Confidential Final Report

Organisational Structure and Workforce Climate Review for the Coroners Court of Queensland

Department of Justice and Attorney-General

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workplaceedge

This Report has been prepared for:

Queensland Government

Coroners Court of Queensland

Department of Justice and Attorney-General

By:

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Table of Contents

LIST OF FIGURES

LIST OF TABLES

1. Glossary of Terms

Term	Acronym
Administrative Officer	AO
Birth, Deaths and Marriages	BDM
Business Support	BS
Clinical Forensic Medical Unit	CFMU
Coroners Case Management System	CCMS
Coroners Court of New South Wales	CCoNSW
Coroners Court of Queensland	CCoQ
Coroners Court of Victoria	CCoV
Coroners Court of Western Australia	CCoWA
Coronial Admissions and Enquiry Office	CAEO
Coronial Case Management Unit	CCMU
Coronial Services	CS
Cradle to Grave	CtG
Department of Justice and Attorney-General	DJAG
Domestic and Family Violence Death Review Unit	DFVDRU
Electronic Document Management System	eDOCs
Forensic Scientific Services	FSS
General Practitioners	GPs
Hospital and Health Service	HHS
Human Resources	HR
Information and Communications Technology	ICT
Inquest and Investigations	II
Local Case Management System	LCMS
National Coronial Information System	NCIS
Natural Causes	NC
Police Coronial Support Unit	PCSU
Professional Officer	PO
Queensland Health	QH
Queensland Police Records and Information Management Exchange	QPrime
Queensland Police Service	QPS
Responsibility, **A**ccountability, Who to **C**onsult with and Who to **I**nform	RACI
Single Body Identifier	SBI
Victorian Institute of Forensic Medicine	VIFM

2. Executive Summary

Purpose: The purpose of this consultancy was to review the current organisational structure and workforce climate of the Coroners Court of Queensland (CCoQ), including existing systems, management and reporting relationships, as well as the business and operating environment.

Consideration was also to be given to opportunities to enhance the effectiveness and efficiency of the CCoQ, and to strategies or structures required to support positive organisational health, and staff well-being.

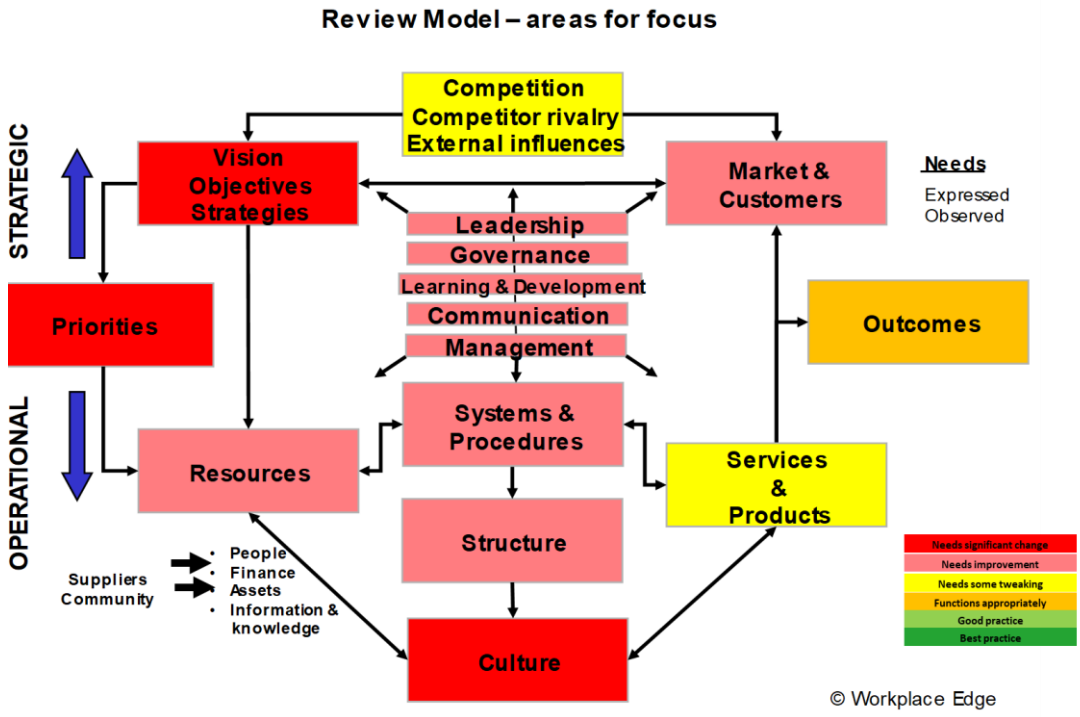
The aim was to provide recommendations about ways to improve capacity management, capability development, business processes, service provision and organisational health, to equip the CCoQ to be able to effectively respond to both current, and future demands.

Approach - The Review involved an eleven-stage process with extensive consultation within CCoQ, and with 55 one-on-one and 5 group interviews with staff, management, Coroners, stakeholders and similar organisations in Victoria, New South Wales and Western Australia. Workplace Edge wishes to acknowledge the very high-quality cooperation and assistance of CCoQ management and staff throughout the review process.

