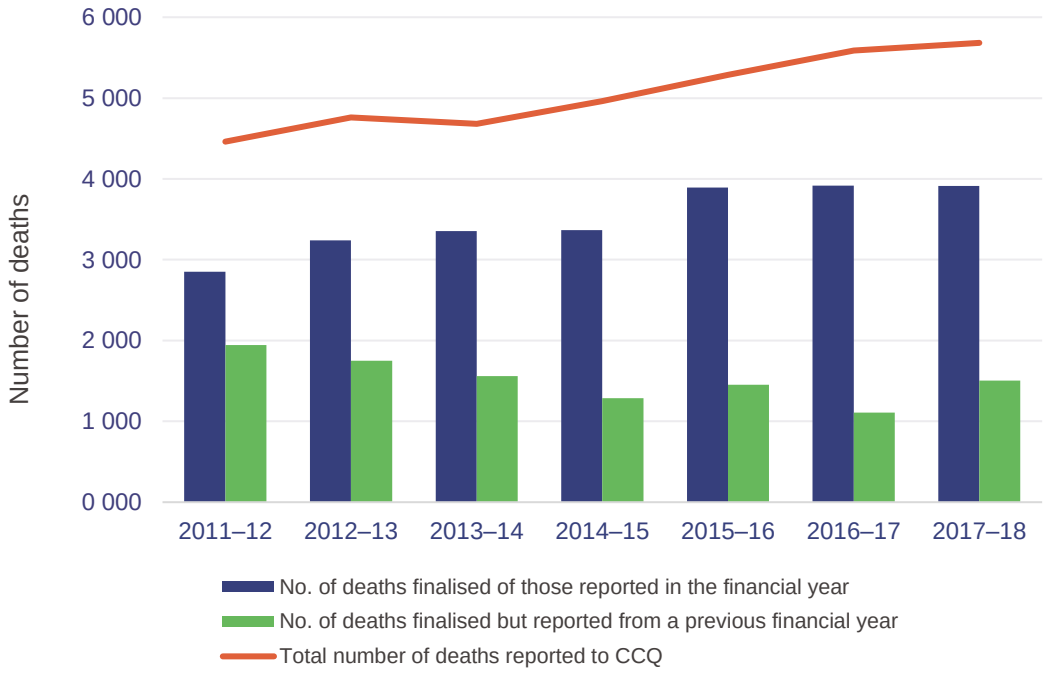
Clearance rate

Between 2011–12 and 2017–18, the Coroners Court of Queensland's clearance rate has fluctuated between 108 per cent and 90 per cent. Queensland has the lowest clearance rate when compared to jurisdictions such as Victoria and New South Wales, which have a similar number of reportable deaths.

The Coroners Court of Queensland was maintaining a clearance rate of 105 per cent prior to its office restructure in 2014, meaning that it was clearing some of its backlog. But over the past four financial years, its clearance rate has been much lower and is now 95 per cent. This means that the backlog continues to grow.

Figure 2B shows the status of all deaths reported to the coroner between 2011–12 and 2017–18 and the number finalised between this period and prior to 2011–12.

Figure 2B
Number of deaths reported, and the number of cases finalised, 2011–12 to 2017–18



Source: Queensland Audit Office, using data recorded in the Coroners Court of Queensland's case management system. The data displayed in this graph was extracted from the case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland in 2017–18.

The Coroners Court of Queensland has improved the number of coronial cases it finalises of those reported within a financial year, but it is finalising fewer of the backlogged cases. Because it finalises approximately 70 per cent of the new cases each year and has finalised fewer from previous years, the backlog has increased since 2011–12.

The percentage of cases finalised varies across the state. The Coroners Court of Queensland's North Queensland region's clearance rate has dropped from 108 per cent in 2011–12 to 78 per cent in 2017–18. In the South East region, it has dropped from 110 per cent to 84 per cent over this period. Appendix C shows a breakdown by region.

Backlog of coronial cases

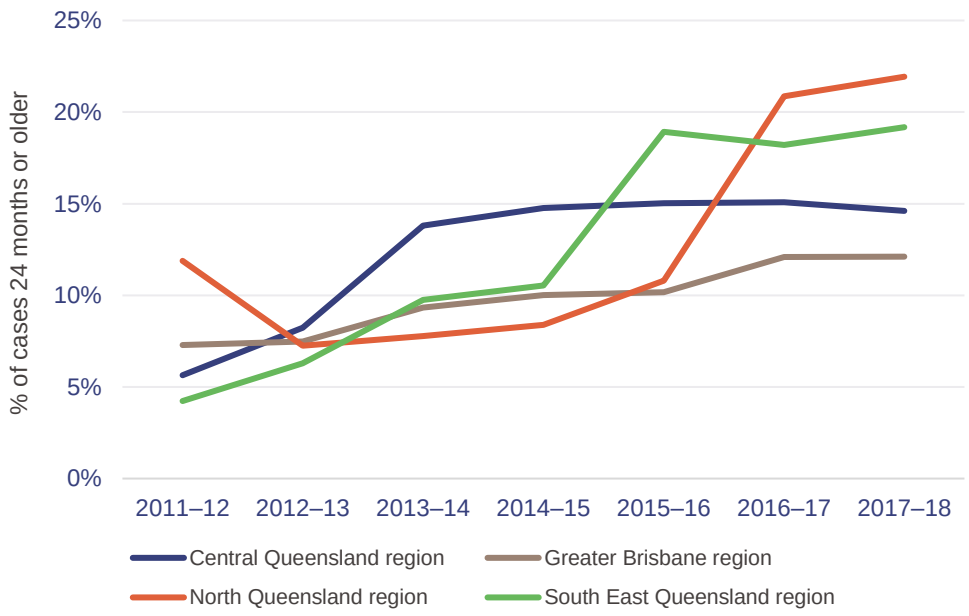
There is a significant and growing backlog of ageing and unfinalised coronial cases across the state. Since 2011–12 the Coroners Court of Queensland has continued to let its backlog of coronial cases grow without due attention. More recently it has taken temporary measures to address the backlog in the northern region, allocating two staff in Brisbane to work through the backlog of outstanding coronial cases. These measures are useful in the short term, but the Coroners Court of Queensland requires a more long-term plan to effectively support the northern coroner and families in the future.

Across the state, the percentage of coronial cases 24 months or older has grown from seven per cent in 2011–12 to 16 per cent in 2017–18. Queensland currently has the highest backlog of coronial cases older than 24 months when compared to New South Wales and Victoria, which have a similar number of deaths reported to the coroner. While direct comparison between the states is complicated by different practices and legislative requirements, the trends over time are useful. Queensland's five-year trend shows an increase, while New South Wales' and Victoria's trend shows a decrease.

Across the Coroners Court of Queensland's four regions, there is an increasing trend in the percentage of cases that are 24 months or older, with the most notable increase being in the North Queensland region. Since 2011–12, the percentage of cases 24 months or older in North Queensland has increased from 12 per cent to 22 per cent.

Figure 2C shows the percentage of coronial cases that are 24 months or older for the Coroners Court of Queensland's regions between 2011–12 and 2017–18.

Figure 2C
Percentage of coronial cases 24 months or older for the Coroners Court of Queensland's regions, 2011–12 to 2017–18



Notes: This graph excludes 148 coronial cases delayed due to criminal proceedings.

Source: Queensland Audit Office, using data recorded in the Coroners Court of Queensland's case management system. The data displayed in this graph was extracted from the case management system on 21 June 2018 and may not capture all deaths reported to the Coroners Court of Queensland in 2017–18.

Timeliness of autopsy reports and other coronial services

Lengthy delays in finalising autopsy reports and neuropathology and histology (the study of the microscopic structure of animal and plant tissue) services contribute to the delayed finalisation of cases.

