Parliamentary Committees

Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015

Report No. 5, 55th Parliament

Communities, Disability Services and Domestic and Family Violence Prevention Committee

October 2015

Parliamentary Committees

Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015

Report No. 5, 55th Parliament

Communities, Disability Services and Domestic and Family Violence Prevention Committee

October 2015

Communities, Disability Services and Domestic and Family Violence Prevention Committee

Chair	Ms Leanne Donaldson MP, Member for Bundaberg
Deputy Chair	Mr Mark McArdle MP, Member for Caloundra
Members	Miss Nikki Boyd MP, Member for Pine Rivers
	Ms Ann Leahy MP, Member for Warrego
	Mr Matt McEachan MP, Member for Redlands
	Mr Rob Pyne MP, Member for Cairns
Committee Staff	Mr Karl Holden, Research Director
	Ms Lucy Manderson, Principal Research Officer
	Ms Carla Campillo, Executive Assistant
Technical Scrutiny Secretariat	Ms Renée Easten, Research Director
	Mr Michael Gorringe, Principal Research Officer
	Ms Kellie Moule, Principal Research Officer
	Ms Tamara Vitale, Executive Assistant
Contact Details	Communities, Disability Services and Domestic and Family Violence Prevention Committee Parliament House George Street Brisbane Qld 4000
Telephone	+61 7 3553 6601
Fax	+67 7 3553 6639
Email	CDSDFVPC@parliament.qld.gov.au
Web	www.parliament.qld.gov.au/CDSDFVPC

Acknowledgements

The Committee acknowledges the assistance provided by the Department of Justice and Attorney-General and Department of Communities, Child Safety and Disability Services.

Contents

Abbreviations

AASW	Australian Association of Social Workers – Queensland Branch
ATSILS	Aboriginal and Torres Strait Islander Legal Service (Qld) Ltd
Attorney-General	Attorney-General and Minister for Justice and Minister for Training and Skills
BAQ	Bar Association of Queensland
Bill	Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015
Board	Domestic and Family Violence Death Review and Advisory Board
Committee	Communities, Disability Services and Domestic and Family Violence Prevention Committee
Coroners Act	*Coroners Act 2003*
Department	Department of Justice and Attorney-General
DFVDR Unit	Domestic and Family Violence Death Review Unit
DFVP Act	*Domestic and Family Violence Protection Act 2012*
IPPs	Information Privacy Principles
QCDFVR	Queensland Centre for Domestic and Family Violence Research
QLS	Queensland Law Society
RTI Act	*Right to Information Act 2009*
Taskforce	*Special Taskforce on Domestic and Family Violence in Queensland*
Taskforce Report	*Not now, not ever: putting an end to domestic and family violence in Queensland*
WLS	Women's Legal Service Inc. Queensland
WWILD-SVP	Women with Intellectual and Learning Disabilities – Sexual Violence Prevention Association

Chair's foreword

This Report presents a summary of the Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015.

The Committee's task was to consider the policy outcomes to be achieved by the legislation, as well as the application of fundamental legislative principles – that is, to consider whether the Bill had sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

On behalf of the Committee, I thank those individuals and organisations who lodged written submissions on the Bill and participated in the public hearing. I also thank the Committee's Secretariat, the Technical Scrutiny Secretariat, the Department of Justice and Attorney-General and the Department of Communities, Child Safety and Disability Services.

I commend this Report to the House.

Ms Leanne Donaldson MP

Chair

Recommendations

Recommendation 1 **10**

The Committee recommends that the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015 be passed.

Recommendation 2 **18**

The Committee recommends that the Department of Justice and Attorney-General and Department of Communities, Child Safety and Disability Services use the review of the *Domestic and Family Violence Protection Act 2012* to draw on the knowledge and expertise of stakeholders to ensure that definitions are sufficiently clear and inclusive to capture the broad range of relationship contexts and circumstances in which domestic and family violence can occur.

Recommendation 3 **25**

The Committee recommends that the Department of Justice and Attorney-General, in conjunction with the Domestic and Family Violence Death Review and Advisory Board (Board), takes steps to ensure that the distinct, but complementary, functions of the Domestic and Family Violence Death Review Unit (DFVDR Unit) and the Board are clearly understood by the Coroner, DFVDR Unit and Board, as well as by the courts, service providers, law enforcement agencies and stakeholders who work to prevent domestic and family violence.

Recommendation 4 **41**

The Committee recommends that the Attorney-General inform the Legislative Assembly during the second reading debate about how the Department of Justice and Attorney-General and the Domestic and Family Violence Death Review and Advisory Board will ensure that the Board's research and reports are made widely available and in an accessible format.

1. Introduction

1.1 Role of the Committee

The Communities, Disability Services and Domestic and Family Violence Prevention Committee (Committee) is a portfolio committee of the Legislative Assembly established on 27 March 2015 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The Committee's primary areas of responsibility include:

- Communities, Women, Youth, Child Safety and Multicultural Affairs
- Domestic and Family Violence Prevention, and
- Disability Services and Seniors.[2]

Section 93(1) of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for examining each Bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles, and
- for subordinate legislation – its lawfulness.

1.2 Committee process

The Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015 (the Bill) was introduced into the House on 15 September 2015 by the Hon Yvette D'Ath MP, Attorney-General and Minister for Justice and Minister for Training and Skills (Attorney-General). The Bill was referred to the Committee for examination. The Committee was required to report to the Legislative Assembly by 9 October 2015.

On 16 September 2015, the Committee wrote to the Department of Justice and Attorney-General (the Department) seeking advice on the Bill. Officers from the Department and the Department of Communities, Child Safety and Disability Services briefed the Committee on the Bill on 18 September 2015.

On 18 September 2015, the Committee wrote to the Department to confirm the Questions Taken on Notice at the public briefing and to seek further information. The Department responded on 22 September 2015.

The Committee invited submissions on its website and by notice to subscribers to updates on the work of the Committee. The Committee also directly invited submissions from 286 stakeholder organisations. The Committee received twelve submissions (see **Appendix A**). On 29 September 2015, the Department responded to the issues raised in submissions.

The Committee held a public hearing on the Bill on 30 September 2015 to hear from invited witnesses (see **Appendix B**).

1 *Parliament of Queensland Act 2001*, section 88 and Standing Order 194, Standing Rules and Orders of the Legislative Assembly, Standing Order 194

2 Standing Rules and Orders of the Legislative Assembly, Schedule 6

The transcript of the public briefing on 18 September 2015, correspondence from the Department, the transcript of the public hearing on 30 September 2015 and the submissions received and accepted by the Committee are published on the Committee's website: http://www.parliament.qld.gov.au/work-of-committees/committees/CDSDFVPC/inquiries/current-inquiries/04CoronersBill.

1.3 Policy objectives of the Bill

The objectives of the Bill are to implement the recommendation in the *Special Taskforce on Domestic and Family Violence in Queensland's* (Taskforce) report, *Not Now, Not Ever: Putting an End to Domestic Violence in Queensland* (Taskforce Report) to immediately establish an independent Domestic and Family Violence Death Review Board, consisting of multi-disciplinary experts to:

- identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures
- report to the oversight body every six months on these findings and recommendations, and
- be supported by and draw upon the information and resources of the Domestic and Family Violence Death Review Unit (Taskforce Recommendation 8).[3]

The Bill amends the *Coroners Act 2003* (Coroners Act) to establish the Death and Family Violence Death Review and Advisory Board (Board). The Bill:

- provides that the Board's membership includes government and non-government entity representatives with specialist experience, qualifications and expertise
- confers a right on the Board to information necessary to perform its functions
- empowers the Board to make recommendations for government and non-government entities
- enables the Board to monitor the implementation of the recommendations, and
- requires the Board to report to the Minister annually, and otherwise at the Board's discretion.[4]

1.4 Consultation on the Bill

The Explanatory Notes refer to the extensive consultation undertaken by the Taskforce in preparing its report, including meetings with 367 different groups of victims, service providers and community leaders. The Explanatory Notes state that this consultation informed the Taskforce recommendations implemented by the Bill.[5]

The Department has consulted with the State Coroner and officers from the Office of the State Coroner in preparation of the Bill.[6]

Since the introduction of the Bill, the Department has consulted the heads of court jurisdictions, the Queensland Law Society, Bar Association of Queensland, other legal stakeholders, and key domestic and family violence organisations. The Department also intends to consult key legal and domestic and family

3 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015, *Explanatory Notes* (Explanatory Notes), p.1
4 Explanatory Notes, p.2
5 Explanatory Notes, p.5
6 Explanatory Notes, p.5

violence support services and stakeholders prior to debate on the Bill to identify and resolve any operational and technical issues.[7]

The Explanatory Notes state that the "Parliamentary Committee consultation process will provide a forum for stakeholders and concerned community members to provide their views on establishing the Board".[8]

Committee comment

The Committee notes that the proposed reforms in the Bill have been 'fast tracked' in light of recent tragic domestic and family violence incidents, including deaths in South East Queensland and, therefore, the scope for consultation on the Bill prior to its introduction has been limited.

However, the Committee reminds the Department that the Committee's consultation process when examining a Bill, including inviting submissions from stakeholders, is not a substitute for government consultation in the policy development stage of drafting a Bill.

The Committee acknowledges the consultation the Department has undertaken since the Bill's introduction, and its intention to undertake further consultation with service providers and stakeholders prior to debate on the Bill.