What works well – The CCoQ has many staff and Coroners who are committed and work extremely hard to make a difference to their internal and external customers in search of the truth and through recommendations which contribute to reducing the number of preventable deaths.

The CCoQ delivers its products and services through the dedication and hard work of these officers and Coroners.

Areas for Focus – in undertaking the review, Workplace Edge used the review model illustrated below. The model identifies the areas for focus and attention as identified from the review process.



4. Introduction and Background

4.1 Coroners Court of Queensland

Function

Queensland's coronial jurisdiction is established and governed by the *Coroners Act 2003*. It is focussed on the investigation of 'reportable deaths', these being certain categories of death considered to warrant independent scrutiny by virtue of the nature of the incident that precipitated the death or the deceased person's particular vulnerability.

The Coroner's role is to establish the identity of the deceased, when and where they died, the medical cause of death and the circumstances in which the death occurred. In doing do, Coroners also consider whether the death may have been preventable and if so, whether systemic or policy or procedural changes could contribute to improvements in public health and safety, or the administration of justice, or reduce the likelihood of other deaths occurring in similar circumstances.

The CCoQ is supported by 45 administrative and other professional officers, who provide a range of support functions for the court, including legal advice, operational support for inquests and inquiries, coronial support services and business support.[1]

Structure

As at 30 May 2017, CCoQ had 45 administrative and other professional officers, ranging from Senior Officer level, Professional Officer (PO) levels five to six and Administrative Officer (AO) levels two to eight. The support function of the CCoQ is divided into five teams:

- Directorate (2 staff members)
- Legal Services Team (7 staff members)
- Inquest and Investigations (II) Team (9 staff members)
- Coronial Services (CS) Team (16 staff members)
- Business Support (BS) Team (5 staff members)
- Domestic and Family Violence Death Review Unit (DFVDRU) (6 staff members).[2]

Previous Review

In 2015, the CCoQ commenced implementation of recommendations made by the 2013 Operational Review of the former Office of the State Coroner's administrative staffing structure and regional service delivery. Recommendations of the review included the centralisation of lower level administrative work to Brisbane to assist regional offices to better manage their workloads; the revised structure of existing teams within the office, including the establishment of an Executive Manager and other applicable roles; and a range of other supporting recommendations.

It was anticipated that with these recommendations, the revised structure would better support the CCoQ in achieving enhanced collaboration with stakeholders; focus operational staff on operational work and managers on leading institutional change; and specify the requirements of each position within the office administrative structure. The review also aimed to address previous issues with staff recruitment and retention within regional offices, and provide greater supervision and oversight of administrative staff.

[1] Request for quote CSPR 040.1718 – summary of opportunity and customer objectives

[2] *Ibid.*

The anticipated benefits of this review and restructure in 2015, have not been fully realised, with a number of the recommendations, such as a dedicated Practice Manager for the Counsel Assisting not being trialled or implemented. Also, Central region has not been transitioned over to the new model, although recent changes to operating processes have transferred responsibility for Form 1A's from this regional Coroner to the Brisbane-based Coronial Registrar.[3]

Key challenges

The CCoQ continues to face a number of challenges impacting on its optimal performance including:

- an ongoing increase in the number of deaths reported annually to the office as a result of population growth, with no corresponding increase in staff;
- increasing community and stakeholder awareness and expectations regarding the coronial process; and
- identified issues with the current CCoQ staffing structure and arrangements including current role designations and responsibilities, governance and reporting structures, and the size and organisation of teams.

This Organisational Review aims to identify an effective operating model within current resources, to ensure that the CCoQ is appropriately equipped to provide the best possible services to Coroners, bereaved families and the community. Given the often-confronting nature of working within the coronial jurisdiction, it also seeks to assess the current organisational climate and identify the appropriate supports and structures required to achieve optimal organisational health.

Sch4(4)(4)(1)

5. Scope of Work

The Scope encompassed a review the current organisational structure and workforce climate of the CCoQ including existing systems, management and reporting relationships, as well as the business and operating environment.

Consideration was to be given throughout the review to opportunities to enhance the effectiveness and efficiency of the CCoQ, and to the strategies or structures required to support positive organisational health, and staff well-being.

[3] Request for quote CSPR 040.1718 – summary of opportunity and customer objectives

[4] *Ibid.*

The consultant was required to provide advice and recommendations about the following areas of focus:

1. Organisational Structure including, but not limited to:

- Appropriate organisational structures for the CCoQ that support the needs of Coroners located both in Brisbane and in three regional offices (Cairns, Southport and Mackay);
- The allocation of work across the recommended organisational structure, including workflow arrangements to support Coroners conducting their investigations, both within and across different teams; and
- The appropriate leadership and governance structures required to support the CCoQ to function effectively and efficiently now, and into the future.

2. Staffing and Team Requirements including, but not limited to:

- Defining the roles and responsibilities of administrative positions within the judicial environment of the CCoQ, and how these positions interact with, and support, Coroners;
- Identifying the key skills, competencies and expectations placed on existing roles as benchmarked against comparable internal and external positions, as well as how these roles might be better aligned (e.g. work across program areas, alternative team or reporting arrangements); and
- The size and organisation of teams to ensure appropriate levels of supervision, support, professional development and mentoring of staff.