The Act requires a forensic pathologist to complete their autopsy report as soon as practicable after completing an autopsy. The time taken by pathologists to complete an autopsy report depends on the type of autopsy performed, condition of the body, circumstances of the person's death, and any additional tests performed. More complex cases often result in larger autopsy reports.

Several coroners suggested some pathologists provide too much detail, particularly for simpler cases, such as natural causes deaths. Forensic and Scientific Services provides limited guidance to pathologists regarding the level of detail they capture in their autopsy reports.

The Royal Australian College of Pathologists requires pathologists to capture sufficient information that would enable another pathologist reviewing the case to form the same conclusion. Each pathologist must exercise their independent professional judgement when documenting their findings, given these could be challenged in court. As a result, it is difficult for Forensic and Scientific Services to regulate how much information they capture.

The delays by pathologists in completing their autopsy reports can be excessive and a barrier to coroners finalising their investigations. Between 2011–12 and 2016–17, it took forensic pathologists on average more than four months (135 days) to issue their autopsy report to coroners after an autopsy. The average increased from 135 days in 2011–12 to 151 days in 2014–15 but dropped to 137 days in 2016–17.

A pathologist's caseload and case mix can influence the time they take to issue an autopsy report. As such, we examined how long it took pathologists to issue their report after performing an external examination for a particular type of death—a reported hanging. (These cases are often less complex.)

We found a significant variance in the time taken by pathologists to issue these autopsy reports. Between 2011–12 and 2017–18, it took pathologists (that had completed 100 or more cases) between 64 days and 224 days to issue their report for an external examination for a hanging.

In some cases, pathologists were waiting for other forensic tests, such as histology and neuropathology, before they could issue their autopsy reports to coroners.

Forensic histology services

As part of some autopsies, body tissue and organs may require specialised examination. This varies, depending on the nature of the death. In many cases a pathologist can only form an opinion about the cause of death once they have examined histology samples from the deceased. In these cases, small samples of tissue are usually taken for further analysis. In such cases, pathologists must examine the tissue before they can issue their autopsy report.

A shortage of laboratory technicians and scientists within Forensic and Scientific Services' histology unit is causing a delay in preparing the tissue for examination and is contributing to delays in autopsy reports.

Prior to 2012, Forensic and Scientific Services had six full-time staff working in its histology unit. This included a senior scientist and senior technician, a scientist, and three technicians. Two full-time technicians and two part-time technicians now staff its histology unit. Approximately 47 per cent (7 837) of cases lodged with Forensic and Scientific Services for autopsy between 2011–12 and 2017–18 required the histology unit to prepare samples for examination.

Pathologists took on average of 170 days to issue the autopsy report to coroners in cases involving histology, but only 83 days for those that didn't.

Forensic neuropathology services

A coroner may order a neuropathologist to examine injuries to the brain, spinal cord and peripheral nerves. Most coronial cases that involve neuropathology also require histology. There are only two forensic neuropathologists currently practising in Queensland. Forensic and Scientific Services also engages the services of a forensic neuropathologist practising in South Australia. Given the complexity of these cases and the shortage of neuropathologists these coronial cases often experience significant delays.

Between 2011–12 and 2017–18, 871 coronial investigations required neuropathology. Of these, 849 required both neuropathology and histology and took on average 308 days for the final autopsy report to be issued to the coroner. For the 22 cases that only required neuropathology, it took on average 229 days to issue the report to the coroner.

Clinical advice

Clinical advice is another factor contributing to delays in the finalisation of investigations. Coroners can engage the services of the Forensic and Scientific Services' Clinical Forensic Medicine Unit for independent clinical advice or seek advice from relevant clinical experts on a fee for service basis.

The Clinical Forensic Medicine Unit's forensic medical officers provide coroners with independent clinical advice about a wide range of issues, including the clinical management of the deceased and whether a reported death could have been prevented. They also provide advice to the coronial registrar as to whether a hospital-related death is reportable and whether the case warrants an autopsy and coronial investigation. They provide timely advice in relation to hospital-related reported deaths. Since June 2015, it has taken them just over one day to provide advice to the coronial registrar.

However, the time it takes for forensic medical officers to provide advice for form 1 reported deaths (reported by police officers) is much higher. Often, these deaths are more complex in nature and require the forensic medical officers to review vast amounts of medical records for patients with chronic health issues. On average, it has taken forensic medical officers more than seven months (236 days) to provide advice to coroners since June 2015. Despite these cases being more complex, the time taken to provide advice is significant and is a major delay to a coronial investigation.

Expert reports

Depending on the circumstances of a death, a coroner may also seek advice from other experts. This may include medical specialists, ballistics experts, crash scene investigators, experts in child death and others. Some agencies are required to undertake prolonged investigations themselves prior to completing their report to the coroner. For example, Workplace Health and Safety may undertake a detailed investigation before issuing its report to a coroner. At times the limited number of experts in a particular field, and the complex nature of the expertise sought can result in high costs and cause a delay in coronial investigations.

Due to limitations with the Coroners Court of Queensland's case management system data we were unable to distinguish between the time taken to issue expert reports and investigative reports to coroners. The Coroners Court of Queensland does not accurately capture which experts' coroners have sought advice from. As such it cannot monitor the timeliness of their services.

Practices of government undertakers

The Department of Justice and Attorney-General has not managed the performance of government undertakers well. As a result, government undertaker performance is variable with some instances of inappropriate and some unethical conduct being reported.

Contracting

The Department of Justice and Attorney-General's procurement unit is responsible for contracting service providers (referred to as government undertakers) to transport deceased people. In Queensland, funeral directors are contracted to transport the deceased from the scene to the local mortuary and as otherwise required.

The Department of Justice and Attorney-General has contracted three providers to provide selected services for one cent, but additional rates for kilometres travelled apply. Although the government secured these services cheaply, these contracts increase the risk of providers touting for business. The department recognised these risks and incorporated a number of clauses within the standing offer arrangement to mitigate these risks. This risk raises the need for adequate monitoring for compliance.

However, the Coroners Court of Queensland has received formal complaints about the performance of government undertakers, including some promoting their funeral services, despite this being a breach of their contract.

In another Australian jurisdiction, some transportation contracts in metropolitan areas have been awarded to not-for-profit organisations, eliminating issues of contracted undertakers touting for business (encouraging families to conduct the funeral with them). Contracting not-for-profit organisations in regional areas is more difficult due to limited providers. Although the Department of Justice and Attorney-General ran an open procurement process, it did not contact not-for-profit organisations directly. It is likely these organisations were unaware of the opportunity to submit a tender.

Managing contracts

Once awarded, the Coroners Court of Queensland is responsible for the ongoing management of government undertakers, but it is not actively monitoring their performance nor effectively addressing complaints about them. As would be expected, the Coroners Court of Queensland relies on the Queensland Police Service and other parties to notify it about underperformance. It does not supplement this with proactive monitoring such as conducting periodic inspections.

Although the contracts clearly outline performance expectations for government undertakers and a performance monitoring framework, the Coroners Court of Queensland has not enforced these expectations. Its lack of monitoring and action has resulted in underperformance, and ultimately impacted the families of the deceased.

We found several examples, where families, police officers and other parties had reported underperformance. Between 2011–12 and 2017–18, the Coroners Court of Queensland received 28 formal complaints in relation to the performance of Government undertakers. This is small when compared to the overall number of transportation services provided over this period. However, some of the complaints reflect significant breaches in performance.

Case study 1 provides an example of a government undertaker that failed to comply with the performance expectations documented in their contract and the failure of the Coroner's Court of Queensland to adequately investigate.

Case study 1
Transporting a deceased person

Quality of transportation services

In March 2018, police attended the scene of a reportable death and engaged a government undertaker to transport the body of the deceased. Police reported that the government undertaker:

- took longer than necessary to arrive
- showed a lack of compassion to the family
- lacked knowledge on handling the body, which caused distress to the family
- used faulty and broken equipment that damaged the family's timber floorboards.