The Committee notes the Queensland Law Society's (QLS) submission that:

> *... we have not really had the opportunity to give it the normal full consideration—and we fully understand that; this legislation is lives-in-the-balance type legislation and we know it needs to go through... as it stands and, given the time we have had to look at it, other than the issues we have raised, we think it is very workable and we hope it will have the desired effect.*[9]

1.5 Related Bill

The Committee examined the Bill, in parallel with the Criminal Law (Domestic Violence) Amendment Bill 2015, which also implements recommendations made by the Taskforce. The Committee's report on this Bill can be found on the Committee's website: http://www.parliament.qld.gov.au/work-of-committees/committees/CDSDFVPC/inquiries/current-inquiries/05CriminalLawDVBill.

1.6 Should the Bill be passed?

Standing Order 132(1) requires the Committee to determine whether or not to recommend the Bill be passed. After examination of the Bill, including its policy objectives, and consideration of the information provided by the Department and from submitters, the Committee recommends that this Bill be passed.

Recommendation 1

The Committee recommends that the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015 be passed.

7 Department of Justice and Attorney-General (Department), *Briefing Note*, 22 September 2015, p.10

8 Explanatory Notes, p.5

9 Mr Shane Budden, Manager, Advocacy and Policy, Queensland Law Society, *Public Hearing Transcript*, 30 September 2015, p.5

2. Policy background and context

2.1 Introduction

In Queensland, nearly half of all homicides over the past eight years have been linked to domestic and family violence. From 1 January 2006 to 31 December 2013, 180 deaths occurred in Queensland in the context of domestic and family violence. The number of deaths occurring in the context of domestic and family violence is increasing.[10]

In 2013-14, there were 66,016 occurrences of domestic and family violence reported to the Queensland Police Service. This equates to over 180 incidents of domestic and family violence being reported every day across the State. Seventeen homicides relating to domestic and family violence occurred in Queensland in 2012-13.[11]

In Australia, on average, two women die each week at the hands of a violent partner, husband or father.[12]

Both the Queensland and Commonwealth Governments have committed to tackle this scourge on our communities. The Queensland Government has committed $28.2 million funding in 2015-16 to preventing domestic and family violence,[13] while the Commonwealth has recently announced a $100 million package of measures to provide a safety net for women and children at high risk of experiencing violence nationally.[14]

2.2 Special Taskforce on Domestic and Family Violence in Queensland

The *Special Taskforce on Domestic and Family Violence in Queensland*, chaired by the Hon. Quentin Bryce AD CVO, was established on 10 September 2014 (Taskforce).

The Taskforce's role was to define the domestic and family violence landscape in Queensland, and make recommendations to inform the development of a long-term vision and strategy for Government and the community, to rid our state of domestic violence.[15]

On 28 February 2015, the Taskforce report *Not now, not ever: putting an end to domestic and family violence in Queensland* was released (Taskforce Report). The Taskforce Report contains 140 recommendations which are comprehensive and cover all aspects of the way government, police, lawyers and the courts deal with domestic and family violence. The recommendations provide direction as to how and where improvements can be made with the ultimate aim of reducing and preventing domestic and family violence.[16]

10 Explanatory Notes, p.2
11 Special Taskforce on Domestic and Family Violence in Queensland Report, *Not now, not ever: putting an end to domestic and family violence in Queensland* (Taskforce Report), February 2015, p.6
12 Attorney-General, *Hansard*, 15 September 2015, p.1739
13 Department of Communities, Child Safety and Disability Services, *Queensland Budget 2015-16 - Service Delivery Statement*, p.8
14 Australian Government Joint Media Release, *Women's Safety Package to Stop the Violence,* accessed on 24 September 2015 from: http://www.malcolmturnbull.com.au/media/release-womens-safety-package-to-stoptheviolence
15 Taskforce Report, February 2015, p.6
16 Department, *Briefing Note*, 22 September 2015, p.1

The Queensland Government released its response to the Taskforce Recommendations on 18 August 2015, and has accepted all 121 recommendations directed at government. The Government will spend $31.3 million over four years on a range of initiatives aimed at tackling domestic and family violence.[17]

The Department is leading the implementation of over 30 Taskforce Recommendations aimed at reforming the law and justice system's response to domestic and family violence.[18]

2.3 Recent public domestic and family violence incidents

Following recent public domestic and family violence incidents, including deaths in South East Queensland, the Government has committed to fast track reforms to increase perpetrator accountability and enhance community protections against domestic violence.[19] These fast track reforms include putting in place the legislative framework for the establishment of the Board.

2.4 Recommendation to establish a Queensland Domestic and Family Violence Death Review Board

The Taskforce was critical of the lack of a comprehensive death review structure to review the system as a whole, and identify failures or gaps that may contribute to domestic and family violence. The Taskforce noted that not all domestic and family violence related deaths are reviewed through the inquest process, because not all deaths subject to the Coroner's jurisdiction will result in an inquest.[20]

The Taskforce suggested that a Queensland Domestic and Family Violence Death Review Board supported by the Domestic and Family Violence Death Review Unit (the DFVDR Unit) could, in a similar way to the Queensland Child Death Case Review Committee, review the circumstances that contributed to the death of any person that died as a result of domestic and family violence. The Taskforce considered that such a systemic review would be able to identify where services – both generic and specialist – worked well or failed, and make recommendations for tangible improvements to systems, policies and procedures, and strategies, to prevent further domestic and family violence related deaths.[21]

Accordingly, the Taskforce recommended the immediate establishment of an independent Domestic and Family Violence Death Review Board, consisting of multi-disciplinary experts to:

- identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures
- report to the oversight body every six months on these findings and recommendations, and
- be supported by and draw upon the information and resources of the DFVDR Unit (Taskforce Recommendation 8).[22]

The Taskforce also made the following recommendations which relate to the Board:

- the Government immediately considers an appropriate resourcing model for the DFVDR Unit in the Office of the State Coroner to ensure it can best perform its functions to enable policy makers

17 Attorney-General, *Hansard*, 15 September 2015, p.1739
18 Department, *Briefing Note*, 22 September 2015, p.1
19 Criminal Law (Domestic Violence) Amendment Bill 2015, *Explanatory Notes*, p.1
20 Explanatory Notes, p.2
21 Taskforce Report, February 2015, p.114
22 Explanatory Notes, p.1

to better understand and prevent domestic and family violence (Taskforce Recommendation 6), and

- protocols be developed with the DFVDR Unit to ensure that government departments with relevant policy development responsibilities have access to the research and resources available from the DFVDR Unit (Taskforce Recommendation 7).[23]

The important relationship between the State Coroner, the DFVDR Unit and the proposed Board is discussed at Section 6 of this report.

23 Department, *Briefing Note*, 22 September 2015, p.2

3. Establishment of the Board

Clauses 4 and 5 of the Bill (new sections 91A and 91C of the Coroners Act) provide for the establishment of the Domestic and Family Violence Death Review and Advisory Board (the Board).

New section 91A provides that the Board is to:

- identify preventative measures to reduce the likelihood of *domestic and family violence deaths* in Queensland
- increase recognition of the impact of, and circumstances surrounding, domestic and family violence and gain a greater understanding of the context in which *domestic and family violence deaths* occur, and
- make recommendations to the Minister for implementation by government entities and non-government entities to prevent or reduce the likelihood of *domestic and family violence deaths*.

The Attorney-General, in her explanatory speech, stated that:

> *Establishing the Domestic and Family Violence Death Review and Advisory Board under the Coroners Act will ensure that the board's activities complement the existing coronial processes and the board can draw on the research and data capabilities of the Office of the State Coroner.*[24]

3.1 Submissions

The majority of submissions strongly supported the establishment of the Board.[25] UnitingCare Community stated that "A legislative basis for the Board will provide it with authority to perform its functions and strengthen the potential for timely and responsive policy and program development".[26] Women's Legal Service Inc. Queensland (WLS) described the establishment of the Board as "… an important initiative that, in time, will result in the identification of gaps and improvements in service delivery and systems' responses to victims and their families".[27]

BoysTown stated that "Informing all systems and services of gaps, really identifying missed opportunities to protect vulnerable people, can only improve future safety of Queenslanders".[28]

However, WLS recommended that the Coroners Act be amended to clearly articulate that the establishment of the Board is about identifying systemic gaps and achieving systemic reform rather than laying blame at individuals. WLS suggested that this approach may help the Board achieve the "buy-in from the government and non-government sector that this Board will rely on for success".[29]

24 Attorney-General, *Hansard*, 15 September 2015, p.1741

25 Submission no.1, Protect All Children Today Inc. (PACT), Submission no.2, UnitingCare Community, Submission no.5, Australian Association of Social Workers – Queensland Branch (AASW), Submission no.7, Aboriginal and Torres Strait Islander Legal Services (Qld) Ltd (ATSILS), Submission no.9, Bar Association of Queensland and Submission no.12, BoysTown.

26 Submission no.2, UnitingCare Community, p.2

27 Submission no.8, Women's Legal Service Inc. Queensland (WLS), p.1

28 Submission no.12, BoysTown, p.1

29 Submission no.8, WLS, p.2

3.2 Department's response

The Department stated that the current wording of new section 91A reflects the Board's intended purpose of identifying common systemic failures, gaps or issues for purposes of system improvement and the prevention and reduction of domestic and family violence deaths. In addition, the Department advised:

> *Section 91E further makes clear that, in reviewing a domestic and family violence death, the focus is on the events leading up to the death, the interaction with and effectiveness and availability of the services and any failings in systems or services that may have contributed to, or failed to prevent the death.*[30]

Committee comment

The Committee notes the broad stakeholder support for the establishment of the Board, as a critical learning and improvement mechanism to enhance the system response to domestic and family violence.

The Committee acknowledges WLS' suggestion that statutory clarification of the Board's focus on system analysis and improvement, rather than individual liability, may encourage more active stakeholder cooperation and participation.

However, the Committee considers that the Bill's provisions adequately communicate the Board's intended purpose, and that its focus and key objectives can be affirmed through engagement with stakeholders.