3. Organisational Climate including, but not limited to:

- Assessing the organisational climate and health of the CCoQ, including any identified psychological or psychosocial workplace health and safety risks, with respect to the requirements of the work being performed, the ways that the roles are currently designed and the existing operating environment.

The Consultant was required to provide recommendations about ways to improve capacity management, capability development, business processes, service provision and organisational health, to equip the CCoQ to be able to effectively respond to both current, and future demands.

This may include, but not be limited to, a re-alignment or reorganisation of existing structures and arrangements, and should extend to recommendations that aim to mitigate or manage any identified psychological or psychosocial workplace health and safety risks.

Proposed options also need to be feasible within the current resource allocation of the office. However, consideration should be given as to what changes may be required, and why, should additional resources be identified. This may include additional roles that may not be provided for under the current staffing structure that would increase the effectiveness and efficiency of the CCoQ, and should take into consideration the provision of direct support to Coroners, as well as possible enhancements to governance, business and administrative supports and structures.

The Consultant was also required to prepare a Workforce Plan to implement any recommended changes within an incremental staged approach, taking into account the supports required to manage this change process. [5]

[5] Request for quote CSPR 040.1718 – summary of opportunity and customer objectives

6. Review Approach

6.1 Review Stages

The review was undertaken through an eleven-stage process as illustrated below:

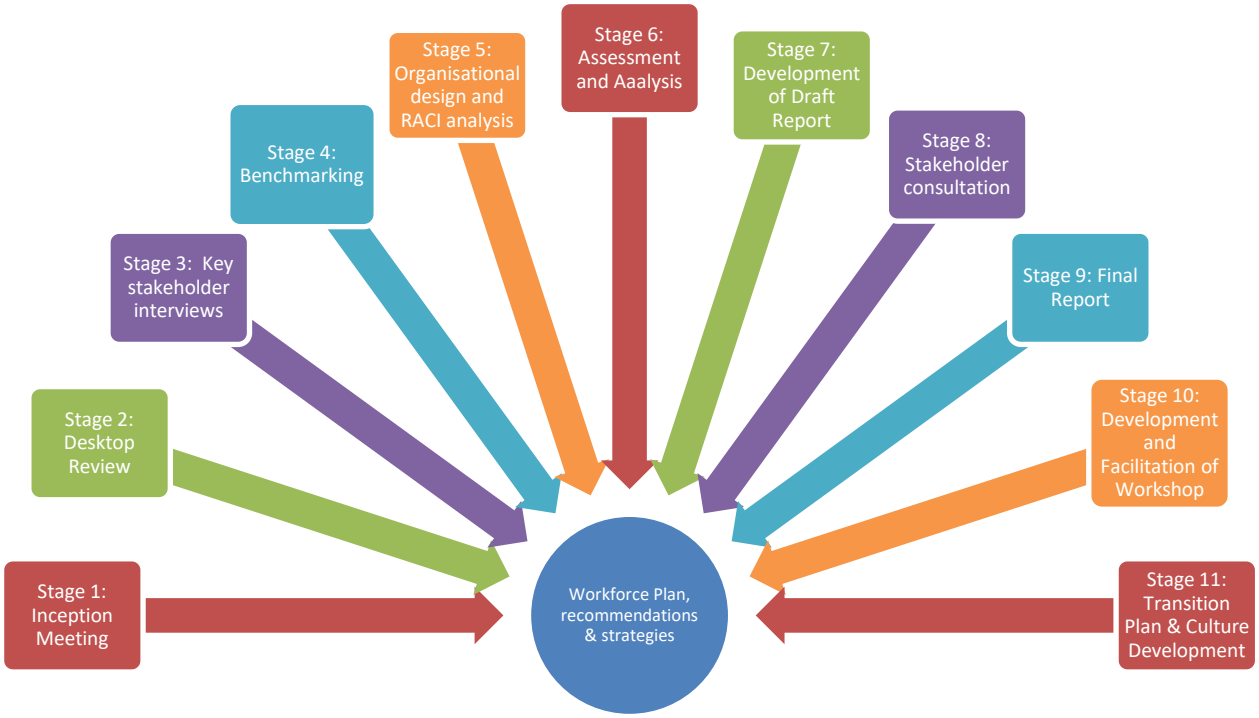


FIGURE 1 REVIEW PROCESS

Our approach to this project will involve 11 stages, namely:

Stage 1 **Inception Meeting**: Meeting with Client to confirm specific project details, deliverables, key milestones and reporting requirements;

Stage 2 **Desktop Review**: Review of all relevant background material regarding the operations of the CCoQ and any other relevant documentation provided by the client or sourced through desktop searches;

Stage 3 **Key stakeholder interviews**: Developing an organisational climate questionnaire and meeting with identified staff and stakeholders as listed above and agreed to by the Project Manager;

Stage 4 **Benchmarking**: Interviews with similar court programs in other jurisdictions to review, compare and benchmark systems and processes in other States and jurisdictions;

Stage 5 **Organisational Design and RACI Analysis:** reviewing the findings of the previous stages and implementing an organisational design process including a RACI process to design the optimal organisational structure for CCoQ and clarify role accountabilities, responsibilities, and organisational capacity and capability;

Stage 6 **Assessment and Analysis**: Review of all information obtained to date. Identification of organisational, functional and operational gaps in the operation of the CCoQ reviewing all elements of the Workplace Edge review model and identification of key findings and draft recommendations for inclusion in the draft report.