Police also reported that the undertaker's van (used to transport the deceased) was 'a disgusting mess with what appeared to be dirty laundry and there were no points to secure the trolley or body'.

Police reported the government undertaker's conduct to the Coroners Court of Queensland. There had been other complaints about this government undertaker's performance when transporting bodies.

The Coroners Court of Queensland phoned the government undertaker in April 2018 to discuss the performance and followed up with a written letter detailing the issues raised and requesting a response. The government undertaker responded in late April 2018, apologising for the incident but dismissing some of the issues raised. The Coroners Court of Queensland did not investigate the matter further or take any additional action. The contractor continues to provide coronial transportation services.

In August 2018, the Coroners Court of Queensland received another complaint about this government undertaker's performance, which it is now investigating.

Acting on coronial recommendations

Coroners' ability to prevent further deaths by making recommendations is hampered by:

- delays in finalising investigations, which defers recommendations intended to prevent further deaths
- the lack of mandatory requirement for organisations, agencies, or individuals to respond or act on recommendations
- a lack of follow-up or scrutiny by the state government of its decisions and actions on implementing recommendations.

Under Section 46 of the Act, a coroner may comment on (or recommend) anything connected with a death investigated at an inquest that relates to:

- public health or safety
- the administration of justice
- ways to prevent deaths from happening in similar circumstances in the future.

Between 2011–12 and 2017–18, coroners made 522 coronial recommendations to public agencies.

Under the Act, there is no obligation for agencies, public or private, to respond to coroner's recommendations. Despite this, the Queensland Government has chosen to respond to all coronial recommendations made to state government agencies. Other jurisdictions, including Victoria, South Australia, the Northern Territory, and the Australian Capital Territory, have legislation that requires agencies or chief executive officers to respond to coronial recommendations.

The Department of Justice and Attorney-General's Legal Services Coordination Unit coordinates state government responses to coronial recommendations. Government departments are required to respond to coronial recommendations within six months of notification and provide an update to the Legal Services Coordination Unit until the recommendation is implemented. The Legal Services Coordination Unit reviews the responses and provides feedback. If a response is vague, it will follow up with the relevant department and request they redraft their response.

Figure 2D shows the status of the 522 coronial recommendations made to state government agencies between 2011–12 and 2017–18.

Figure 2D
Acceptance of coronial recommendations made to state government agencies between 2011–12 and 2017–18

Status of recommendations	Number of recommendations
Agreed (or agreed in part)	400
Not agreed	33
Under consideration	17
Awaiting a response	72
Total	**522**

Source: Queensland Audit Office, using data reported by the Department of Justice and Attorney-General's Legal Services Coordination Unit.

State government agencies have self-reported to the Legal Services Coordination Unit that they have implemented 91 per cent (365) of the 400 recommendations agreed to or agreed in part. The remaining nine per cent (35) are in progress.

The self-reporting by agencies provides limited assurance that they have implemented coronial recommendations and that their actions have addressed the outcomes intended to prevent deaths. This is because neither the Legal Services Coordination Unit nor anyone else:

- investigates the reasoning behind decisions not to implement a coronial recommendation
- requires or receives supporting evidence confirming status updates
- assesses whether actions to implement a recommendation were appropriate to address the recommendation.

What is the effect on families?

We expected to find that agencies kept families informed throughout the coronial process and provided adequate support in accordance with the *Coroners Act 2003*. Specifically, we expected that agencies would:

- provide families with adequate and timely information during the entire coronial process
- consider and where possible act on the views of family members in accordance with the *Coroners Act 2003*.

Families come into contact with Queensland's coronial system at a time of grief, as they deal with the loss of a loved one. Although some families find the idea of a coronial investigation confronting, it can provide answers to questions about the death of their loved one.

Proactive management of coronial cases, along with adequate and timely information throughout the coronial process, helps families as they navigate this difficult time. It is for this reason that the Act and the State Coroner's Guidelines 2013 require coroners to consider the views of families and keep them informed during the coronial investigation.

There is a need for coroners to balance the rights and needs of family members, while still fulfilling their judicial functions under the *Coroners Act 2003*. For example, at times it may not be appropriate for the circumstances of the death to be released to the family until the investigation is finalised. In these cases, family members may become frustrated or feel unsupported, but the actions of the coroner are necessary to ensure an independent and robust investigation.

The Queensland Police Service, the Department of Health, and the Department of Justice and Attorney-General all play key roles in helping coroners provide this support to families during a coronial investigation.

Initial contact with the family

The death of a loved one is a traumatic time for families, and people may not take in or remember information verbally communicated to them on initial contact. This needs to be reinforced with supporting written material. The Queensland Police Service, Forensic and Scientific Services and the Coroners Court of Queensland have developed useful written material for families for this purpose.

Written correspondence provided to families

A family's first point of contact is normally the police officer who attends the scene. The Queensland Police Service provides its officers with brochures to provide to families of the deceased. The brochure explains the coronial process and includes the contact details for various support associations, including the Forensic and Scientific Services' coronial counsellors. The Queensland Police Service has established procedures to increase the likelihood of officers providing the brochures to families. We have no reason to believe that its officers haven't been providing them but have no way to test this.

Families also receive a letter and fact sheet from the Coroners Court of Queensland when an investigation starts. It contains general information about the coronial process and relevant contact details. The Coroners Court of Queensland's website contains useful information about the key aspects of a coronial investigation and clearly explains how families can obtain support during the process. For cases admitted to the Forensic and Scientific Services, most families also receive a letter from a coronial counsellor if accurate next of kin details are available.

Informing and supporting families

Once families receive notice from coroners that an investigation has started, they rarely receive much more information. On average, it takes almost six months to finalise a coronial investigation for a reportable death.

The agencies are not proactively ensuring families are well informed during this time, and in many cases (though not all) families only receive information if they contact agencies to inquire on progress.

The insufficient communication during this period is largely due to:

- a lack of a single point of contact. Agencies do not appoint a case manager with responsibility for the file across the duration of the investigation
- workload of agency staff. High workloads and backlogs mean that staff don't have the time to proactively communicate with families
- lack of procedures, processes, or systems for sharing information across agencies and prompting staff to update families
- inadequate staffing and structures in some areas. This can mean that when staff take leave there is limited or no coverage of their roles by other staff. As a result, actions such as communicating with families are often delayed until the staff member returns.

We found documented complaints from families frustrated by the lack of information provided to them across the coronial process and the lack of timely follow-up to their queries.

Case study 2 provides examples of family members who were upset by misinformation or delays.

Case study 2
Communication with the family of the deceased person

Communicating with families

Family One—autopsy report

In December 2014, the daughter of a deceased person contacted the Coroners Court of Queensland requesting a copy of the autopsy report. The Coroners Court of Queensland advised her that they had not yet received the autopsy report and that they would forward the material once received.

On 27 October 2015, the daughter contacted them to again request a copy of the autopsy report. At this point she expressed her frustration that it had taken almost a year to obtain a copy of the report.

On 28 October 2015, the Coroners Court of Queensland sent a letter to the daughter advising that the information was still outstanding. The daughter called them, upset and angry that the investigation was taking so long and questioning why she still hadn't received a copy of the report. The Coroners Court of Queensland took no further action to follow up with the family.

In May 2016, the Coroners Court of Queensland's Brisbane region transferred the case to its Gold Coast regional office for further investigation. Upon review, the Gold Coast region identified that the office had received the autopsy report on 18 August 2015. The counsel assisting followed up with the family to apologise for the lack of communication and provided the family with the autopsy report.