30 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.2

4. What is a domestic and family violence related death?

The scope of the Board's work relates to *domestic and family violence deaths*. The Bill defines the term *domestic and family violence related death* as a death of a person (the deceased person):

- caused by another person (the second person) if:
    - the deceased person was or had been in a *relevant relationship* with the second person that involved *domestic and family violence*
    - at the time of death, the deceased person was in a *relevant relationship* with a person who was or had been in a *relevant relationship* with the second person that involved *domestic and family violence*
    - at the time of death, the second person mistakenly believed the deceased person was in a *relevant relationship* with a person who was or had been in a *relevant relationship* with the second person that involved *domestic and family violence*
    - at the time of death, the deceased person was a witness to or present at, or attempted to intervene in, *domestic and family violence* between the second person and a person who was or had been in a *relevant relationship* with the second person
    - at the time of death, the deceased person was a witness to or present at, or attempted to intervene in violence between the second person and a person who the second person mistakenly believed was in a *relevant relationship* with the second person that involved *domestic and family violence*, or
- by suicide or suspected suicide if the person was or had been in a *relevant relationship* with another person that involved *domestic and family violence*.

A *relevant relationship* is defined at section 13 of the *Domestic and Family Violence Protection Act 2012* (DFVP Act) as:

- an intimate personal relationship, including a spousal relationship, engagement or couple relationship
- a family relationship – which acknowledges the wider concept of family and relatives for Aboriginal people, Torres Strait Islander people, communities with non-English speaking backgrounds and people with particular religious beliefs, or
- an informal care relationship – a non-commercial arrangement where one person is dependent on the other for help in an activity of daily living.

The term *domestic and family violence* is defined at section 8 of the DFVP Act, and includes behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a *relevant relationship* that:

- is physically or sexually abusive
- is emotionally or psychologically abusive
- is economically abusive
- is threatening
- is coercive, or

- in any other way controls or dominates the second person and causes the second person to fear for their safety or wellbeing or that of someone else.

The Department acknowledged that the definition of *domestic and family violence death* is very broad and advised that it means:

> *… the death of a person caused by another person who was either currently or formerly in a family relationship with the deceased person or that the person who caused the death thought that they were in a current or former relationship. Then there is the element where the deceased person is a bystander in a domestic and family violence death where they were a witness to the death or they tried to help. Lastly, a domestic and family violence death means the death of a person by suicide if the person was, or had been, in a relationship with another person that involved domestic and family violence.*[31]

4.1 Submissions

WLS considered that the definition of *domestic and family violence death* does not cover the situation of a child being killed as an act of domestic violence. WLS stated that "Children are also victims of domestic violence and the motivation for killing the child can be to punish the mother or an act of revenge against the mother (who was or is currently in a relationship with the perpetrator)". Accordingly, WLS recommended that the definition of *domestic and family violence death* be amended to specifically cover children who are killed in circumstances of domestic violence and murder/suicide.[32]

Ms Leona Berrie, Manager, Women with Intellectual and Learning Disabilities - Sexual Violence Prevention Association (WWILD-SVP), recommended that the Committee consider amendments to the DFVP Act to ensure paid care relationships are included in the definition of *domestic and family violence*, and therefore, within the scope of the Board's reviews of any *domestic and family violence death*.[33]

Ms Berrie also highlighted the need to ensure consistency in definitions across the relevant legislation, noting some issues experienced in New South Wales in this regard.[34]

4.2 Department's response

In response to WLS's submission, the Department clarified that the term *domestic and family violence death* includes the death of a person caused by a person (the second person) if both people were in, or had been in a *relevant relationship* that involved domestic and family violence.[35]

The Department highlighted that the term *relevant relationship*, as defined by section 13 of the DFVP Act, includes a family relationship which is a relationship between two persons, if one of them is or was

31 Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department, *Public Briefing Transcript*, 18 September 2015, p.4

32 Submission no.8, WLS, p.4

33 Ms Leona Berrie, Manager, Women with Intellectual and Learning Disabilities - Sexual Violence Prevention Association (WWILD-SVP), *Public Briefing Transcript*, 30 September 2015, p.12

34 Ms Leona Berrie, Manager, WWILD-SVP, *Public Briefing Transcript*, 30 September 2015, p.15

35 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.10

connected to the person by blood or marriage (a *relative)*. The examples of a *relative* provided in the section include an individual's child and stepchild.[36]

The Department further advised:

> *It is the policy intent to ensure that the definition of a 'domestic and family violence death' is sufficiently broad to include the death of a child where there was a history of domestic violence between the child's parents or caregivers and also homicides and murder suicides which have occurred within the context of a family relationship as defined under the Domestic and Family Violence Protection Act 2012.*[37]
>
> *After receiving detailed further advice from the Office of the State Coroner in relation to the deaths that they investigate, and again reviewing the definition of a domestic and family violence death in the Bill, the Department is satisfied that there is no legislative gap in the definition as currently drafted. OQPC [Office of the Queensland Parliamentary Counsel] have been consulted further and agrees with this analysis.*[38]

In addition, the Department acknowledged the issue of whether the definition of *paid carers* should be included within the definition of a *relevant relationship.*

The Department of Communities, Child Safety and Disability Services advised it is currently undertaking "a wholesale review of the entire Domestic and Family Violence Protection Act".[39] This review will consider the definition of *domestic and family violence*, including whether it should cover *paid carers* and ensuring that consistent definitions are used across legislation dealing with domestic and family violence.

Committee comment

The Committee recommends that the Department and Department of Communities, Child Safety and Disability Services use the review of the DFVP Act to draw on the knowledge and expertise of stakeholders to ensure that definitions are sufficiently clear and inclusively capture the broad range of relationship contexts and circumstances in which domestic and family violence can occur.

Recommendation 2

The Committee recommends that the Department of Justice and Attorney-General and Department of Communities, Child Safety and Disability Services use the review of the *Domestic and Family Violence Protection Act 2012* to draw on the knowledge and expertise of stakeholders to ensure that definitions are sufficiently clear and inclusive to capture the broad range of relationship contexts and circumstances in which domestic and family violence can occur.

36 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.10
37 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.11
38 Department, *Correspondence*, 6 October 2015.
39 Ms Cathy Taylor, Deputy Director-General, Child, Family Community Services and Southern Regions, Department of Communities, Child Safety and Disability Services, *Public Hearing Transcript*, 30 September 2015, p.26

5. Functions and powers of the Board

Clause 5 (new section 91D) provides that the Board has the following functions:

- review *domestic and family violence deaths* in Queensland, including deaths that occur before the Board was established and deaths that are still being investigated by the Coroner under the Coroners Act
- analyse data and apply research to identify patterns, trends and risk factors relating to *domestic and family violence deaths* in Queensland
- carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of *domestic and family violence deaths*
- use data, research findings and expert reports to compile systemic reports into *domestic and family violence deaths*, including identifying key learnings and elements of good practice in the prevention of and reduction in the likelihood of *domestic and family violence deaths* in Queensland
- make recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government entities and non-government entities to prevent or reduce the likelihood of *domestic and family violence deaths* in Queensland, and
- monitor the implementation of those recommendations.

The Board may perform its functions in relation to the death of a person who dies outside of Queensland if it is a *reportable death*[40] mentioned in section 8(2)(b) of the Coroners Act.[41]

New section 91H provides that the Board must act independently and in the public interest when discharging its functions. New section 91G provides that the Board may do all things necessary or convenient to be done for or in connection with the performance of its functions.

New section 91D(3) provides that it is not a function of the Board to carry out an investigation of a death. The Department explained that the investigation of individual deaths will remain the responsibility of the Coroner (see Section 6 of this report).

The Department advised that:

> *The model for the board as reflected in the bill is based on … the operation of similar bodies, in particular, the Domestic Violence Death Review Team, which has been established under the New South Wales Coroners Act 2009. However, there are some important differences in the New South Wales model, including that the proposed board will consider not just closed coronial cases but also open cases that are still subject to coronial investigation.*[42]

40 *Reportable death* includes a death which happened outside Queensland, but the person's body is in Queensland, at the time of death; the person ordinarily lived in Queensland; or the person, at the time of death, was on a journey to or from somewhere in Queensland; or the death was caused by an event that happened in Queensland – *Coroners Act 2003*, section 8(2)(b)

41 Explanatory Notes, p.7

42 Mr David Mackie, Director-General, Department, *Public Briefing Transcript*, 18 September 2015, p.3

5.1 Review functions

In relation to the Board's review functions, new section 91E provides that the Board, when reviewing a *domestic and family violence death*, must among other things, consider the following matters:

- the events leading up to the death
- any interactions with, and the effectiveness of, any support or other services provided to the deceased person and the person who caused the death
- the general availability of services, and
- failures in the systems or services that may have contributed to, or failed to prevent, the death.

New section 91F provides that the Board may review a *domestic and family violence death* even though the death is or may be the subject of an investigation by a coroner. The Bill clarifies that the Board's review is independent of, and separate to, the coroner's investigation.

