Queensland Audit Office
Better public services

Delivering coronial services

(Report 6: 2018–19).
Tabled 18 October 2018.

Slide 1: Welcome

This presentation summarises our performance audit report on delivering coronial services.

Please note that this is a summary. The full report can be read on our website.

Slide 2: Audit objective

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:

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

Slide 3: Context

Under the *Coroners Act 2003*, coroners (who are magistrates) are responsible for investigating deaths that occur in Queensland under certain circumstances. Their primary responsibility is to make formal findings in respect of the death, including the circumstances and cause of the death.

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

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

Slide 4: Our findings

We found:

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

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.

Slide 5: Our findings

We also found:

- agencies have improved their triaging practices, reducing the number of deaths proceeding to a full investigation unnecessarily, but this triage process could be expanded and applied more consistently across the state
- the communication provided to families at the beginning of a coronial investigation is sufficient, but agencies do not provide adequate support to families throughout the investigation
- the Coroners Court of Queensland does not actively monitor the performance of government undertakers, as such the performance of some government undertakers is variable and there are instances of inappropriate conduct being reported
- agencies have not effectively planned for the ongoing delivery of forensic pathology services.

Slide 6: Our conclusions

We concluded that Queensland's coronial system is under stress and is not effectively and efficiently supporting coroners or families. If left unaddressed, structural and system issues will further erode its ability to provide services beyond the short-term.

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.

Slide 6: What we recommend

We recommended agencies:

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

Slide 7: For more information

For more information on the issues, opportunities and recommendations highlighted in this summary presentation, please see the full report on our website.

Thank you.