Stage 7 **Development of Draft Report**: Development of draft report including key findings and recommendations for change, incorporating benchmarking findings and organisational climate research findings;

Stage 8 **Client and Stakeholder consultation process**: This stage will involve socialising draft copies of the report with key client and stakeholder representatives and gaining their feedback for incorporation in the final report;

Stage 9 **Development and delivery of Final Report and Presentation**: Incorporation of feedback into final report, development of presentation material, and a Workforce plan for implementation of recommendations and delivery to client;

Stage 10 **Development and Facilitation of Workshop**: Development and delivery of workshop for the client to deliver the findings; and

Stage 11 (optional) Culture **Development Plan and Cultural Change:** development of a culture Development plan and change/transition management plan, which would be developed to provide CCoQ with a blueprint regarding how to successfully drive the changes, create the desired culture, and successfully position the organisation for the future.

6.2 Review Model and Consultation

Workplace Edge used the following Organisational and Operational Review Model which is divided into strategic and operational elements. One-on-one interviews were held with 55 interviewees, and five team focus group meetings were held with representatives from different teams, customers and stakeholders. The consultation included one-on-one interviews with each Coroner and a meeting of all Coroners together. A complete list of interviewees is available at Appendix 1.

FIGURE 2 ORGANISATIONAL AND OPERATIONAL REVIEW MODEL

7. Operations and Organisational Review

The operations and organisational review is split into four main sections, the first identifying what works well at the CCoQ; the second identifying issues impacting on the efficient and effective performance of the CCoQ, and then listing the findings and recommendations for change; and the third represents the results of the benchmarking study with similar jurisdictions in New South Wales, Victoria and Western Australia. The last section identifies the next steps and the proposed transition process for implementation of the recommendations.

8. What works well at CCoQ

Many of the staff work at CCoQ because they are passionate about the nature of the work and genuinely work exceptionally hard to support the Coroners, and to meet the needs of the CCoQ external customers, namely the deceased and their families.

In addition, there are many long serving, knowledgeable, highly qualified and intelligent professionals at CCoQ who produce exceptional research and legal output in support of the Coroners and the customers and stakeholders of CCoQ.

The Coroners and Registrar are very dedicated professionals who work hard to make a difference for customers and the families of the deceased, and in search of the truth, and in their efforts to develop recommendations that assist in reducing the number of preventable deaths

Sch4(4)(4)(1)

Sch4(4)(4)(1)

10. Benchmarking

The scope of the review included a benchmarking of the CCoQ with other Australian jurisdictions. For the purposes of benchmarking, Coroners courts in New South Wales, Victoria and Western Australia were contacted. A summary of findings for each jurisdiction is provided below and then final conclusions are provided.

10.1 New South Wales

In NSW, all Magistrates, by virtue of their office, are Coroners. The Coroner has jurisdiction to conduct an inquest if a person has died a violent unnatural death, a sudden death cause unknown, or under suspicious or unusual circumstances. A death must be reported to the State Coroner or Deputy State Coroner where a person dies during the course of a police operation or whilst in custody, and an inquest must be conducted into the circumstances of that death.

The State Coroner or a Deputy State Coroner also has sole jurisdiction in relation to deaths of children in care or at risk of harm and certain deaths of people with disabilities. Coroners also have jurisdiction to hold an inquiry into the cause and origin of fires and explosions where property has been damaged or destroyed. The State Coroner is responsible for overseeing and coordinating all coronial services in NSW.

The Coroner's Court of New South Wales (CCoNSW) is headquartered in Glebe and investigates approximately 6,000 reportable deaths annually, with 3,500 deaths being coordinated through Glebe while investigations into a further 2,500 deaths annually are coordinated by Coroners and Assistant Coroners in various rural and regional locations throughout NSW, primarily Newcastle and Wollongong.

There are currently seven Deputy State Coroners of NSW, two being part-time. Five are based in Glebe, one in Newcastle and one in Wollongong. Each Coroner is supported by a dedicated team; a team leader, a clerical officer and a junior clerk. This team approach provides consistency for each Coroner. The CCoNSW also employs three Social Workers who provide information and support to families, process information and handle all dispute resolutions and negotiations, particularly with difficult cases. The CCoNSW is supported by Coronial Support Team comprising Registrars and administrative support.

In early 2017, the CCoNSW implemented the Coronial Case Management Unit (CCMU) in order to streamline and provide consistency for the processes leading up to the reporting of a death to the Coroner, including communication with families. The CCMU is a multi-disciplinary team comprising resources including the Duty Coroner, Duty Pathologist, Police, Lawyer, Coronial Support, a Counsellor and a Nurse.

