Impact Analysis Statement

Summary IAS

Details

Lead department	Department of Justice and Attorney-General
Name of the proposal	Expansion of the reportable deaths in care framework under the *Coroners Act 2003* to reinstate coverage for people in Queensland who receive funding under the Commonwealth Disability Services for Older Australians (DSOA) program.
Submission type	Summary IAS
Title of related legislative or regulatory instrument	Disability Services and Other Legislation (Senior Practitioner) Amendment Bill 2024
Date of issue	June 2024

What is the nature, size and scope of the problem? What are the objectives of government action?

Nature of the problem

The coronial system

The coroner is a magistrate who is responsible for investigating "reportable deaths" - these include deaths where the identity of the person is unknown, the death was violent or unnatural, such as accidents, falls or suicides, the death was suspicious, the cause of death is unknown, the death occurred in care, the death occurred in custody or as a result of police operations or the death was the unexpected outcome of health care being provided. The coroner will investigate the death to find out the identity of the deceased person, when and where they died, how they died and the medical cause of death. It is not the coroner's role to find that people are guilty of criminal offences or civilly liable.

As part of the investigation, the coroner will decide if an inquest is required. An inquest is a court hearing conducted by the coroner to gather more information about the cause and circumstances of a death. If an inquest is held the coroner may make recommendations aimed at preventing deaths in the future. The coroner will consult with the family about whether an inquest will be held. Very few coronial investigations proceed to inquest. However, the coroner may decide to hold an inquest if it is in the public interest. For example, an inquest may be ordered if there is significant doubt about the cause and circumstances of death or it may help to prevent future deaths or uncover systemic issues which affect public health and safety. The family of the deceased will be advised if an inquest is to be held. A notice will also be published on the Queensland Courts website at www.coronerscourt.qld.gov.au. Family members can ask the coroner to hold an inquest. This written request should outline why it is in the public interest for an inquest to be held. The coroner must make a decision (and provide reasons) within six months of receiving the request, or a longer period the coroner considers necessary to enable the coroner to obtain relevant information for making the decision.

Once the coronial investigation is complete, the coroner will, if possible, make findings about the identity of the deceased; when, where and how they died; and what caused them to die. If an inquest is held the coroner may also make recommendations aimed at preventing similar deaths from occurring in future. The findings will be provided to the family. If an inquest is held the findings will also be published on the Queensland Courts website at www.coronerscourt.qld.gov.au. If the coroner makes recommendations, they will be sent to the relevant entity.

Deaths in care

The *Coroners Act 2003* (Coroners Act) makes the deaths of specific types of vulnerable people in the community (namely children in care, involuntary mental health patients and people with disability who either resided in certain types of supported accommodation and/or were receiving high level support as a participant under the National Disability Insurance Scheme (the NDIS)) reportable to a coroner, whatever their cause of death may be wherever the person died. The significance of a death being reported as a death in care lies in the requirement under s.27(1)(a)(ii) of the Coroners Act for an inquest to be held when the circumstances of the death raise issues about the deceased person's care.

Not every death of a person with a disability is reportable under the Coroners Act. This category of reportable death applies only to the death of a person with a disability who was the resident of certain types of supported accommodation services (Coroners Act, section 9(1)(a)) and/or who was receiving high level support under an NDIS participant plan (Coroners Act, section 9(1)(e)).

Anyone who becomes aware of a death in care must report it to the coroner or the police, provided they do not reasonably believe that this has already occurred (Coroners Act, section 7). In addition, registered NDIS providers must report the death of certain NDIS participants to the coroner or police, regardless of whether someone else has reported or may report the death. Persons may also voluntarily report a death to the coroner or police if they believe it may be a reportable death in care.

Separate to the coronial framework, registered NDIS providers must also report the death of a person with disability to the NDIS Quality and Safeguarding Commission (*National Disability Insurance Scheme Act 2013*, section 73Z and *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018*, Part 3).

The problem

Section 8 of the Coroners Act defines what currently constitutes a 'reportable death'. A 'reportable death' includes a 'death in care', defined by section 9 of the Coroners Act. Currently, the definition of 'death in care' includes people who at the time of death, were a National Disability Insurance Scheme (NDIS) participant, not living in a private dwelling or an aged care facility and were receiving or entitled to receive, under the person's NDIS plan:

- services or supports paid for wholly or partly from funding under the NDIS; and
- provided by a registered NDIS provider that is registered under the NDIS Act, section 73E to provide a relevant class of supports; and
- within the relevant class of supports.