5.2 Submissions

The Bar Association of Queensland (BAQ) noted that the Bill's provisions are intended to ensure that the Board may review domestic and family violence deaths simultaneous to and independent of any investigation by a coroner. The BAQ considered that "The independence of this Board will provide key oversight of the review of domestic and family violence related deaths in Queensland".[43]

UnitingCare Community (UnitingCare) stated that systemic reviews of domestic and family violence deaths will require "… specialised knowledge of the complex array of services and interactions that characterise the domestic and family violence system and the different cultural and social understandings and expertise of domestic and family violence". UnitingCare suggested that the Board would need to develop protocols in relation to its review process, including structures for multidisciplinary input to allow the Board to call on relevant expertise.[44]

UnitingCare also suggested that the Board, when undertaking a systemic review, consider the impact of community action, including by members of the public, on domestic and family violence matters. This may then position the Board to make recommendations about community action and make practical suggestions. UnitingCare recognised that such recommendations would need to be handled sensitively to ensure that individuals do not feel they are being blamed.[45]

WLS stated that it supports the Bill's provision for the Board to consider deaths that may have occurred before its ultimate establishment.[46] However, WLS recommended the amendment of the functions of the Board in section 91E, as well as the purpose of the Board in section 91A, to clarify that the Board is able to consider legislative issues when conducting its reviews and recommending changes, if deemed necessary to reduce domestic and family violence deaths.[47]

43 Submission no.9, Bar Association of Queensland, p.2
44 Submission no.2, UnitingCare Community, p.2
45 Submission no.2, UnitingCare Community, p.2
46 Submission no.8, WLS, p.1
47 Submission no.8, WLS, p.3

WLS also expressed concern that State or Federal courts are not included in section 91D's provision for the Board to make recommendations to government and non-government entities. WLS submitted that "it is also very important that the role of the courts is included in any reviews undertaken by the Board".[48]

5.3 Department's response

In relation to WLS's submission that the Bill be amended to clearly state that the Board may consider legislative issues, the Department stated that section 91D(1)(e) provides that the Board can make recommendations to the Minister about improvements to legislation to prevent or reduce the likelihood of domestic and family violence deaths in Queensland. The Department also stated:

> *The list of matters set out in section 91E is not exhaustive and is not intended to limit the matters to which the Board may have regard. The Board may therefore consider legislative issues when reviewing deaths.*[49]

The Department stated, however, that it would not be appropriate for the Board to review decisions made by a court in individual cases, or specific actions taken by a court:

> *Under the doctrine of the separation of powers, the courts operate independently of the legislative and executive arms of government. Consistent with this principle, the only mechanism for review of decisions made by courts is through current appeal processes.*[50]

Committee comment

The Committee notes the Department's advice that the lists of functions provided in sections 91D and 91E are intended to provide the Board with a broad remit, including the ability to review legislation and make recommendations to the Minister for legislative reform.

The Committee agrees with stakeholder submissions that the degree to which the proposed Board will be able to fulfil these functions and translate new learnings into improved system outcomes will depend largely on the development of appropriate structures and protocols to facilitate constructive engagement of key agencies and the community.

48 Submission no.8, WLS, p.3
49 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.3
50 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.6

6. Respective roles of the State Coroner, Domestic and Family Violence Death Review Unit and the Domestic and Family Violence Death Review and Advisory Board

The Committee considers that the relationship between the State Coroner, the DFVDR Unit and the Board is a vital part of the reforms to prevent or reduce the risk of future domestic and family violence related deaths.

The QLS raised concerns that the Board and the DFVDR Unit appear to have similar roles and responsibilities which could lead to conflict. The QLS, therefore, supported amendments to clarify the roles and obligations of the Board and the DFVDR Unit.[51] The BAQ stated that clear demarcation between the Board and the Coroner's functions will also be critical.[52]

6.1 Role of the Coroner

In Queensland, domestic and family violence related deaths are currently reviewed within the Office of the State Coroner.[53] The role of the Coroner is to investigate the circumstances leading up to the incident in which a person died. The Coroner is required to make findings about the deceased's identity, date and place of death, medical cause of death and how the death occurred.[54]

Under the Coroners Act, the Coroner has the power to make recommendations connected with a death investigated at an inquest (including domestic and family violence related deaths), relating to matters including how to prevent future deaths.

The Committee understands, however, that only a small number of domestic and family violence related deaths proceed to inquest, thereby limiting the capacity of the coronial process to make recommendations to address gaps and failings in service responses. Ms Susan Beattie, Manager, DFVDR Unit, Office of the State Coroner, indicated that the amount of cases investigated by the Coroner that proceed to inquest is roughly five per cent.[55]

In addition, in cases where a person has been charged in respect of a death, the Coroner is prevented by section 29 of the Coroners Act from holding or continuing an inquest until the criminal process (including any appeals) has been finalised.[56]

6.2 Role of the Domestic and Family Violence Death Review Unit

The DFVDR Unit, which sits within the Office of the State Coroner, reviews deaths that have been identified as related to domestic and family violence. The DFVDR Unit is empowered, under the Coroners Act, to investigate such deaths, and has the capacity to request additional reports, statements or information about the death to inform the Coroner's findings. The DFVDR Unit may access a variety of information,

51 Submission no.6, Queensland Law Society, p.1
52 Submission no.9, Bar Association of Queensland, p.3
53 Explanatory Notes, p.2
54 Department, *Briefing Note*, 22 September 2015, p.9
55 Ms Susan Beattie, Manager, Domestic and Family Violence Death Review Unit, Office of the State Coroner, *Public Hearing Transcript*, 30 September 2015, p.22
56 Department, *Briefing Note*, 22 September 2015, p.2

including from doctors, hospitals, police, community services, the courts and other witnesses.[57] The DFVDR Unit's powers to access information are to ensure that information about the broader context of the death is gathered and examined within the context of the coronial investigation.[58]

To support this investigatory role, the DFVDR Unit also maintains a database of domestic violence related deaths, including information about the perpetrators and victims and their circumstances. Through the database and other information, the DFVDR Unit may identify factors that may increase the risk of death in a relationship (i.e. a homicide, suicide or murder suicide). For example, threats to kill, strangulation, controlling behaviour and previous assaults with a weapon may indicate a heightened risk of harm to a victim.[59]

The Committee notes that the primary role of the DFVDR Unit is to provide assistance and support to individual coroners who are investigating homicides, murder suicides and suicides identified as related to domestic and family violence, to inform the coroner's findings.[60]

Although the DFVDR Unit may assist with the identification of these issues and any systemic shortcomings and with the formulation of preventative recommendations for those matters that proceed to inquest, it cannot independently make recommendations.[61]

6.3 Proposed role of the Domestic and Family Violence Death Review and Advisory Board

The Department stated that the Board's primary purpose will be to review deaths related to domestic and family violence to prevent or reduce the likelihood of deaths.

New section 91D(3) distinguishes the Board's functions from those of the State Coroner, assisted by the DFVDR Unit (i.e. investigating the incidents leading up to an individual's death), by providing that it is not a function of the Board to carry out an investigation of a death, but rather to review *domestic and family violence deaths* and consider events leading up to a death for example contact with support services.

The Department advised that:

> *… the Board's review function, which under section 91E allows it to consider the events leading up to the death, will not focus on investigating and making findings about the particulars of a person's death, but rather examining and making recommendations in relation to the supports and services provided that preceded the death with a view to preventing future deaths.*[62]

The Committee notes that the Board will be able to review and examine the events leading up to all domestic and family violence related deaths and make recommendations to the Minister without the need for a coronial inquest or to wait for the conclusion of any criminal proceedings. The Department stated

57 Taskforce Report, February 2015, p.113
58 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.14
59 Taskforce Report, February 2015, p.113
60 Department, *Briefing Note*, 22 September 2015, p.2
61 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.14
62 Department, *Briefing Note*, 22 September 2015, p.9

that "This will allow the Board to make timely recommendations which take into account current systems, policies and practices (which might have changed by the time an inquest has been held)".[63]

It is envisaged that the Board will rely significantly on investigation documents held by the Office of the State Coroner, including the DFVDR Unit, to support its review functions.

Ms Susan Beattie, Manager, DFVDR Unit, explained that it is intended that the DFVDR Unit will perform the secretariat function for the Board and provide systemic analysis of its data and research into individual cases for the Coroner, as facilitated by provision in the Bill for the State Coroner to enter into an agreement with the Board surrounding information sharing and access protocols.[64]

The Attorney-General, in her explanatory speech, stated that:

> *The passage of this Bill is central to ensure that the independent board working with the enhanced death review unit within the Office of the State Coroner can identify systemic risk factors that may place a person at increased risk of death or injury in a relationship, identify any existing gaps in services provided and how services and responses to victims of domestic violence can be improved with a view to reducing the number of domestic and family violence related deaths in the future.*[65]

Ms Susan Beattie further explained:

> *The recommendation for the board stems from the Special Taskforce on Domestic and Family Violence In Queensland obviously and the identification of certain limitations in the systemic review function of the Domestic and Family Violence Death Review Unit in that, essentially, it is a departmental unit within the Office of the State Coroner and very much focused on assisting coroners in their investigation. Part of that is recognising that many of those cases do not meet the provisions to go to inquest and there is a loss of valuable learnings from those reviews because there are no opportunities to disseminate that publicly. There are many different types of mortality review mechanisms and domestic and family violence mortality review mechanisms supported by a board function. The difference here is that this will be a multidisciplinary board which has significant value in the identification of systemic shortcomings across cases which the unit is not able to do at this point in time because we are restrained by the powers of the Coroners Act. We do not have the power to make recommendations that are made by a coroner, and it can only be made for matters that proceed to inquest. We are a support function for a coroner as opposed to a death review.*[66]

63 Department, *Briefing Note*, 22 September 2015, p.9

64 Ms Susan Beattie, Manager, Domestic and Family Violence Death Review Unit, Office of the State Coroner, *Public Hearing Transcript*, 30 September 2015, p.23

65 Attorney-General, *Hansard*, 15 September 2015, p. 1742

66 Ms Susan Beattie, Manager, Domestic and Family Violence Death Review Unit, Office of the State Coroner, *Public Hearing Transcript*, 30 September 2015, p.23

Committee comment

The Committee notes the QLS' submission that during consultation sessions the Department had endeavoured to clarify the distinction between the roles of the Coroner, the DFVDR Unit and the Board. In terms of the DFVDR Unit and the Board respectively, the QLS reported its understanding of the Unit "being public servants performing a role for the Coroner whereas the Board, as the Department have pointed out to us, would have the ability to engage people to provide them with analytical detail on the functions that the Board has".[67]

The Committee highlights the importance of avoiding unnecessary duplication between the functions of the DFVDR Unit and the Board. Accordingly, the Committee recommends that the Department, in conjunction with the Board, takes steps to ensure that the distinct, but complementary, functions of the DFVDR Unit and Board are clearly understood by the Coroner, DFVDR Unit and Board, as well as by the courts, service providers, law enforcement agencies and stakeholders who work to prevent domestic and family violence.