The team meets daily as is chaired by the Duty Coroner. Each Coroner is rostered to chair the CCMU for a week and take on the cases referred to the Coroner for that week. At present, the CCMU is only handling cases coming into Glebe, however the intention is to have all cases come into Glebe and then be referred back to the regions as required.

NSW has geographic challenges to overcome and as such regional areas are constrained by a lack of specialists in certain fields, primarily Pathology. Further, local Magistrates are often newly appointed Magistrates and are unfamiliar with coronial processes. As such, it is the intent of the CCoNSW to use the CCMU to process all notifications, make early and timely decisions as to the most appropriate pathway for the case and this give regional coroners “guidelines” for the case, transferring knowledge and reducing time for regional Coroners to process the case.

The Department of Forensic Medicine (DOFM) conducts all pathology and post mortems for the State Coroner and are collocated with the CCoNSW in Glebe. The DOFM is in the process of building a dedicated facility in Lidcombe for the Coroners Court and Forensic Medicine, a similar model to Victoria.

The CCoNSW does not have fully integrated systems with DOFM and use the Justice Link System for case management.

10.2 Victoria

The Coroners Court of Victoria (CCoV) is located at Southbank in Melbourne where the majority of the State’s inquests are held. The facility also houses the state mortuary where deceased persons are taken into the care of the court and as such operates 24 hours per day, seven days per week. Inquests are sometimes held in regional Victoria at the local Magistrates Court in the place where the death or fire occurred.

In Victoria, all Coroners except the State Coroner, are Magistrates or lawyers who have been practising for at least five years. The State Coroner, who is a Judge of the County Court has nine full time Coroners who investigate approximately 6,250 reportable deaths per annum.

Victoria's Coroners are supported by coronial services delivered by a number of different organisations including the Victorian Institute of Forensic Medicine (VIFM), Victoria Police and the Police Coronial Support Unit (PCSU). VIFM supports Coroners by receiving notifications of reportable deaths and performing all pathology and forensic examinations. The PCSU supports Coroners by helping Victoria Police officers nominated to perform the role of the coroners with questions they may have about Coroners' requests for statements and preparing briefs of evidence. PCSU members appear in court as the Coroner's Assistant for inquests.

The VIFM have managers at the Coronial Admissions and Enquiry Office (CAEO), who take all reports of deaths, determine the appropriate response (including preliminary forensic examinations), manage transfers of the deceased from the place of death to the state mortuary and liaise with the family and funeral directors. The duty coroner and duty pathologists meet daily to review reported deaths and discuss whether as autopsy or no autopsy is required. The NSW CCMU has been modelled on the VIFM CAEO.

More than 60 Court staff support the Coroners and manage the administration of the Court[8]. Coroners in Victoria are each supported by a dedicated team comprising a Registrar and a Legal Officer. The role of Bench Clerk is performed by a pool of administration staff, relieving Registrars of time consuming, routine administrative tasks and allowing them to focus on case management.

The organisation comprises four divisions as per the organisation structure provided below.

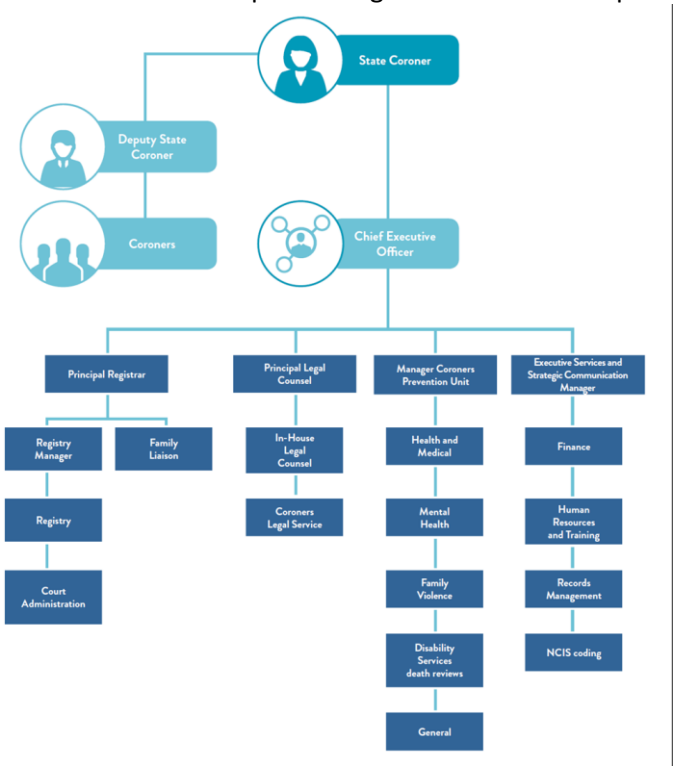


FIGURE 8 CCoV ORGANISATION STRUCTURE

[8] Coroners Court of Victoria, 2017 Annual Report,

The **Coroners Support Service** is managed by the Principal Registrar and undertakes Court administration, manages case files, supports families, and liaises with other parties.