At the time that Queensland (and other states) transitioned to the NDIS, various people with disability were in receipt of funding from state-funded disability services, but for various reasons were not eligible for the NDIS. To ensure that persons with disability were not disadvantaged by the establishment of the NDIS, State and Commonwealth governments provided for continuity of supports for this cohort of people. Some members of this cohort were grandfathered to a State continuity of supports (COS) program - funded by the department in which disability services are provided (currently, the Department of Child Safety, Seniors and Disability Services).

Other members of this cohort were 'grandfathered' to new funding under the Commonwealth Government's Continuity of Supports Program. The Commonwealth DSOA program replaced the Continuity of Supports Program on 1 July 2021[1] (persons who receive disability services under the DSOA program are referred to as "DSOA clients").

[1] The Commonwealth Government administers the DSOA program under the authority granted by the *Financial Framework (Supplementary Powers) Regulations 1997*, Schedule 1AB Part 4 Item 470.

To be eligible for the program the person must have been an existing client of state-administered specialist disability services at the time the NDIS commenced in their region and either:

- 65 years and over when the NDIS commenced in their region and assessed as ineligible for NDIS; or
- an Aboriginal or Torres Strait Islander person aged 50 to 64 years when the NDIS commenced in their region and assessed as ineligible for the NDIS.

The death of a person with disability who was grandfathered to the State COS program is a reportable death in care under the Coroners Act (section 9(1)(a)(ii)). However, the death of a person with disability who was grandfathered to the Commonwealth COS program (now the DSOA program) is not a reportable death in care (unless the death is reportable for another reason under the Coroners Act). Prior to the establishment of the NDIS, DSOA clients were covered by the reportable deaths in care framework.

This means that DSOA clients have reduced safeguards compared to safeguards that applied to them prior to the establishment of the NDIS. Therefore, there is currently an inconsistent policy approach across the reportable deaths framework under the Coroners Act, whereby a vulnerable cohort of people (DSOA clients) in care are excluded, simply by virtue of the arrangements at the time that Queensland transitioned to the NDIS.

Size and scope of the problem

There is a small cohort of individuals currently receiving disability services funded by the DSOA Program in Queensland. These clients live in a range of accommodation settings, including: hostels, private accommodation, supported independent living and private residential aged care.

As acknowledged by the DSOA Program Manual, many DSOA clients exit the program each year for a variety of reasons, such as transitioning to the aged care system. Therefore, it is anticipated that the cohort of individuals receiving funding under the DSOA program in Queensland will continue to reduce each year. Notably, the DSOA program is also a closed program, meaning that it is not available to new clients.

Objectives of government action

The objective of government action is to reinstate coverage of the reportable deaths in care framework for persons with disability who receive disability services under the DSOA program, restoring them to the same safeguards that applied to them prior to the commencement of the NDIS.

What options were considered?

Given the issues identified above, two broad options were considered:

- **Option 1 – Status quo (no action)**: As the status quo option, option 1 represents the base case against which option 2 is compared. As this option entails no further government action, it has zero costs and produces zero additional benefits. It also does not address the identified objectives of government action.

- **Option 2 – Legislated response**: This involves amendment of the Coroners Act to achieve the objectives of government action. The proposal will amend the Coroners Act definition of 'death in care' by inserting new subsection 9(1)(f), to include a person who was receiving services or supports under the program administered by the Commonwealth and known as the DSOA Program who are not living in aged care or private dwellings.

What are the impacts?

- **Option 1 – Status quo (no action):**

Under this option, the existing reportable deaths framework in the Coroners Act would be maintained. This would entail no legislative amendments being made to the Coroners Act. Consequently, there would be no requirement for the death of a person with disability receiving disability services under the DSOA program to be reported to the police or coroner under the Coroners Act (unless required to be reported for another reason).

This would result in a continuation of the status quo under the current legislative framework for reportable deaths, whereby a vulnerable cohort of people (DSOA clients) are not afforded the safeguards and protections of the coronial system.