Recommendation 3

The Committee recommends that the Department of Justice and Attorney-General, in conjunction with the Domestic and Family Violence Death Review and Advisory Board (Board), takes steps to ensure that the distinct, but complementary, functions of the Domestic and Family Violence Death Review Unit (DFVDR Unit) and the Board are clearly understood by the Coroner, DFVDR Unit and Board, as well as by the courts, service providers, law enforcement agencies and stakeholders who work to prevent domestic and family violence.

67 Mr Michael Fitzgerald, President, Queensland Law Society, *Public Hearing Transcript*, 30 September 2015, p.4

7. Administration and resourcing of the Board

New section 91I provides that the chief executive of the Department must ensure the Board has the administrative support services reasonably required for the Board to perform its functions effectively and efficiently.

The Explanatory Notes state that "… the Board will have the benefit of sharing resources and expertise with the DFVDR Unit. As secretariat support will be provided by the DFVDR Unit information research and analysis prepared and developed by the Unit will be available to the Board".[68]

7.1 Submissions

The BAQ stated that adequate resourcing of the Board will be critical to ensuring the Board's effective function.[69] The Queensland Centre for Domestic and Family Violence Research, Central Queensland University (QCDFVR), welcomed the

> *… enhanced capacity of the Domestic Violence Death Review Unit to provide the Review and Advisory Board with adequate research expertise and capability to respond to informing particular cases or comparisons between cases.*[70]

68 Explanatory Notes, p. 3

69 Submission no.9, Bar Association of Queensland, p.3

70 Submission no.10, Queensland Centre for Domestic and Family Violence Research, Central Queensland University (QCDFVR), p.1

8. Board membership

New section 91J provides that the Minister will decide on the appropriate number of Board members, up to a maximum of 12 persons (including the chairperson).

8.1 Chairperson

New section 91K provides that the Minister must appoint the State Coroner or Deputy State Coroner as the Chairperson of the Board. The Department advised that "This provision makes sure that there are clear linkages between the coronial jurisdiction and the functions of the Board and that we have … a good transfer of information from the Office of the State Coroner to the board".[71] The Minister may also appoint a member of the Board to be the deputy chairperson.[72]

8.2 Submissions

The BAQ expressed concerns about the appointment of the State Coroner or Deputy State Coroner as the Chairperson of the Board. The BAQ stated that "…the relationship between the Board and the Office of the State Coroner may involve conflict of interests at times" and "… this issue ought to be carefully monitored to ensure that any conflict between the complimentary [sic], but possibly at times competing, roles is identified and appropriately managed at an early stage".[73]

The QLS also noted this concern, and its awareness that in some cases it may not be appropriate for the Coroner to be the chairperson.[74]

Dr Silke Meyer submitted that Board needs to have a chairperson who is not part of the Coroner's office. Dr Meyer stated that "if the argument is to have an independent review with expertise that is brought and sits outside the Coroner's office, I do not think that the Coroner should be the chair of the Board".[75]

8.3 Department's response

In response to submissions, the Department noted that while stakeholders had identified the potential for conflicts of interests to arise, it had also been recognised in consultation sessions that there are ways in which such conflicts may be handled:

> *… for example, if the State Coroner was appointed as the chair of the board, the State Coroner could not hear DV related deaths. That is a way the conflict could be handled. This is a matter that the judiciary deal with every day. They are equipped, by the very*

71 Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department, *Public Briefing Transcript*, 18 September 2015, p.5

72 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015, clause 5 (new section 91M of the *Coroners Act 2003*)

73 Submission no.9, Bar Association of Queensland, p.3

74 Mr Michael Fitzgerald, President, Queensland Law Society, *Public Hearing Transcript,* 30 September 2014, p.4.

75 Dr Silke Meyer, Postdoctoral Research Fellow, Institute for Social Science Research, University of Queensland, *Public Hearing Transcript*, 30 September 2015, p.9

> *nature of their role, to deal with conflict, and they are independent and able to do that with great sophistication.*[76]

In addition, the Department emphasised that the State Coroner's role as Chairperson stands to facilitate crucial sharing of coronial information and will not impinge on the Board's independence. The Department stated:

> *The clear policy decision of government was that the board should be able to leverage off the coronial system. That means that the best person to bring these two bodies together in investigating individual deaths and also providing a systemic view is someone who is an expert in the coronial system—that is obviously the State Coroner or the Deputy State Coroner—and that that independent person can bring both systems together. That does not mean that the board will not be independent. The State Coroner is an independent judicial officer and has very specific roles and responsibilities in relation to the legislative functions and powers of the board. That is the way this government decided to deal with who should be the chair of the board.*[77]

In response, the Department stated that the policy behind the Bill is that "it is essential for the chair to be an acting and present State Coroner or Deputy State Coroner so the board will be able to have a clear pathway between all the information held by the coronial system as controlled by the State Coroner and get that to the board".[78]

Committee comment

The Committee acknowledges that the appointment of the Coroner or Deputy Coroner as Chairperson of the Board may give rise to conflicts of interest from time-to-time. However, the Committee recognises that there is a strong rationale for the Coroner or Deputy Coroner to be the Board's chairperson, including access to coronial information, leadership and coordination of the Board.

The Committee notes that the Bill includes provisions to manage any conflicts of interests. New section 91X of the Coroners Act provides that a Board member, including the chairperson, must declare a direct or indirect pecuniary or other interest in a matter being considered at a Board meeting, if the interest appears to raise a conflict with the member's proper performance of their duties. New section 91X(3) provides that after declaring their interest, the Board member must not be present during a deliberation of the Board about the matter in question, unless the Board decides otherwise.

The Committee acknowledges that the decision as to whether to declare a conflict of interest, and not participate in a Board meeting, will be a matter for each Board member. However, the Committee considers that the Coroner or Deputy Coroner, in his or her role as chairperson, would need to carefully

76 Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department, *Public Hearing Transcript*, 30 September 2015, p.25

77 Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department, *Public Hearing Transcript*, 30 September 2015, p.25

78 Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department, *Public Hearing Transcript*, 30 September 2015, p.26

consider whether their involvement in a matter before the Board, for example a coronial investigation of a domestic and family violence death, would give rise to a conflict of interest under new section 91X.

The Committee considers that the establishment of appropriate mechanisms and procedures for dealing with conflicts will ensure the integrity and independence of the Board's review activities.

8.4 Other Board members

The appointment of other Board members is at the discretion of the Minister, however, he or she must ensure that the Board's membership reflects the diversity of the Queensland community; includes at least one member who is an Aboriginal or Torres Strait Islander; and includes government and non-government entity representatives. The Minister must also ensure that members have relevant experience, knowledge or skills (for example, expertise, knowledge or skills in relation to domestic and family violence, the justice system and health).[79]

The Department stated that:

> *This membership criteria is to ensure representation on the Board of people from sectors with an interest and expertise in the work of the Board, including those with expertise in the nature and dynamics of domestic and family violence, mortality review processes and building effective system responses.*[80]

New section 91O provides that Board members are to be appointed for a maximum term of three years which may be renewed.

Fees and allowances for Board members are to be decided by the Minister. However, State employees who are Board members are not entitled to paid remuneration.[81] The Explanatory Notes state that "Non-Government members will receive sitting fees and expenses pursuant to the *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies – Adjudication and Determination"*.[82]

8.5 Submissions

QCDFVR stated that "the specific make-up of the Board is likely to determine the extent to which key decision-makers in relevant sectors may be influenced by review findings".[83]

Dr Silke Meyer submitted that the Board's multidisciplinary composition is especially important because:

> *... we need to get people who are in a position to generate change and in a position to generate protection for victims to be involved in the dialogue. I do not think that we are doing ourselves any favours if we have a whole lot of specialised services from the women's sector involved if the police, other law enforcement agencies or Child Safety*

79 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015, clause 5 (new section 91L of the *Coroners Act 2003*)
80 Department, *Briefing Note*, 22 September 2015, p.5
81 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015, clause 5 (new section 91N of the *Coroners Act 2003*)
82 Explanatory Notes, p.3
83 Submission no.10, QCDFVR, p.2

> *remain on the outside. It always ends up being a blaming and shaming process because they tend to be the ones where those reviews identify most frequent gaps in the system. So the organisations that have those gaps identified for themselves need to become part of the dialogue in order to improve systematic responses to domestic violence and to protect victims and their children.*[84]

Submitters indicated their interest in contributing to the activities of the Board and to the development of protocols in relation to the review process, making a number of recommendations regarding Board representation.