Family Two—staffing

In October 2015, a coroner sent a letter to the family of a deceased confirming that they were commencing a coronial investigation. More than a year later, the coroner sent a follow-up letter advising that they had made little progress due to a lack of staff. In February 2017, the family wrote to the Coroners Court of Queensland explaining that they were extremely upset by the letter. They asked why the Coroners Court of Queensland did not consider the death of their loved one to be important. The Coroners Court of Queensland responded to the family's concerns in the same month, explaining that the investigation had been delayed because the coroner was waiting on a report from a third party.

It is difficult to determine the extent of these sort of complaints because the Coroners Court of Queensland does not record all complaints made by families.

We also identified examples where the Coroners Court of Queensland were prompt in their feedback and kept families informed throughout the coronial investigation. These examples reflect the dedication and investment of front line staff to support families in these times of crisis.

Case study 3 provides an example of a family who thanked the Coroners Court of Queensland for how its staff had communicated information to them about their son's death.

Case study 3
Communication with the family of the deceased person

Keeping families informed

In June 2017, the mother of a deceased person contacted the counsel assisting to express her sincere gratitude for their sensitive handling and provision of information regarding the coronial inquest into her son. She said, 'I feel you have imparted all information to me in such a kind and caring way'.

The Coroners Court of Queensland staff maintained regular communication with the family throughout the coronial investigation. Staff provided the family with both written and verbal information about the coronial process and promptly responded to the family queries throughout the coronial investigation.

Training provided to staff

Each of the agencies fields calls from families during coronial investigations and provides a level of support. Despite this, we found that agencies either don't train their staff in the appropriate skills to support families or provide inadequate training.

Families seeking additional information from the Coroners Court of Queensland will in most instances speak with its coronial support officers or its coronial investigation officers. Staff in neither of these roles have received training to help them communicate with and support grieving families. We spoke with numerous support and investigation officers who said they did not feel adequately trained to support families. At times they are required to communicate with grieving and highly emotional families and witnesses, and these interactions can have a significant personal toll on staff.

The Coroners Court of Queensland needs to do more to ensure it effectively supports its staff and witnesses during a coronial investigation. The vicarious trauma training it has offered to its staff has not been compulsory and as such only some of its staff have completed it. There is limited support and counselling services provided to witnesses that must give evidence during coronial investigations. In September 2018, the Deputy State Coroner made a recommendation that the Queensland government facilitate and fund a program that provides counselling for families, witnesses and others who may be involved in and impacted by a coronial investigation.

Forensic and Scientific Services' administrative team also field calls from families seeking additional information about the coronial process or counselling support or raising objections to an autopsy or to organ retention. The responsibility for the administrative team to field calls from families began in 2016. Forensic and Scientific Services has not trained its staff to perform this function, nor is it listed in their job description. However, Forensic and Scientific Services recognises this gap and is currently looking at training packages that will equip its staff with the skills to respond to distressed or angry family members.

The Queensland Police Service provides some training to its officers, but it does not deliver this consistently across the state due to limited staff at the coronial support unit. All new recruits receive a two-hour training session as part of their academy training. First-year constables also receive some training from the Coronial Support Unit. The quality and accuracy of information its officers capture at the scene (such as next of kin contact details), in part reflects this lack of training.

Accurate and reliable contact details

Forensic and Scientific Services' counsellors and other coronial staff rely on accurate next of kin contact details to support families, particularly if the family raises concerns about autopsy or organ retention.

The Queensland Police Service' Coronial Support Unit audited the accuracy of all form 1s received between 2011–12 and 2016–17. It found that approximately 26 per cent (2 382) of the 9 225 form 1s lodged in this period were either inaccurate or incomplete. In these instances, the Coronial Support Unit had to follow up with the officer who reported the death to amend the form, resulting in delays. Sometimes it can be difficult for its officers to obtain accurate information from grieving families, or if the family is not present or if the deceased is unidentifiable.

Although the Queensland Police Service has not audited the accuracy of form 1s in other regions, it is likely that this error rate is representative of practices occurring across the state. It is exploring options to improve the quality of information captured by its officers for coronial investigations (such as completing form 1s on an iPad), but it has not set a timeframe for these improvements.

Forensic and Scientific Services' coronial counsellors

Families seeking support during a coronial investigation can contact Forensic and Scientific Services' coronial counsellors. They are qualified social workers or psychologists. Since 2012, the number of full-time counsellors has dropped from seven to five.

Stakeholders across Queensland's coronial system recognise the value of these coronial counsellors. However, current resourcing constraints limit the support counsellors can provide to families. Counsellors do not proactively contact families unless the family has an objection to an autopsy or organ retention, or the death is a homicide, or involves a child.

In the cases where families raise concerns about an autopsy or organ retention, the counsellors play a key role in listening and responding to the family's views.

The Act requires the coroner to seek the views of the family, but it does not require the coroner to comply with those views. In these instances, the counsellors will work with the family to explain the prerogative of the coroner and why the coroner has ordered the autopsy.

Families that directly contact the counsellors can receive short-term counselling support over the phone. The counsellor's direct families that require long-term support to other support associations, such as Lifeline or Victims Counselling and Support Services. At present, there is no one coordinating counselling services and support to families across the three agencies.

In addition, counsellors only become involved if the deceased's body has been lodged at the Forensic and Scientific Services' Coopers Plains facility (where the counsellors are located on site). In regional cases, counsellors only contact a family if a coroner specifically requests them to. This is in part, due to a lack of resources and the absence of reliable next of kin contact details.

Appendices

A. Full responses from agencies

As mandated in Section 64 of the Auditor-General Act 2009, the Queensland Audit Office gave a copy of this report with a request for comments to:

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

The head of these agencies are responsible for the accuracy, fairness and balance of their comments.

We also gave a copy of this report to the State Coroner for comment.

This appendix contains their detailed responses to our audit recommendations.

Comments received from State Coroner, Coroners Court of Queensland

QUEENSLAND COURTS

CHAMBERS OF THE STATE CORONER

Coroners Court of
Queensland
363 George Street
Brisbane QLD 4000
G.PO Box 1649
Brisbane QLD 4001

PH (07) 3404 8333
FX (07) 3109 9617
www.courts.qld.gov.au

8 October 2018

Mr Brendan Worrell
Auditor-General
Queensland Audit Office
Level 14
53 Albert Street
BRISBANE QLD 4001

Dear Mr Worrell

Performance Audit on Coronial Services

Thank you for your letter of 19 September 2018 attaching the audit report on coronial services. I extend my appreciation to you for consulting with coroners in the preparation of this report.

My colleagues and I welcome the Queensland Audit Office's efforts in examining whether the three Queensland Government agencies that contribute services to the coronial system are working effectively and efficiently in supporting coroners in our role in the investigation and prevention of deaths.

As the report highlights, I have been concerned about the sustainability and efficiency of the current system for a number of years. I have made recommendations to Government with respect to the need to plan for the future in a systematic way, particularly in relation to managing increasing demands on all agencies through options such as legislative amendments, a common information technology platform and enhanced triaging arrangements. However, most of those recommendations have not been implemented as agencies have failed to allocate the necessary resources to plan for the future in a coordinated way.

Coroners agree with the finding that the current governance arrangements for the coronial system have created a void, with no single agency taking the necessary initiative to respond in a timely way to clear risks such as the diminishing forensic pathology workforce.

While the Interdepartmental Working Group has been a valuable forum for agencies to share information and identify issues, it has lacked the capacity to marshall the necessary resources to respond to those issues. It also lacks the authority to make any decisions that require a shift in the allocation of resources within Departments and across the system.

Coroners also agree with the finding that while each of the three primary agencies has endeavoured to support the investigation of reportable deaths by coroners and supporting bereaved families, those activities are not the core business of those agencies. This has seen an overall diminution in the resources dedicated to coronial work across those agencies, particularly in regional Queensland.

Coroners welcome the recognition in the report that the regional disparity continues within the coronial system, and that Government needs to carefully consider the impact that any changes to the system will have on regional communities. The outcomes of the review into the future model for forensic pathology services highlight the concerns of coroners in this regard.