Legal Services assist Coroners with their investigations by analysing evidence gathered as part of an investigation, preparing draft findings, preparing matters for inquest and sometimes appearing as counsel to assist the Coroner at inquest.

A **Coroners Prevention Unit** helps Coroners identify and research matters that may lead to the making of recommendations to prevent similar deaths.

Executive Services supports the operation of the Court through records management, finance, communications and human resources functions.

In 2015 the CCoV commenced a project to design and build a bespoke case management system that would support the unique operational requirements of the Court[9], and allow coroners and staff to manage a coronial investigation from the notification of a reportable death to case completion.

10.3 Western Australia

The State Coroners Court of Western Australia (CCoWA) is headquartered in Perth and there are nine regional magisterial jurisdictions, where the local Magistrate is also the coroner. Approximately 2,400 investigations were conducted in 2016/17. There are four Coroners in Perth, the State Coroner, a Deputy State Coroner and two Coroners.

The CCoWA has 23 staff (see below) providing a range of services including legal, administrative and counselling services. Each Coroner is supported by a small team comprising a legal counsel assisting and an administration officer (clerk).

FIGURE 9 CCoWA ORGANISATION STRUCTURE

Coroners and Inquest staff	Management and Registry Staff	Counselling Service
State Coroner	Principal Registrar	Senior Counsellor
Deputy State Coroner	Office Manager	Counsellor
Coroner	Registry Manager	Counsellor
Coroner	Assistant Registry Officer	
Principal Counsel Assisting	Systems Information Officer	
Counsel Assisting	Senior Findings Clerk	
Counsel Assisting	Findings Clerk	
Listings Manager	Customer Service Officer	
Administrator	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	

Other services supporting the court include two part-time doctors (0.4 and 0.6FTE each) who assist in determining the appropriate response to a reported death and two Police Officers, one of whom acts as counsel assisting the Coroner. They serve summonses, execute warrants, conduct investigations and liaise with investigating officers with the WA Police Service. All forensic examinations are conducted in Perth and by PathWest which is part of the Department of Health at the QEII Medical Centre, located in Nedlands, Perth.

[9] Coroners Court of Victoria, Chief Executives Officers Message, http://www.coronerscourt.vic.gov.au/home/about+us/chief+executive+officers+message/ , Accessed 26 November 2017

The CCoWA does not have an electronic case management system and as such runs on a paper based system, using standard forms and emails to process a case. A project to implement an electronic case management system for the CCoWA is scheduled to commence in 2017/18 with an anticipated completion date in 2018/19.

As the CCoWA is a relatively small team and are all co-located, they have focused on creating a multi-skilled, flexible workforce. This approach has enabled the court to continue to manage an increasing caseload while also reducing a significant backlog of cases.

10.4 Benchmarking Conclusions

The three jurisdictions have very similar approaches to manage reportable deaths. Each jurisdiction allocated dedicated resources to Coroners to ensure consistency of process and create close working relationships.

NSW and Victoria have established a dedicated multi-disciplinary team to handle the initial report of a death and have or are moving to a centralized model to perform this function. WA have applied the same model but not in a formal manner.