Recommendations included calls for the appointment of key service provider representatives and members with specialist expertise, such as:

- researchers, practitioners and representatives from regional domestic violence service providers
- the Queensland Police Service Domestic Violence Liaison Officer cohort
- child safety representatives and perpetrator intervention program representatives[85]
- a representative from the non-government education sector[86]
- a lawyer with domestic violence and family law expertise,[87] and
- a representative of the culturally and linguistically diverse community and a member with expert knowledge of sexual violence, in particular Intimate Partner Sexual Violence.[88]

Ms Leona Berrie of WWILD-SVP submitted:

> *Within the review board, I do not know whether it is necessary for somebody to be sitting permanently on that board with knowledge of disability, cognitive disability, mental health systems or whether it might be more useful for it to be required that those elements are looked for and identified when things come to the death review, and where those things are identified perhaps expertise is sought around how those systems have either worked or failed or exacerbated the violence that has occurred.*[89]

8.6 Department's response

The Department stated that under Division 3 of the Bill, the Minister has the discretion to appoint, other than the chairperson, up to eleven persons the Minister considers appropriate to constitute a Board with multi-disciplinary expertise.[90]

84 Dr Silke Meyer, *Public Hearing Transcript*, 30 September 2015, p.9
85 Submission no.3, Dr Silke Meyer, p.1
86 Submission no.4, Queensland Catholic Education Commission, p.2
87 Submission no.8, WLS, p.3
88 Submission no.11, Gold Coast Centre Against Sexual Violence Inc., p.4; Ms Stephanie Anne, Manager, Zig Zag Young Women's Resource Centre Inc. and Secretariat, Queensland Sexual Assault Network, *Public Hearing Transcript,* 30 September 2015, p.11
89 Ms Leona Berrie, Manager, WWILD-SVP, *Public Hearing Transcript*, 30 September 2015, p.13
90 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.7

The Department stated that:

> *The requirements of section 91L adequately reflect the need for the board to consist of members with relevant expertise without being prescriptive about particular areas to be represented and may include, for example, people with relevant legal experience with expertise in domestic violence and family law issues. The requirement to ensure that the Board reflects the diversity of the Queensland community also encompasses issues such as ensuring the Board reflects the cultural and linguistic diversity and gender diversity of the broader community.*
>
> *All suggestions for Board membership as raised by the submitters fall within the parameters for Board membership established by section 91L of the Bill.*[91]

Committee comment

The Committee considers that the Bill makes appropriate provision for the appointment of a range of key stakeholders to the Board, as well as for additional consultation with specialists in regard to particular emerging issues or cases.

It notes also that there is recognition amongst stakeholders that the legislation "should not codify specific structures and processes".[92]

8.7 Restrictions on appointment and holding office as a Board member

New section 91L(2) provides that a person may not be appointed as a Board member, if the person: is insolvent; has a conviction, other than a spent conviction, for an indictable offence; or is a member of the Legislative Assembly.

New section 91P outlines the circumstances where the office of a Board member becomes vacant. These circumstances include if the member is absent from three consecutive meetings without the Board's permission or reasonable excuse. The Minister may also end a Board member's appointment if the Minister is satisfied the member is incapable of satisfactorily performing their duties.

In determining whether a person may be appointed, or continue, as a Board member, the Minister may, with the written consent of the person in question, ask the Police Commissioner for a written report about the person's criminal history. The Police Commissioner must comply with the request, if the information is in the Police Commissioner's possession or he or she has access to the information. After the report is no longer needed, the Minister must ensure the report is destroyed as soon as practicable.[93]

The potential fundamental legislative principles issues raised by this provision are discussed at Section 12 of this report.

New section 91R provides that if a Board member is convicted of an indictable offence during their term of appointment, they must, unless they have a reasonable excuse, immediately give notice of the

91 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.7

92 Submission no.2, UnitingCare Community, p.2

93 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill, clause 5 (new section 91Q of the *Coroners Act 2003*)

conviction to the Minister. A failure to notify the Minister is an offence attracting a maximum penalty of 100 penalty units ($11,780).

8.8 Protection from civil liability

New section 91ZE provides that a Board member or person engaged to help the Board is not civilly liable for an act done, or omission made, honestly and without negligence. Civil liability instead attaches to the State. Board members, or other persons helping the Board who are also State employees, are protected from civil liability under the *Public Service Act 2008*.

The potential fundamental legislative principles issues raised by this provision are discussed at Section 12 of this report.

9. Governance

Clause 5 (new sections 91S to 91W of the Coroners Act) make provision about the conduct of business of Board meetings, including the time and place of meetings, quorum for meetings and minutes, and provides that questions at meetings are to be decided by a majority of votes, with the chairperson having a casting vote if votes are equal.

New section 91X provides for the disclosure of conflicts of interests of Board members.

10. Access to information and confidentiality

10.1 Access to information of prescribed entities

Clause 5 inserts new section 91Y into the Coroners Act to provide that to perform its functions, the Board has right to all information in the custody or under the control of a *prescribed entity*. A *prescribed entity* is:

- the chief executive of a Government department
- the Queensland Family and Child Commission
- the Police Commissioner
- an entity that provides services to persons in *relevant relationships* if those persons are affected by *domestic and family violence deaths*, and
- an entity prescribed by regulation.

New section 91Y provides that the Board may, by written notice, require a *prescribed entity* to give information to the Board or allow the Board to inspect a document and take a copy of it, within a reasonable period. A failure by the *prescribed entity* to comply with a notice, without a reasonable excuse, is an offence attracting a maximum penalty of 100 penalty units ($11,780).

A reasonable excuse for a failure to comply includes where compliance:

- might tend to incriminate an individual
- would require the disclosure of information subject to legal professional privilege
- would prejudice effectiveness of a lawful method or procedure for preventing, detecting, investigating or dealing with a contravention or possible contravention of a law
- would enable the existence or identity of a confidential source of information to be ascertained
- would endanger a person's life or physical safety, or
- would prejudice a prosecution or another matter before the courts.[94]

New section 91Y(7) provides that a *prescribed entity* may comply with a notice by allowing the Board to inspect a copy of a document with any exempt information removed. The term *exempt information* is defined as any information for which the prescribed entity considers it would not be required to give because of a reasonable excuse under section 91Y.[95]

New section 91ZF provides that a *prescribed entity* which gives information to the Board, in compliance with a notice under section 91Y, is not liable civilly, criminally or under an administrative process, for giving the information (see Section 12 of this report in relation to potential fundamental legislative principles issues raised by this provision).

94 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015, clause 5 (new section 91Y of the *Coroners Act 2003*)

95 Explanatory Notes, p.11

The Attorney-General, in her explanatory speech, stated that "These information-sharing provisions are critical to ensuring the Board can effectively discharge its functions".[96]

10.2 Information sharing with the State Coroner and other jurisdictions

New section 91Z provides that the Board may enter into arrangements with the State Coroner about the exchange of information. Such arrangements may include:

- that the Board be notified by a coroner that a reportable death is or is likely to be a domestic and family violence death
- that the Coroner gives the Board access to investigation documents and other relevant documents relating to domestic and family violence deaths, and
- details about when and where such documents may be accessed by the Board.

New section 91ZA provides that the Board may, for its functions, also enter into arrangements with a *corresponding entity* (an entity in another State with the same or similar functions to the Board) to share or exchange information. Under such arrangements, the Board may disclose information in its possession or under its control, unless the disclosure would prejudice the investigation of a contravention or possible contravention of a law or a coroner's investigation.

However, before disclosing coronial information, the Board must consult the State Coroner.

10.3 Confidentiality

New section 91ZD provides that a Board member or person engaged to help the Board must not disclose *confidential information* (including a document) to anyone else other than:

- in performance of a function under the Coroners Act
- to the Police Commissioner in connection with a possible criminal offence
- to a coroner to the extent it may relate to a reportable death
- to the Crime and Corruption Commission
- to the ombudsman about the death of a person to the extent it is relevant to the ombudsman's functions, or
- to the extent otherwise required or permitted under an Act.

The term *confidential information* is defined as information that is not publicly available and is in a form which identifies an individual and was acquired by, or may be accessed, by a person in their capacity as a Board member or person engaged to help the Board.

10.4 Submissions

The submissions supported the proposed amendments aimed at ensuring the Board may access information to effectively discharge its functions.[97] QCDFVR stated that the Bill appears to "cover well the key issues of access to information, confidentiality, liability and immunity" and "this stands to ensure that

96 Attorney-General*, Hansard*, p. 1742

97 Submissions no.1, PACT, Submission no. 10, QCDFVR and Submission no. 12, BoysTown

critical information is made available and also that participants in the process are able to freely contribute their views and experience".[98]

Gold Coast Centre Against Sexual Violence Inc. stated that to perform its functions the Board:

> *… should have the absolute right to all information in the custody or under the control of a prescribed entity or a non-government agency. These entities/agencies should be compelled to provide this information without exemption so there is a true picture of the events and contact leading up to the homicide.*[99]

WLS stated that Board should have the power to compel the disclosure of relevant court files for its consideration.[100] Ms Angela Lynch, Community Legal Education Lawyer, WLS, stated that:

> *I think there can be cases where the parties may have separated for a period of time and there is a death and the parties may have actually been involved in Family Court proceedings. An example would be the Darcey Freeman case down in Victoria, where the young child was thrown from the bridge by her father. They had been involved in Family Court proceedings. I think it is important that the death review board also has access to those documents, as all information comes before them. Were there points of intervention that could have taken place in the system? Could there have been changes? Why did the judge make a decision in that matter? …Why can't she get legal aid?... You can see that those court files can be important.*[101]

WLS recommended that protocols be established between the Queensland Government and the Federal Government and Federal Courts regarding their cooperation and support for the Board's processes. WLS noted that protocols are especially required with "states bordering Queensland, in relation to a deceased's involvement with dual police, dual state agencies or courts".[102]

In addition, WLS suggested that the Bill be amended to include a legislative process for determination by a judge of the reasonableness of a prescribed entity providing information to the Board in circumstances where the Board does not accept or questions an entity's reasonable excuse, under new section 91Y of the Coroners Act, for not providing information to the Board.[103]