Coroners support the recommendations contained in the report. We consider that unless decisive action is taken at the whole of government level in response to the recommendations, the coronial system will continue to operate in a less than optimal way. This will lead to inefficient practices becoming more entrenched, more deaths that should be diverted from the system being reported, and increasing delays in the finalisation of coronial findings to the detriment of bereaved families, whose needs should be the focus of the system.

The report recognises that the current governance arrangements impede the State Coroner in the exercise of statutory functions under the *Coroners Act 2003* in overseeing and coordinating the coronial system, and ensuring the system is administered and operated efficiently. I would expect any new governance arrangements flowing from the audit report to recognise and facilitate those roles, and the work of all coroners, in a way that protects and respects judicial independence.

Yours sincerely

Terry Ryan
State Coroner

Comments received from Director-General, Department of Justice and Attorney-General

Queensland Government

Department of Justice and Attorney-General
Office of the Director-General

In reply please quote: 512445/1, 4545722

11 OCT 2018

1 William Street Brisbane
GPO Box 149 Brisbane
Queensland 4001 Australia
Telephone 13 74 68 (13 QGOV)
www.justice.qld.gov.au

ABN 13 846 673 994

Mr Brendan Worrall
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002
brendan.worrall@qao.qld.gov.au

Dear Mr Worrall Brendan

Thank you for your email dated 19 September 2018 enclosing a copy of the Queensland Audit Office (QAO) proposed report, *Delivering Coronial Services* (Report).

I welcome the findings of this Report, and the opportunity it represents to enhance cross-agency support to coroners and bereaved families. The need for a more coordinated, cohesive system with stronger leadership and governance across agencies is evident.

Recommendations made within the Report broadly align with work currently underway within the Department of Justice and Attorney-General (DJAG), which is informed by a 2017 independent organisational review of the Coroners Court of Queensland (CCQ). This includes a number of ongoing improvements to case management processes that aim to enhance the delivery of support to coroners and families.

A review of current information systems within the CCQ was also undertaken by an independent Business Analyst in mid-2018. Based on the findings of this review, strategies are now being implemented to improve the timeliness and accuracy of reporting on backlogs, to better understand where workload pressures may exist, and identify any underlying system issues.

DJAG has further allocated funding to Caxton Legal Centre and the Townsville Community Legal Service to provide legal advice and representation to bereaved families. This is an important step in ensuring that unrepresented families are supported throughout the investigation, including for those matters that proceed to inquest.

While the Report notes an environment of increasing demand and a lack of system wide planning, it is also important to highlight the positive and innovative outcomes that have been achieved by agencies over time. This is acknowledged by the QAO with the trial and establishment of the coronial registrar, who has overseen the finalisation of 60% of the 13,665 deaths reported to the office between 2012-13 and 2016-17. It is also apparent in a range of other reforms including the establishment of coronial nurses and coronial counsellors within Queensland Health and the recent introduction of non-narrative findings for apparent natural causes deaths.

Such initiatives have been successfully implemented because of the commitment and dedication of staff within the CCQ, and strong interagency partnerships, which have ensured that, despite the demand pressures, the coronial system has continued to deliver for all Queenslanders.

Further while there may be opportunities to enhance the management of Government undertaker contracts, it should also be noted that from 2016-17 to present there have been a total of 8,191 conveyances, with only 20 complaints received. This represents 0.24% of all conveyances and highlights in general terms, the quality of these services.

The high response rate by public sector agencies in implementing coronial recommendations should also be acknowledged. This is indicative of a strong commitment by all agencies to prevent future deaths, and the valuable role of coroners in driving such reforms. Information generated through coronial investigations continues to be of significant value for research and policy initiatives that aim to reduce or prevent future deaths. This is best demonstrated through the ongoing commitment by the State Coroner to support the Queensland Suicide Register, managed by Griffith University. This is an internationally recognised database, which was the first of its kind in Australia, and provides valuable data to inform suicide prevention planning and research.

As requested, please find enclosed the completed table outlining DJAG's response to the recommendations contained in the report. DJAG supports all recommendations in principle, noting this support is subject to appropriate resourcing being made available to DJAG to undertake implementation.

Should you require further information regarding this matter, please contact Mr Daniel Matthias, Director, CCQ, DJAG, on (07) 3109 9698, or at daniel.matthias@justice.qld.gov.au

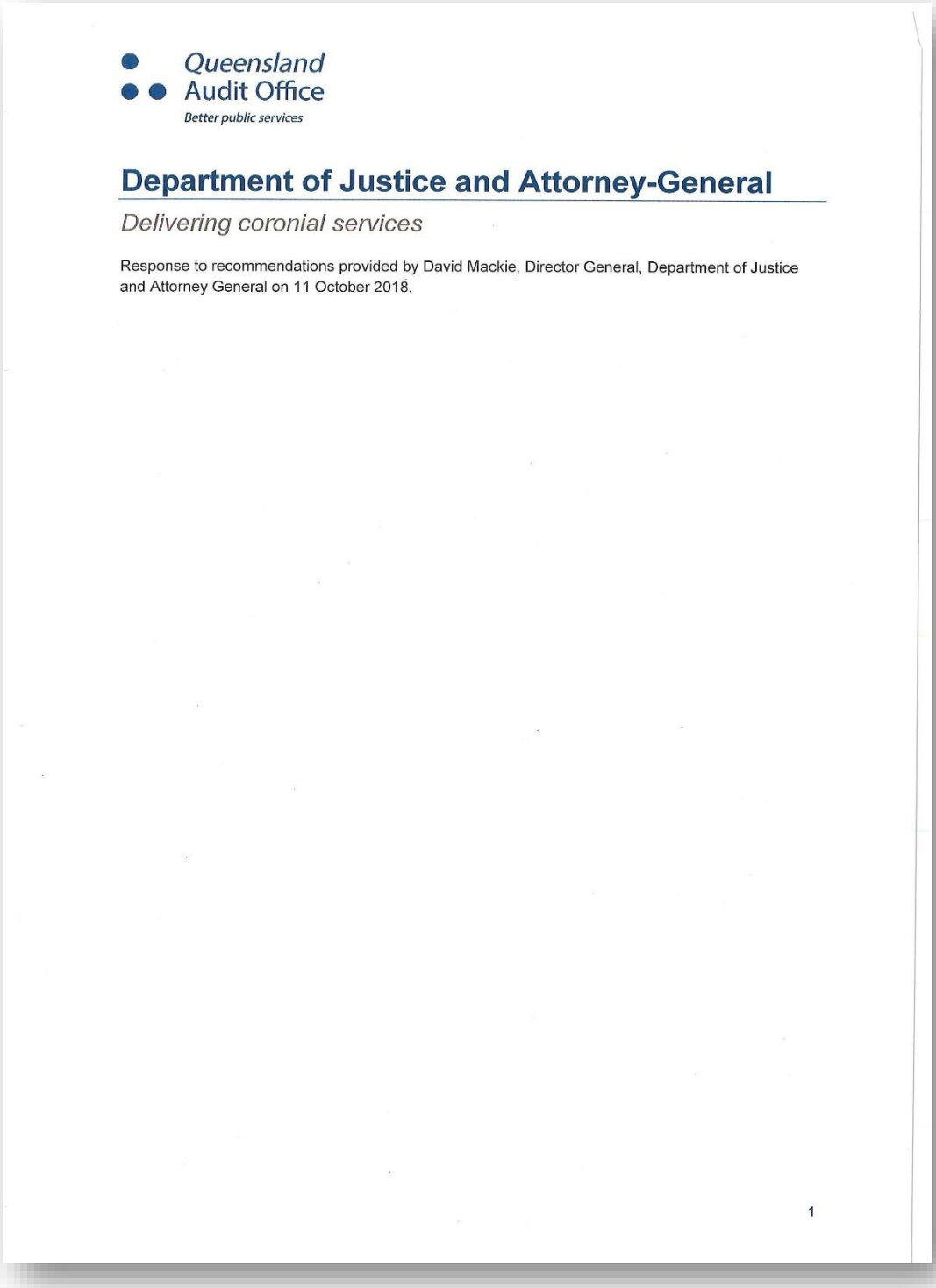
Yours sincerely

David Mackie
Director-General

Enc.

cc Mr Darren Brown
Director
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002
darren.brown@qao.qld.gov.au

Responses to recommendations



Queensland Audit Office
Better public services

Department of Justice and Attorney-General

Delivering coronial services

Response to recommendations provided by David Mackie, Director General, Department of Justice and Attorney General on 11 October 2018.