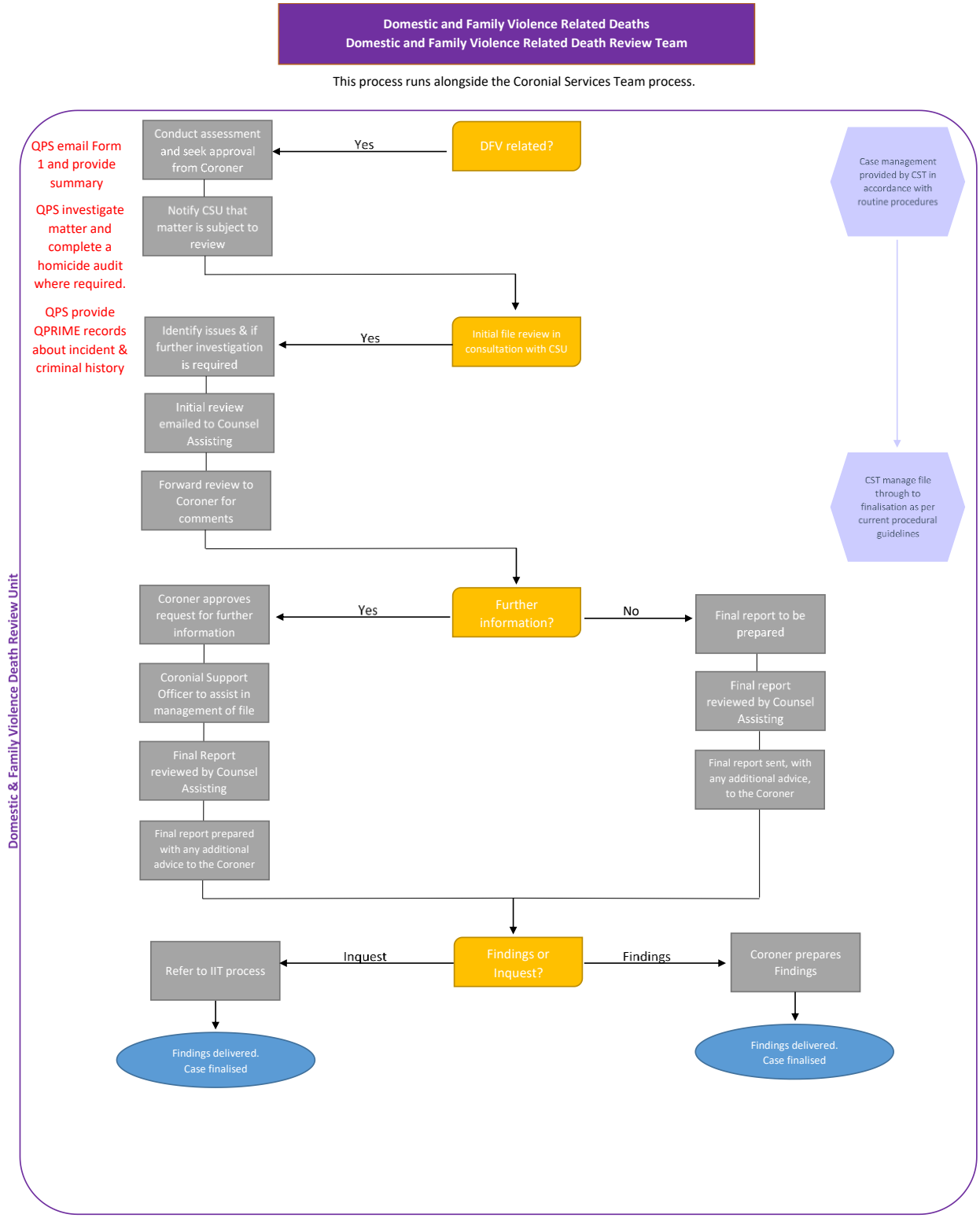
In Queensland, the triaging is undertaken by the Registrar for Form 1A's and the CS Team in consultation with the Manager IIT for Form 1's. Cases are then allocated to the Coroners.

Victoria has a purpose built Coronial facility and is enjoying the benefits of colocation and efficiency from this approach, and NSW is in the process of building an equivalent centre.

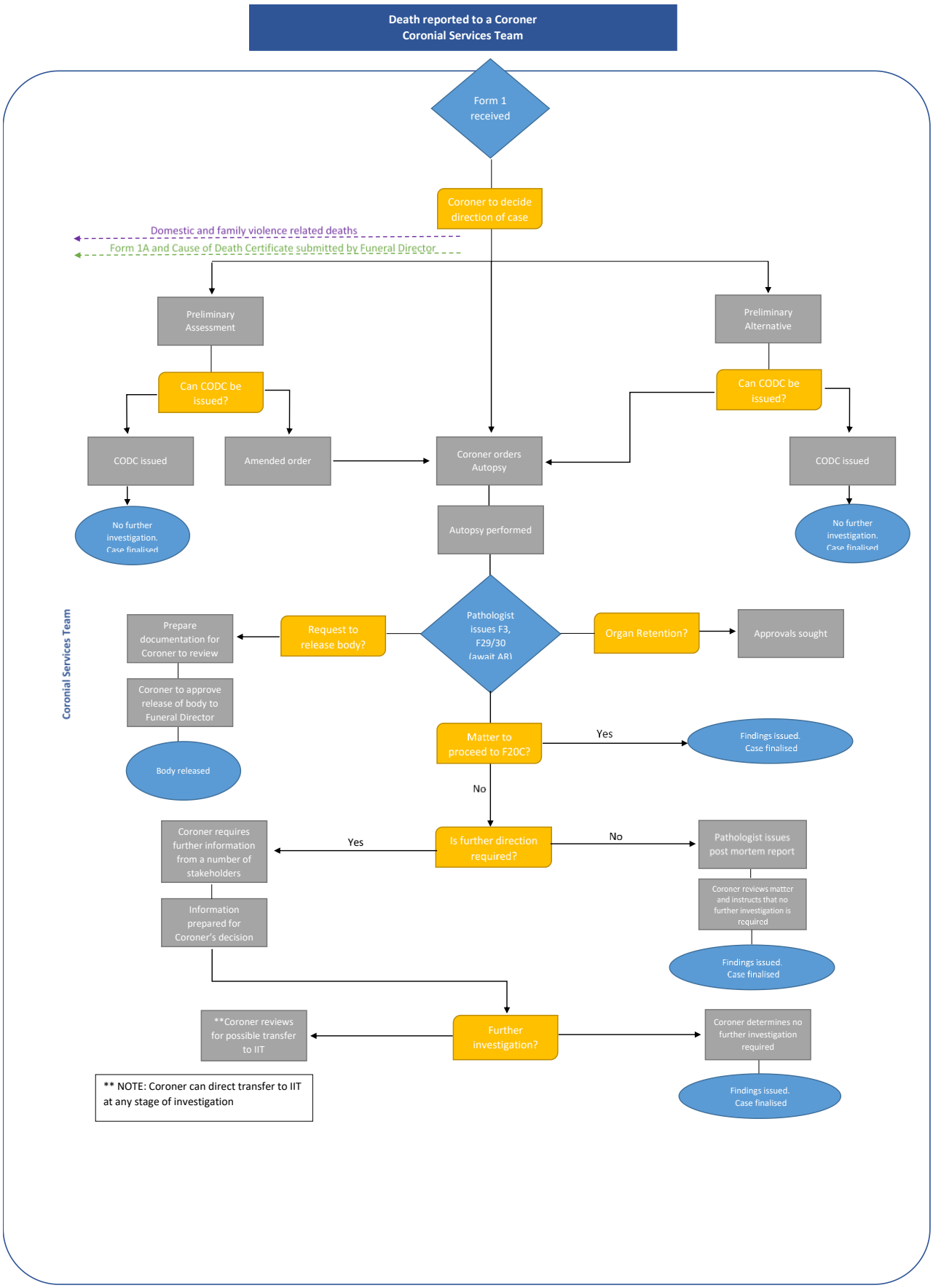
Queensland has a distributed model along the east coast.