Further, in order to avoid any conflict between the Board's right to access information under the control or custody of a prescribed entity and the Information Privacy Principles (IPPs) under the *Information Privacy Act 2009*, the QLS recommended that the Bill specify that a request for information by the Board, under new section 91Y, is taken to be a request authorised by law for the purpose of the IPPs.[104] Mr Shane Budden, Manager, Advocacy and Policy, QLS, stated:

98 Submission no.10, QCDFVR, p.1
99 Submission no.11, Gold Coast Centre Against Sexual Violence Inc., Submission no.11, p.4
100 Submission no.8, WLS, p.3
101 Ms Angela Lynch, Community Legal Education Lawyer, WLS, *Public Hearing Transcript,* 30 September 2015, p.20
102 Submission no.8, WLS, p.2
103 Submission no.8, WLS, p.4
104 Submission no.6, Queensland Law Society, p.2

> *The reason we bring it to mind is that we have seen it in other less serious areas where a regulator might license a certain professional trade and also do debt recovery against them and the information they collect for the licensing is not allowed to be transferred to the debt-recovery people because it is not for that purpose. That is the sort of situation we wanted to make sure was avoided.*[105]

10.5 Department's response

The Department stated that under new sections 91Y, 91Z, and 91ZA the Board may:

- access information in the custody or under the control of a Queensland government agency and any entity that provides services to people in relevant relationships if those persons are affected by domestic and family violence deaths
- access coronial investigation documents that relate to domestic and family violence under an information sharing arrangement with the State Coroner, and
- share and exchange information with an entity in another State that performs the same functions as the Board under an information sharing arrangement with the relevant entity.[106]

The Department noted that there is no specific provision for accessing court files under the Bill. Access of court files would have to be under existing information sharing principles, and under Family Court rules with regard to Family Court documents.[107] However, "to the extent that the provision of information might be facilitated by the establishment of relevant protocols with the Commonwealth or interstate entity concerned, this work could be led by the Board once established".[108]

In addition, the Department highlighted that, in practice, when the Board reviews deaths, it will rely on the information that is gathered by a coroner's investigation. In investigating a death, a coroner has broad powers under the Coroners Act and is able to access relevant information from interstate and Commonwealth entities, including courts. Therefore, the power of the Board to enter into information sharing arrangements with the State Coroner will also facilitate the Board obtaining relevant information from interstate and Commonwealth agencies.[109]

In response to WLS's suggestion to include a legislative process for a determination by a judge of the reasonableness of an entity not providing information to the Board, the Department stated that section 91Y(4) of the Bill provides that it is an offence for a *prescribed entity* to fail to comply with the Board's notice requiring the giving of information to the Board, without a reasonable excuse. The section specifies what may constitute a *reasonable excuse* and the Department advised that the Magistrates Court has jurisdiction to determine whether or not the excuse is reasonable and the offence has been committed.[110]

105 Mr Shane Budden, Manager, Advocacy and Policy, Queensland Law Society, *Public Hearing Transcript,* 30 September 2015, p.5

106 Department, *Response to Issues Raised in Submissions*, 29 September 2015, pp.3-4

107 Ms Victoria Moore, Acting Director, Strategic Policy, Department, *Public Hearing Transcript*, 30 September 2015, p.30

108 Department, *Response to Issues Raised in Submissions*, 29 September 2015, pp.4-5

109 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.4

110 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.12

The Department also stated that:

> *Administrative guidelines can be developed by the Board, as appropriate, in circumstances where an entity claims a reasonable excuse for not providing the Board with information, to assist the Board in determining whether or not it is satisfied that the reasonable excuse criteria have been satisfied and whether or not prosecution action should be pursued. It is noted that the Board has the power under section 91G to do all things necessary or convenient to be done for or in connection with the performance of its functions, which may include seeking legal advice in relation to these matters.*[111]

The Department stated that these powers to require information and related offence provisions are "considered sufficient and appropriate for the Board to fulfil its functions".[112]

With regard to the QLS' suggestion that it be clarified that a request for information under section 91Y is taken to be a request authorised by law for the purposes of the IPPs; the Committee notes the QLS' testimony that following further discussion with the Department, it is now satisfied that the Department has "considered this issue quite fully" and "gone to some length to assure themselves that this will function as they want it to".[113]

In keeping with this, while the information held by the Board will be subject to the *Right to Information Act 2009* (RTI Act) and the *Information Privacy Act 2009* and, therefore, subject to potential disclosure; the Department advised that:

> *The Right to Information Act 2009 contains a number of exemption provisions and factors supporting non-disclosure that will apply to documents created or obtained by the Board, therefore, it was not considered necessary to include any additional exclusion criteria.*[114]

Committee comment

The Committee recognises that sections 91Y, 91Z and 91ZA provide the Board with wide ranging powers to access information in support of their review role, and considers that this may also include scope to facilitate oral briefings and forums or other active forms of dialogue as it considers appropriate, in addition to the exchange of written materials on request and through information sharing arrangements.

The Committee is also satisfied that the current exemptions from the requirement to disclose information under the RTI Act provide an adequate protection against inappropriate disclosure of personal and sensitive information about individuals held by the Board – including, for example, the exemptions: for coronial documents; where disclosure would be a breach of confidence; and for personal information of individuals.

111 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.12
112 Department, *Response to Issues Raised in Submissions*, 29 September 2015, p.13
113 Mr Shane Budden, Manager, Advocacy and Policy, Queensland Law Society, *Public Hearing Transcript,* 30 September 2015, pp.4-5
114 Department, *Briefing Note*, 22 September 2015, p.8

11. Reporting by the Board and recommendations

11.1 Annual reports

The Bill provides that the Board must, within three months after the end of each financial year, give the Minister an annual report about the performance of the Board's functions during the financial year. The annual report must include information about the progress made to implement recommendations made by the Board. The Minister must table a copy of the annual report in the Legislative Assembly.[115]

In her explanatory speech, the Attorney-General stated that the requirement to provide an annual report will "ensure the Board is … meeting its objectives".[116]

11.2 Reports about systemic matters

The Bill provides that the Board may also prepare a report about a matter arising from the performance of its functions, including:

- about its findings in relation to a review, or
- making recommendations to the Minister about any other matter likely to prevent or reduce domestic and family violence deaths.[117]

New section 91ZC(3) provides that the Board must not include information adverse to a *person*[118] unless, before the report is prepared, the Board gives the person an opportunity to make submissions about the information. If the person makes a submission and the Board still proposes to include the information in its report, the Board must ensure the person's submission is fairly stated in the report.

The Board may decide to give a copy of the report to the Minister. If the Board does so, it must recommend whether the report should be tabled in the Legislative Assembly. However, the Board may only recommend that a report be tabled in the Legislative Assembly if it does not contain information which identifies or may identify an individual in their private capacity.

New section 91ZC(8) provides that if the Board recommends that a report not be tabled in the Legislative Assembly, the Minister may only table the report if he or she is satisfied the public interest outweighs any other consideration. New section 91ZC(9) provides that if the Board recommends that the report be tabled in the Legislative Assembly, the Minister must do so within five sitting days after receiving the report.

115 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill, clause 5 (new section 91ZB of the *Coroners Act 2003*)

116 Attorney-General, *Hansard,* 15 September 2015, p.1742

117 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill, clause 5 (new section 91ZC of the *Coroners Act 2003*)

118 The term *person* is defined at section 32D of the *Acts Interpretation Act 1954* as a person generally and includes a reference to a corporation as well as an individual.

If a report includes information relating to the death that is still be investigated by the Coroner, the Board must give a copy of the report to the Coroner. If the Board intends to give a copy of the report to the Minister, the Board must ensure the report is given to the Coroner before it is given to the Minister.[119]

The Department advised that:

> *In addition to making recommendations, it is intended that the board will increase recognition of the impact of, and circumstances surrounding, domestic and family violence deaths and assist government and the community in gaining a greater understanding of the context in which domestic and family violence deaths occur.*[120]

11.3 Submissions

Submitters, such as UnitingCare, supported the transparent process provided for in the proposed legislation, including the requirement for the Board's annual report, which will outline progress in the implementation of recommendations and systemic reviews, to be tabled in the Parliament.[121]

Dr Silke Meyer stated that the Board should report to the Minister at least annually to provide an annual overview of trends. Dr Meyer suggested that more frequent reports may be useful, if the Board identifies critical changes in the nature and extent of domestic and family violence related deaths.[122]

Submitters also noted, however, that government and non-government entities are not compelled to act on recommendations by the Board and called for strengthened accountability mechanisms.[123] AASW submitted that "If we are to make this amendment to the Act meaningful, it has to prescribe the full range of accountability measures, in the pursuit of a united response to stopping domestic and family violence in Queensland".[124] The Gold Coast Centre Against Sexual Violence Inc also called for mechanisms for accountability and consequence to be considered in relation to the distribution and implementation of Board recommendations.[125]

WLS and UnitingCare recommended that, in addition to the annual report tabled by the Attorney-General, other Ministers or government departments should be required to report to Parliament about their compliance with and/or reasons for non-compliance with Board recommendations.[126]

WLS also stated that the Queensland Government should establish protocols with the Federal Government and other States to ensure that the Federal Courts, departments and agencies and other States' courts, departments and agencies cooperate with and implement any recommendations made by the Board which may affect them.[127]

---

119 Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill, clause 5 (new section 91ZC of the *Coroners Act 2003*)
120 Mr David Mackie, Director-General, Department, *Public Briefing Transcript*, 18 September 2015, p.3
121 Submission no.2, UnitingCare Community, p.2
122 Submission no.3, Dr Silke Meyer, p.2
123 Submission no.2, Uniting Community, Submission no. 5, AASW and Submission no. 8, WLS
124 Submission no.5, AASW, p.3
125 Submission no.11, Gold Coast Centre Against Sexual Violence Inc., p.4
126 Submission no.8, WLS, p.4 and Submission no.2, UnitingCare Community, p.2
127 Submission no.8, WLS, pp.2-3

11.4 Department's response

The Department highlighted that section 91ZB provides that the Board must give the Minister an annual report including information about progress made to implement recommendations. Section 91ZC provides that the Board may prepare a report about a systemic matter arising from the performance of the Board's functions.[128]

During its examination of the Bill, the Committee questioned how the Board would ensure that its recommendations were complied with, in particular by non-government entities.