- **Option 2 – Legislated response:**

Impacts on Coroners Court of Queensland

Based on data within the 2024 Report on Government Services (RoGS), published by the Australian Government Productivity Commission, the average cost of a coronial case in Queensland is approximately $2,941.65.[2]

This figure was calculated by reference to data contained within Table 7A.2 and Table 7A.12 of the RoGS, detailing the total of reportable deaths in Queensland and the total expenditure for the Queensland Coroners Court, i.e., for 2022-23 6,530 deaths were reported to the Coroners Court of Queensland (CCQ) , and in the same year, real recurrent expenditure in Queensland (including autopsy and forensic science) was $19,209,000. The cost of a coronial investigation varies greatly depending on a range of factors, including the complexity of a matter, and whether the matter proceeds to inquest. Only a proportion of matters proceed to inquest. The CCQ Annual Report indicates that in 2022-23, 24 deaths were investigated at inquest.

It is estimated that the reinstatement of DSOA clients to the reportable deaths in care framework will lead to an additional 6-14 reportable deaths per year.

However, this volume may be further reduced noting that:

- the deaths of DSOA clients who live in aged care or private dwellings will not be required to be reported;
- DSOA clients are routinely exiting the program for reasons other than death e.g., transitioning to the aged care system; and
- the DSOA program is a closed program, meaning that it is not available to new clients and the cohort will continue to reduce in size over time.

Further, not all reportable deaths in care will require an inquest and many of these reportable deaths may arise from natural causes (particularly given that DSOA clients are all over 65 years of age, or over 50 years of age for Aboriginal or Torres Strait Islander persons).

On the assumption that there will be an additional 10 reportable deaths, there may be an additional cost of approximately $29,000 to the Coroners Court Queensland (based on an average cost of $2,941 per reportable death). However, this figure does not take into account the complexity of a matter and whether the matter proceeds to inquest. On balance, it is reasonable to assume that few, if any, matters within the additional category will proceed to inquest, and for those that do proceed to inquest, they may have been captured by another category of reportable death in any event so that the financial impact of the amendment is neutralised.

[2] https://www.pc.gov.au/ongoing/report-on-government-services/2024

Impacts on Disability Service Providers

Option 2 is not anticipated to involve significant additional impacts for disability service providers. This is because all providers who would be brought into scope of the new reportable deaths framework under this proposal are required, under the terms and conditions of the DSOA program manual, to be registered NDIS providers, and it is a condition of their registration that they comply with the NDIS Quality and Safeguards Rules about notifying the NDIS Quality and Safeguarding Commission of reportable incidents. [3]. As stipulated by the DSOA Program Manual, DSOA service coordinators are responsible for "reporting and responding to incidents relating to the quality or safety of DSOA services, including dealing with critical/serious incidents (emergencies, deaths, assaults or abuse, serious unexplained injuries and incidents that impact the safety of clients)."

Consequently, given impacted disability service providers are already required to report client deaths under their existing obligations as registered NDIS providers, it is not anticipated that an additional reporting obligation to the coroner would have significant impacts. The impact of the proposal would simply require service providers to duplicate an existing NDIS report and send this via a secondary channel i.e., the coroner.

Who was consulted?

DJAG consulted closely with the Coroners Court of Queensland and the Commonwealth Department of Health and Aged Care (DHAC).

What is the recommended option and why?

Ultimately, Option 2 is the recommended option. This is because the proposed legislative amendment to the Coroners Act will reinstate coverage of the reportable deaths in care framework for DSOA clients, restoring them to the same safeguards that applied to them prior to the commencement of the NDIS.

Consistent with the objects of the Coroners Act, Option 2 will ensure that any deaths of DSOA clients in care throughout Queensland are appropriately reported and investigated, to prevent them from happening similarly in the future.

https://www.ndiscommission.gov.au/providers/registered-ndis-providers/reportable-incidents-0

Impact assessment

	First full year	First 10 years**
Direct costs – *Compliance costs**	Not assessed	Not assessed
Direct costs – *Government costs*	$8,825 to - $29,410 (assuming a range of 3 to 10 additional reportable deaths per year)	$88,250 to - $294,100 (assuming a range of 3 to 10 additional reportable deaths per year)

Signed

Jasmina Joldić PSM
Director-General
Date: 03/06/2024

Yvette D'Ath MP
Attorney-General and Minister for Justice
Minister for the Prevention of
Domestic and Family Violence
Date: 05/06/2024