1

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners:			
1. establish effective governance arrangements across the coronial system by:			
• creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist.	Agreed	Quarter 3, 2019	The Department of Justice and Attorney-General (DJAG), supports the creation of a governance board, assisted by an appropriately resourced secretariat, and considers that it will be well placed to provide leadership, governance and accountability across the key agencies.
• more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services	Agreed	Quarter 4, 2019	DJAG supports the approach of more clearly defining agency responsibilities, and will work with partner agencies to consider system-wide resourcing needs. Additional resourcing is a matter for government.
• establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.	Agreed	Quarter 3, 2019	DJAG supports a review of the current interdepartmental working group membership and terms of reference to improve collaboration, reporting and accountability across agencies
We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners 2. Evaluates the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.	Agreed	Quarter 4, 2020	DJAG continues to support interagency planning processes that aim to improve the efficiency and effectiveness of the coronial system. DJAG considers that, once established, a governance body would be best placed to evaluate the merits of an independent statutory body or other comparable models.

2

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
3. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners improve the systems and legislation supporting coronial service delivery by:			
• identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports.	Agreed	Quarter 4, 2019	DJAG will continue to explore opportunities to interface systems across agencies to achieve efficiencies. This will build upon work currently underway in the Coroners Court of Queensland (CCQ) as recommended by an independent Business Analyst who completed a review in early 2018.
• reviewing the Coroners Act 2003 to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process. • reviewing the Burials Assistance Act 1965 and the burials assistance scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.	Agreed	Quarter 4, 2019	DJAG is committed to improving systems and frameworks to enhance coronial service delivery, including exploring potential legislative amendments to the *Coroners Act 2003* and *Burials Assistance Act 1965*.
4. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners improve processes and practices across the coronial system by:			
• ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported investigators to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators	Agreed	Quarter 2, 2020	DJAG is committed to continuous improvement in case management processes and practices to enhance the support provided to coroners and families. The governance board would be best placed to drive system-wide agreement on the central role and authority of case managers, and consider the associated resourcing implications of these key roles.

3

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
• ensuring there is a coordinated, statewide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy	Agreed	Quarter 2, 2020	DJAG considers that the governance board would be best placed to lead strategic cross-agency planning to explore proposed enhancements to current triaging processes. This would include consideration of the scope and focus of the proposed enhancements, and the resources and supports required to implement such an initiative.
• establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process	Agreed	Quarter 3, 2019	DJAG has a strong commitment to supporting families and witnesses in contact with the coronial system, and will review agency processes to ensure that families receive information at key stages through the investigation.
• ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.	Agreed	Quarter 4, 2020	DJAG has a strong commitment to supporting families and witnesses in contact with the coronial system; and is exploring opportunities across agencies to improve counselling supports. The governance board would be well placed to determine the sufficiency and locality of counselling services and the associated resourcing implications of enhanced supports in this area.
5. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners: assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.	Agreed	Quarter 2, 2020	DJAG will continue to support planning processes that aim to ensure the delivery of sustainable and timely forensic pathology services across the state to all Queenslanders. DJAG considers that subject to its establishment, a governance board would be best placed to oversee this body of work.

4

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
We recommend the Department of Justice and Attorney-General: 6. implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners.	Agreed	Quarter 2, 2020	DJAG has temporarily allocated additional funding and staff in 2018-19 to assist the CCQ to meet demand pressures. This additional funding has also enabled the CCQ to make some progress in addressing backlogs, within the context of other workforce priorities. As such, actual timeframes for completion may be influenced by agency resources. Work undertaken by an independent Business Analyst commissioned by the CCQ in mid-2018 is expected to improve the timeliness and accuracy of reporting on backlogs, to better understand where workload pressures may exist and identify any underlying system issues. Interagency collaboration is also occurring across the key agencies and in consultation with coroners, to develop a longer term strategy to improve efficiencies and reduce backlogs.
We recommend the Department of Justice and Attorney-General: 7. improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.	Agreed	Quarter 2, 2020	DJAG will do a review of performance monitoring and management of government undertakers as part of its contract management processes. Broadening the scope to proactive contract management will have resourcing implications that will require further consideration.

5

Comments received from Director-General, Department of Health

Queensland Government

Enquiries to: Dr Michel Lok
General Manager
Strategy, Community and Scientific Support
Telephone: 3069 2181
File Ref: C-ECTF-18/8564

11 October 2018

Mr Brendan Worrall
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002

Email: qao@qao.qld.gov.au

Dear Mr Worrall

Thank you for your letter to the Honourable Steven Miles MP, Minister for Health and Minister for Ambulance Services, dated 19 September 2018, about the Performance Audit of Coronial Services. The Minister has referred your letter to the Department of Health for response.

I acknowledge the audit's conclusions and welcome the opportunity to consider the recommendations made by the Queensland Audit Office to improve the responsiveness of the coronial system to better support Coroners and serve the needs of Queenslanders.

As highlighted in the report, the delivery of coronial services has been challenged over a number of years as the number of deaths reported continues to rise and the need to prioritise resources along with other areas of increasing demand as part of the normal budget processes applied to the allocation of funds.

The Queensland Audit Office has acknowledged that agencies have taken individual and collective action to respond to this challenge. Together with the Coronial Registrar, forensic medical officers review healthcare related deaths and successfully divert over 90 per cent of these deaths from further investigation. Working with police and coronial staff, coronial nurses and forensic pathologists have been able to use medical records and consultation with treating physicians to obtain death certificates and divert around 30 per cent of new cases from investigation. This taken together with the extended use of computed tomography scanning and external examinations, the number of autopsies performed in Queensland has been reduced by eight per cent despite the 30 per cent increase in reported deaths since 2011-2012.

Accordingly, the Department supports the audit recommendation to review the *Coroner's Act 2003* to consider amendments to reduce the number of reported deaths entering the coronial system and to further reduce avoidable investigations and autopsies.

As noted in the audit report, the State Coroner raised concerns in 2015 concerning the sustainability of statewide coronial services with the imminent retirement of regional fee-for-service forensic pathologists. In late 2015, the Department allocated additional funding to establish two extra forensic pathology positions at Forensic and Scientific Services in Brisbane. Two additional specialist training placements have since been established to enhance future service delivery in the context of a global shortage of specialist forensic pathologists and the small number of specialists in training in Australia.

Office
Level 37
1 William Street
BRISBANE QLD 4000

Postal
GPO Box 48
BRISBANE QLD 4001

Phone
3708 5990

Email:
DG_Correspondence@health.qld.gov.au

While these have been important improvements, the Department agrees that a more integrated and planned approach is needed to ensure the effective performance of the coronial system. The Department notes that Parliament has defined the role, functions and powers of the State Coroner in section 71 of the *Coroner's Act 2003*. These functions (s71(1)) include to oversee and coordinate the coronial system and to ensure the coronial system is administered and operated efficiently. The State Coroner also has the power to enter into arrangements with Government entities (s71(3)).