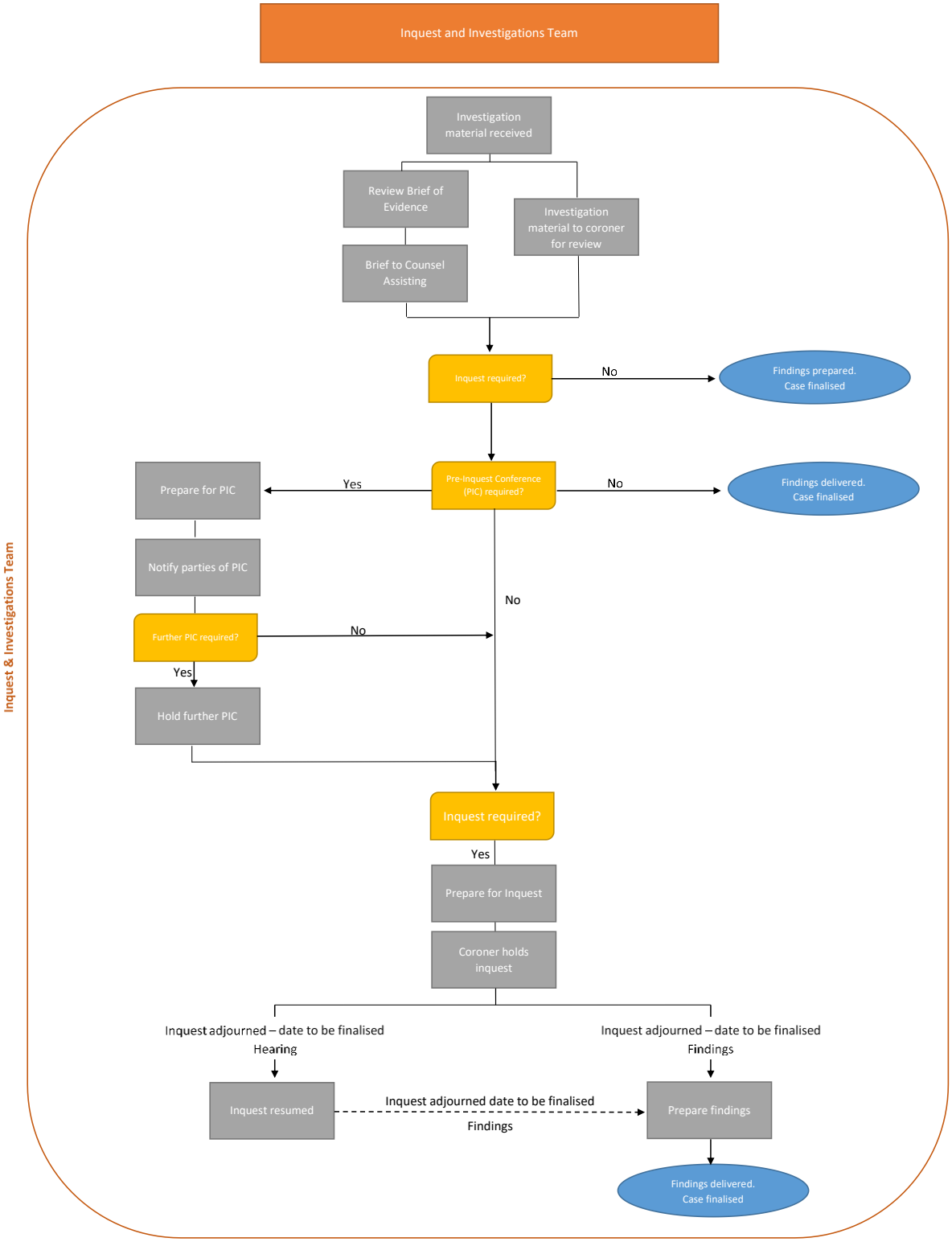
Sch4(4)(4)(1)

Appendix C – Process Maps [10]



10 *Source: CCoQ*





Form 1A and Cause of Death Certificate Submitted by Funeral Director