The Department stated that government and non-government entities that are the subject of a recommendation will be held to account through the reporting mechanism, which will highlight the progress of their implementation of the recommendation in the annual report of the Board tabled in the Parliament. The Department noted that if a copy of the report about a systemic matter prepared under section 91ZC is given to the Minister, the report may also be tabled in Parliament.[129]

These proposed reporting arrangements are consistent with the current approach to the monitoring of the implementation of coronial recommendations in Queensland.[130]

The Department also explained that after the Board's establishment, administrative arrangements can be negotiated between the Minister and the Board to establish arrangements about how government agencies are to respond and to support the Board's monitoring of the implementation of its recommendations.[131]

The Department informed the Committee that:

> *I think there are various models that we can see out there already where there is an NGO relationship with government, and obviously we cannot make them comply with anything. Certainly, in this particular area of domestic violence, in this current environment any recommendations that would come out could be seen as best practice in those circumstances, and I would like to think that most NGOs in that space would want to adopt best practice. It would come down to the organisation itself adopting them…*
>
> *Through the reporting, we would obviously seek some information from NGOs at the time we report about reporting against that.*[132]
>
> *We are hoping that that is an effective mechanism to invite those non-government organisations to provide information to the board. Certainly we would expect that,*

128 Department, *Response to Issues Raised in Submissions,* 29 September 2015, pp.9-10
129 Department, *Response to Issues Raised in Submissions,* 29 September 2015, p.10
130 Department, *Response to Issues Raised in Submissions,* 29 September 2015, p.8
131 Department, *Response to Issues Raised in Submissions,* 29 September 2015, p.10
132 Mr David Mackie, Director-General, Department, *Public Briefing Transcript*, 18 September 2015, p.8

> *given the strong commitment of many NGOs to tackling issues of domestic violence, they would be cooperative and will provide that information.*[133]

Committee comment

The Committee notes that the Victoria's *Coroner's Act 2008* (Vic) provides that where recommendations made by its domestic and family violence death review mechanism target public statutory authorities or entities, a written response specifying what action has or will be taken, is required within three months. However, it also notes that annual reporting of progress towards implementation is the primary accountability mechanism in many other State and Commonwealth jurisdictions, in keeping with collective ownership and engagement of the community's response to domestic and family violence.

In this respect, the Committee notes UnitingCare's submission that "Whilst government and non-government organisations may not be compelled to take action as a result of a review, public accountability and monitoring can be a powerful force for change".[134]

The Committee recognises the importance of transparency and promoting knowledge sharing, best practice and community awareness of domestic and family violence. The Committee encourages the Attorney-General and the Board to ensure that steps are taken to make information about the Board's work, including its research and reports, widely available and accessible.

Recommendation 4

The Committee recommends that the Attorney-General inform the Legislative Assembly during the second reading debate about how the Department of Justice and Attorney-General and the Domestic and Family Violence Death Review and Advisory Board will ensure that the Board's research and reports are made widely available and in an accessible format.

133 Ms Victoria Moore, Acting Director, Strategic Policy, Department, *Public Briefing Transcript*, 18 September 2015, p.8

134 Submission no.2, UnitingCare Community, p.2

12. Fundamental legislative principles and Explanatory Notes

Section 4 of the *Legislative Standards Act 1992* states that 'fundamental legislative principles' are the "principles relating to legislation that underlie a parliamentary democracy based on the rule of law". The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The Committee has examined the application of the fundamental legislative principles to the Bill. The Committee brings the following to the attention of the House.

12.1 Rights and liberties of individuals

Section 4(2)(a) of the *Legislative Standards Act 1992* requires that legislation has sufficient regard to the rights and liberties of individuals.

Clause 5 - Power to obtain criminal history records

Clause 5 inserts new section 91Q into the Coroners Act to provide that the Minister may ask the Police Commissioner for a written criminal history report about a potential or current Board member. The Committee considers that the provision of criminal history about a potential or current Board member raises potential issues regarding a person's right to privacy.

New section 91L provides that a person may not be appointed as a member of the Board if they have a conviction (other than a spent conviction) for an indictable offence. The Committee considers that it is appropriate for the Minister, during the appointment process, to be able to request a written criminal history report from the Police Commissioner to verify whether a person is eligible for appointment or has an indictable offence in their criminal history. The Committee notes that, should an applicant for a position of Board member not wish the Minister to obtain their criminal history, they have the option not to give written consent and withdraw their application.

Similarly, new section 91P provides that if a Board member is convicted of an indictable offence whilst in office, they vacate their position on the Board. New section 91R(2) provides that an offending Board member must, unless they have a reasonable excuse, give immediate notice of their conviction to the Minister. In the event of a Board member failing to notify the Minister or provide insufficient detail, the Committee considers it appropriate for the Minister to seek to independently verify the information by obtaining the member's criminal history record. As above, should the offending Board member not wish the Minister to obtain their criminal history record, they may refuse to give consent.

The Committee also notes that the Bill includes a number of safeguards to ensure a person's privacy. Firstly, the Minister may only request a criminal history record from the Police Commissioner with the person's written consent. Secondly, where a criminal history report is provided to the Minister, the Minister must destroy the report, as soon as practicable, after it is no longer needed. Finally, information about spent convictions may not be included in a person's criminal history report.

Accordingly, the Committee considers that new section 91Q of the Coroners Act has sufficient regard to the rights and liberties of individuals.

Clause 5 - Immunity from proceedings

Section 4(3)(h) of the *Legislative Standards Act 1992* provides that legislation should not confer immunity from proceeding or prosecution without adequate justification.

Clause 5 inserts new section 91ZE into the Coroners Act to provide that a Board member or a person engaged to help the Board is not civilly liable for an act done, or omission made, honestly and without negligence.

The Committee notes that new section 91ZE is a standard provision designed to allow members of boards and statutory authorities to undertake their statutory duties without fear of personal liability (excluding dishonesty and negligence), while providing an avenue for legal redress against the State for an aggrieved person.

Clause 5 inserts new sections 91ZF into the Coroners Act to protect a *prescribed entity* that is required to provide information to the Board, under new section 91Y, from liability civilly, criminally, or under an administrative process. New section 91ZF also provides that providing the information to the Board does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct, and no liability for defamation is incurred by the entity due to providing the information to the Board.

The Committee notes that affording protection from liability to entities which provide information under some degree of compulsion is not unusual, and serves to protect people from attacks on their own professionalism when they were merely acting in accordance with a statutory notice.

Accordingly, the Committee considers that new sections 91ZE and 91ZF have sufficient regard to the rights and liberties of individuals.

12.2 Explanatory Notes

Part 4 of the *Legislative Standards Act 1992* requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

The Committee notes that Explanatory Notes were tabled with the introduction of the Bill, and that the Explanatory Notes were detailed and contained the information required by Part 4 and a reasonable level of background information and commentary to facilitate an understanding of the Bill's aims and origins.

Appendix A – List of submissions

Sub #	Submitter
001	Protect All Children Today Inc.
002	UnitingCare Community
003	Dr Silke Meyer
004	Queensland Catholic Education Commission
005	Australian Association of Social Workers – Qld Branch
006	Queensland Law Society
007	Aboriginal & Torres Strait Islander Legal Service (Qld) Ltd.
008	Women's Legal Service Queensland
009	Bar Association of Queensland
010	Queensland Centre for Domestic and Family Violence Research
011	Gold Coast Centre Against Sexual Violence Inc.
012	BoysTown

Appendix B – List of witnesses at public briefing and public hearing

Public briefing 18 September 2015
Mr David Mackie, Director-General, Department of Justice and Attorney-General
Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General
Ms Victoria Moore, Acting Director, Strategic Policy, Department of Justice and Attorney-General
Ms Julie Rylko, Acting Director, Strategic Policy, Department of Justice and Attorney-General
Ms Megan Giles, Executive Director, Legislative Reform, Department of Communities, Child Safety and Disability Services
Public hearing 30 September 2015
Mr Michael Fitzgerald, President, Queensland Law Society
Mr Shane Budden, Manager, Advocacy and Policy, Queensland Law Society
Dr Silke Meyer, Postdoctoral Research Fellow, Institute for Social Science Research, The University of Queensland
Ms Stephanie Anne, Manager, Zig Zag Young Women's Resource Centre Inc. and Secretary, Queensland Sexual Assault Network
Ms Leona Berrie, Manager, Women with Intellectual and Learning Disabilities - Sexual Violence Prevention Association
Ms Angela Lynch, Community Legal Education Lawyer, Women's Legal Service Inc. Queensland
Ms Susan Beattie, Manager, Domestic and Family Violence Death Review Unit, Office of the State Coroner
Ms Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General
Ms Victoria Moore, Acting Director, Strategic Policy, Department of Justice and Attorney-General
Ms Julie Rylko, Acting Director, Strategic Policy, Department of Justice and Attorney-General
Ms Cathy Taylor, Deputy Director-General, Child, Family Community Services and Southern Regions, Department of Communities, Child Safety and Disability Services