Interdepartmental governance boards have been used to great effect in child protection reform and domestic and family violence in recent years. A similar model, as suggested by your report, may be appropriate to direct and oversee implementation of the coronial services reforms proposed. Any governance board should include as ex-officio officers, the State Coroner and the Chief Forensic Pathologist to provide professional perspectives. The role of this proposed board vis a vis the State Coroner, an appointee of the Governor in Council, will need close consideration by Government and potentially require legislative change.

The Department notes the audit recommendation for the Department of Justice and Attorney-General to lead an evaluation of the merits of establishing an independent statutory body with its own funding and resources to deliver medical services for Queensland's justice and coronial systems (currently provided by Forensic and Scientific Services within the Health portfolio). The Department believes the evaluation should be overseen by the proposed board with the active participation of all agencies. The Department notes that such an evaluation would need to consider the threshold test established by Government in the *Public Interest Map for Queensland Government Bodies* and demonstrate a compelling case to support a non-departmental governance model.

The Department notes that the establishment of a statutory body was previously considered following the 2005 *Ministerial Taskforce Report on the Role and Function of Forensic and Scientific Services in the Queensland Governm*ent, but was not progressed. The Department further notes that, in addition to providing specialist clinical and health science input to both the coronial and justice systems, Forensic and Scientific Services also provides vital analytical laboratory services that support public and environmental health services across the State.

The Department also agrees with the audit recommendation that agencies should further assess options for the sustainable provision of statewide autopsy services with greater consideration of regional factors. Health Support Queensland commenced scoping a consultancy to further evaluate the options identified by an inter-agency Project Reference group in July 2018. This was paused pending the completion of the performance audit. The Department has also taken steps to assess the feasibility of using a major recruitment agency to recruit specialist forensic pathologists to work in regional Queensland to enhance service delivery.

Should officers of your Department require further information, the Department of Health's contact is Mr Michel Lok, General Manager, Strategy Community and Scientific Support, Health Support Queensland, on telephone 3096 2181.

Yours sincerely

Michael Walsh
Director-General
Queensland Health

2

Responses to recommendations

The Department of Health, Delivering Coronial Services

(Report No. XX 2018-2019)

Responses to relevant recommendations provided by The Department of Health on 11 October 2018

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter and year)	Additional Comments
We recommend the Department of Justice and Attorney General, in collaboration with the Department of Health, Queensland Police, the Department of the Premier and Cabinet, and the Coroners:			
1. establish effective governance arrangements across the coronial system by: • creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist. • more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services. • establishing terms of reference of the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.	Agree	Quarter 2, 2019	The Department of Health will work with agencies to establish and support a board comprising Deputy Directors-General to oversight reforms and effect change. The State Coroner and Chief Forensic Pathologist would be ex-officio members. The continuing need for a board could be reviewed in three years. The Department of Health will work with agencies to develop a coronial services framework outlining the government's expectations of the coronial system, contributing agency responsibilities and both end-to-end and agency performance measures. Agency resourcing is a matter for the government.

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter and year)	Additional Comments
2. evaluates the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.	Agree	Quarter 4, 2019	The Department of Health will work collaboratively with agencies to complete the evaluation. The evaluation would be best undertaken under the direction of the proposed board and will need to have regard to government's *Public Interest Map for Queensland Government Bodies*. The Department of Health notes that Forensic and Scientific Services also provides co-located essential public health and clinical services which must be carefully considered independently of the coronial and forensic services. The benefits of establishing a statutory body will need to outweigh the additional cost associated with operating an independent body.
We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with Coroners:			
3. improve the systems and legislation supporting the coronial service delivery by: • identifying opportunities to interface their systems to more effectively share coronial information, including police reports (form 1s), Coroners orders and autopsy reports. • review the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process.	Agree	Quarter 4, 2019	The Department of Health is progressing implementation of a new Laboratory Information Management System to replace Auslab in 2020. Business requirements for coronial autopsy are included within the scope. The Department of Health will assess the feasibility of interim options to enhance the exchange of information between agencies. The Department of Health notes the Department of Justice and Attorney-General is responsible for the *Coroners Act 2003* and will actively participate in the legislative review process.

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter and year)	Additional Comments
4. improve processes and practices across the coronial system by: • ensuring there is a coordinated, statewide approach to triaging all deaths reported to the coroners to help advise the coroner of the need for autopsy. • ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest victims.	Agree	Quarter 4, 2019	In line with recommendations 1 and 3, the Department of Health will work with agencies to design and implement improvements to triage processes and practices. The Department of Health will work with agencies to develop and implement a protocol regarding the role and responsibilities of Coronial Counsellors employed by Forensic and Scientific Services and their role relative to other agencies. Agency resourcing is a matter for the government.
5. assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.	Agree	Quarter 3, 2019	The Department of Health will commission an independent assessment of statewide models for the management of coronial cases and consult with Coroners and other stakeholders. The proposed board should oversee recommendations for the provision of sustainable statewide management of coronial cases.

Comments received from Commissioner of Police, Queensland Police Service

QUEENSLAND POLICE SERVICE

COMMISSIONER'S OFFICE
200 ROMA STREET BRISBANE QLD 4000 AUSTRALIA
GPO BOX 1440 BRISBANE QLD 4001 AUSTRALIA

Email: commissioner@police.qld.gov.au

Our Ref:

Your Ref:

11 October 2018

Mr Brendan Worrall
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002

Dear Mr Worrall

Thank you for your correspondence dated 19 September 2018 regarding the proposed report on the performance audit of coronial services (audit report) to parliament, and an acquittal of our comments raised in response to your preliminary draft report.

The Coronial Support Unit on behalf of the Queensland Police Service has reviewed the comments and have accepted the proposed actions in principle as drafted in the acquittal report. I thank you for considering our responses to your preliminary draft report and making amendments to the audit report to reflect them.

I am pleased to advise that I agree with all recommendations contained in the audit report, and have provided comments against each of them in the attached table as requested.

These recommendations focus on a collaboration by the Department of the Premier and Cabinet, Department of Justice and Attorney General, Department of Health, and the Queensland Police Service.

These agencies met on 2 October 2018 with the intention of establishing a collegial implementation board to address the seven recommendations in the audit report in the first quarter of 2019.

Should you have any further inquiries, please don't hesitate to contact Acting Inspector Mark Lingwood of the Coronial Support Unit on (07) 3006 2501.

Yours sincerely

IAN STEWART
COMMISSIONER

Responses to recommendations

Queensland Audit Office
Better public services

Queensland Police Service

Delivering coronial services

Response to recommendations provided by the Commissioner of Police, Queensland Police Service 11 October 2018.

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners:			
1. establish effective governance arrangements across the coronial system by:			
• creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist.	Agree	Quarter 1, 2019-2020	The Queensland Police Service (QPS) supports the creation of a governance board to be supported by an appropriately resourced secretariat. The board should also include a member of the QPS.
• more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services	Agree	Quarter 2, 2019-2020	QPS supports more clearly defining agency roles and will work with partner agencies to achieve this. Agency funding is matter for the government.
• establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.	Agree	Quarter 1, 2019-2020	QPS supports establishing terms of reference for the interdepartmental working group to deliver outcomes.
We recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners:			
2. evaluates the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.	Agree	Quarter 2, 2019-2020	QPS supports the establishment of a governance body which would be best placed to evaluate the merits of an independent statutory body.

1

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
3. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners: improve the systems and legislation supporting coronial service delivery by:			
• identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports.	Agree	Quarter 2, 2019-2020	QPS continues to support identifying opportunities to interface information sharing systems. QPS has included the Single Person Identifier number on reports of sudden deaths (form 1). This number is currently used in other existing government information sharing interfaces.
• reviewing the Coroners Act 2003 to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process.	Agree	Quarter 2, 2019-2020	QPS supports identifying opportunities for improvement, including legislative changes, to avoid unnecessary coronial investigations including improvements to the triage process. QPS acknowledges that the Department of Justice and Attorney General is responsible for the *Coroners Act 2003*.
• reviewing the Burials Assistance Act 1965 and the burials assistance scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.	Agree	Quarter 2, 2019-2020	QPS supports this recommendation and acknowledges that the Department of Justice and Attorney General is responsible for the *Burials Assistance Act 1965*.
4. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners: improve processes and practices across the coronial system by:			

Queensland Audit Office
Better public services

Recommendation	Agree/ Disagree	Timeframe for implementation (Quarter & year)	Additional comments
• ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported investigators to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators	Agree	Quarter 4, 2019-2020	QPS supports continuous improvement to proactively manage entire investigations delivering better outcomes for families.
• ensuring there is a coordinated, state-wide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy	Agree	Quarter 4, 2019-2020	If a governance board is to be established, it would be responsible for implementing change and considering resourcing implications.
• establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process	Agree	Quarter 4, 2019-2020	QPS supports an enhanced triaging process and considers that should a governance board be established that it would be best placed to implement this recommendation. The QPS supports enhancing process to ensure families receive adequate and timely information at key stages. QPS currently provides families, at the time of death, an information brochure developed in consultation with partner agencies.
• ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.	Agree	Quarter 3, 2019-2020	QPS continues to work with partner agencies to provide improved services to families and inquest witnesses.
5. We recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners:			
assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.	Agree	Quarter 3, 2019-2020	QPS continues to provide a commitment to consulting in assessing a sustainable forensic pathologist model. QPS believes that a governance board would be best placed to undertake this body of work.

3

B. Audit objectives and methods

Audit context

In February 2018, the Auditor-General commenced a performance audit on forensic services in accordance with Section 37A of the *Auditor-General Act 2009*. As a result of the inquiries and consultation we undertook during the planning phase for the audit, the Auditor-General decided to split the audit program into two separate audits:

- Coronial Services—will assess whether agencies are effective and efficient in supporting the coroner to investigate and help prevent deaths.
- Forensic Services—will assess whether public sector entities provide forensic services effectively and efficiently.

On the 3 April 2018, the Auditor-General wrote to the Police Commissioner, and the directors-general of the Department of Health and the Department of Justice and Attorney-General advising them of his decision.

The Forensic Services audit is expected to be finalised and the report tabled, in early 2019.

Audit objective

The objective of the audit was to assess whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths.

We addressed the objective through the following sub-objectives for determining whether:

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

Entities subject to this audit

We selected the three agencies that are responsible for supporting Queensland's coroners, including:

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

Although not subject to this audit, we consulted with the Queensland State Coroner, Deputy-State Coroner and all other coroners and the Department of the Premier and Cabinet. The audit identified learnings and made recommendations that are relevant to whole of government.

Audit approach

We conducted the audit in accordance with the Auditor-General of Queensland Auditing Standards—September 2012, which incorporate the requirements of standards issued by the Australian Auditing and Assurance Standards Board.

Field interviews

We conducted interviews with key people, staff and stakeholders from across the coronial system. This included, but was not limited to:

- interviews with the Queensland Chief Magistrate, Queensland State Coroner, and the six coroners
- interviews with staff across the Department of Health, the Queensland Police Service, and the Department of Justice and Attorney-General including:
  - Coroners Court of Queensland's director, executive manager, coronial registrar, counsel assisting, manager of the Domestic and Family Death Review Unit, funeral assistance officer, data coordinator, manager of the inquest and investigation team, coronial investigation officers, and coronial services officers
  - Forensic and Scientific Services' executive director, managing and supervising scientists, chief forensic pathologist and pathologists, mortuary manager, coronial counsellors and nurses, and the Clinical Forensic Medical Unit's medical director and forensic medical officers
  - Queensland Police Service's inspector of the coronial support unit and coronial support unit staff
- visits to the coroners and regional staff in Cairns, Mackay, and the Gold Coast
- a visit to the Victorian Institute of Forensic Medicine and the Coroners Court of Victoria
- consultation with:
  - National Association of Testing Authorities
  - Royal College of Pathologists Australasia
  - Office of the Director of Public Prosecutions
  - Crime and Corruption Commission
  - Queensland Funeral Directors Association.

Document review

We obtained and reviewed relevant documents and files from the agencies involved in the audit. This included reviewing relevant legislation, organisational reviews, project reports, performance reports, internal guidelines, policies, case files and correspondence.

Data analysis

We obtained data for the period between 2011–12 and 2017–18 from all three agencies:

- Department of Health, Forensic and Scientific Services Auslab database
- Department of Justice and Attorney-General, Coroners Court of Queensland's Case Management System
- Queensland Police Service, Queensland Police Reporting Information Management Exchange database.

We tested the accuracy and completeness of the data with the agencies. This included checking the total number of deaths (reportable and non-reportable) and autopsies (full, partial and external) for each financial year against the Commonwealth Governments Report of Government services and relevant agency reports, such as the Coroners Court of Queensland's annual reports.

Some of the analysis we performed included:

- analysing the state and regional performance of the Coroners Court of Queensland. This included assessing for each region the clearance rate (percentage of coronial investigations finalised by the total lodged in a financial year) and the percentage of outstanding coronial cases that are 24 months or more against the national benchmark, which is zero. We excluded from our analysis coronial cases delayed due to criminal investigations
- analysing the time taken by pathologists to issue their autopsy report after performing an autopsy. As part of this analysis, we assessed the time taken by pathologists to issue their reports for more simpler cases, such as an external examination for a hanging. We isolated this analysis to pathologists that performed 100 or more of these cases.

C. Coroners Court of Queensland regional data

This table captures key information for each coronial region within Queensland. It includes:

- total deaths (reported within each region)
- clearance rate (finalised cases/ total cases reported)
- backlog (cases 24 months old or more / total number of outstanding cases) – excluding cases delayed due to criminal investigations

CCQ regional analysis	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18
North Queensland							
Total deaths	582	595	654	614	607	722	732
Clearance rate	108%	118%	119%	94%	84%	89%	78%
Backlog (% of cases 24 months or more)	12%	7%	8%	8%	11%	21%	22%
Central Queensland							
Total deaths	577	633	555	585	633	690	715
Clearance rate	106%	106%	103%	95%	103%	94%	99%
Backlog (% of cases 24 months or more)	6%	8%	14%	15%	15%	15%	15%
Greater Brisbane							
Total deaths	1986	2706	2796	2991	3246	3364	3373
Clearance rate	106%	94%	104%	94%	100%	90%	101%
Backlog (% of cases 24 months or more)	7%	7%	9%	10%	10%	12%	12%
South East Queensland							
Total deaths	1316	825	677	772	802	811	863
Clearance rate	110%	129%	97%	93%	118%	86%	84%
Backlog (% of cases >24 months)	4%	6%	10%	11%	19%	18%	19%

Auditor-General reports to parliament

Reports tabled in 2018–19

1. Monitoring and managing ICT projects (Report 1: 2018–19)
   10 July 2018
2. Access to the National Disability Insurance Scheme for people with impaired-decision making capacity (Report 2: 2018–19)
   27 September 2018
3. Delivering shared corporate services in Queensland (Report 3: 2018-19)
   27 September 2018
4. Managing transfers in pharmacy ownership (Report 4: 2018-19)
   28 September 2018
5. Follow-up of Bushfire prevention and preparedness (Report 5: 2018-19)
   9 October 2018
6. Delivering coronial services (Report 6: 2018-19)
   18 October 2018

Audit and report cost

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Performance engagement

This audit has been performed in accordance with ASAE 3500 *Performance Engagements.*

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T: (07) 3149 6000
M: qao@qao.qld.gov.au
W: qao.qld.gov.au
53 Albert Street, Brisbane Qld 4000
PO Box 15396, City East Qld 4002

Queensland Audit Office

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