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Parliamentary Committee Briefing Note

For the Communities, Disability Services and Domestic and Family Violence Prevention Committee

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

Background and Policy Intent

Introduction

- The key purpose of the Bill is to give effect to Recommendation 8 of the bi-partisan Special Taskforce on Domestic and Family Violence (Taskforce) in its report: *Not Now, Not Ever: Putting an end to Domestic and Family Violence in Queensland* (the Taskforce Report). In particular, the Taskforce recommended that:

  > *In consultation with key domestic violence stakeholders, the Queensland Government immediately establish an independent Domestic and Family Violence Death Review Board, consisting of multi-disciplinary experts to:*
  > a. *identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures;*
  > b. *report to the oversight body every six months on these findings and recommendations; and*
  > c. *be supported by and draw upon the information and resources of the Domestic and Family Violence Death Review Unit.*

- The Taskforce Report was released on 28 February 2015 and contained 140 recommendations to eliminate domestic and family violence and improve current responses. The recommendations are comprehensive and cover all aspects of the way the 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. To inform its work and recommendations, the Taskforce undertook extensive consultations across the State, including regional and remote communities.

- The Queensland Government has accepted all of the Taskforce recommendations and is now in the process of implementing the 121 recommendations directed at government.

- The Department of Justice and Attorney-General is leading the implementation of over 30 of the recommendations aimed at reforming the law and justice system response to domestic and family violence, with a focus on improving the experience of victims and making victims safer, as well as increasing perpetrator accountability.

- A copy of the Taskforce report and Queensland Government Response is available at: https://www.communities.qld.gov.au/gateway/end-domestic-and-family-violence/queensland-government-response.

- To implement Recommendation 8 of the Taskforce report, the Bill establishes a new Domestic and Family Violence Death Review and Advisory Board through amendments to the *Coroners Act 2003*.

- In recommending that a death review board be established, the Taskforce considered it critical that Queensland establish a comprehensive review structure to look at the system as a whole and identify any failures or gaps that might contribute to a domestic and family violence related death.

- Under the *Coroners Act 2003*, 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. However, 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. Also, in cases where a person has been charged in respect of the death, the coroner is prevented by section 29 of the *Coroners Act 2003* from holding or continuing an inquest until the criminal process (including appeals) has exhausted.

- Further, while a Domestic and Family Violence Death Review Unit has been established within the Office of the State Coroner, the primary role of the 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.

- The Board's role will contribute to the current death review coronial process by enabling the Board to make recommendations on a systemic level by examining individual cases and groups of cases independently of the coronial process, whether or not a matter proceeds to an inquest.

- Relevant to this recommendation, the Taskforce also recommended that:
  - the Government immediately considers an appropriate resourcing model for the Domestic and Family Violence Death Review Unit (the Unit) in the Office of the State Coroner to ensure it can best perform its functions to enable policy makers to better understand and prevent domestic and family violence (Recommendation 6); and
  - protocols be developed with the Domestic and Family Violence Death Review Unit to ensure that government departments with relevant policy development responsibilities have access to the research and resources available from the Unit (Recommendation 7).

The Bill amends the *Coroners Act 2003* to establish the Domestic and Family Violence Death Review and Advisory Board (the Board) to allow the Board to undertake comprehensive reviews of deaths related to domestic and family violence for the purpose of identifying the systemic factors, including policy system and practice failings or gaps, that may have contributed to the deaths and make recommendations for improvement to help prevent or reduce domestic violence.

The Bill will achieve its objective by:

- ensuring membership of the Board includes representatives of government and non-government entities with specialist experience, qualifications and expertise;
- conferring a right on the Board to request information necessary to perform its functions;
- empowering the Board to make recommendations directed at government and non-government entities to implement changes to policies, legislation and practices to reduce the risks of domestic and family violence deaths occurring in future;
- through the issuing of reports, enabling the Board to monitor the implementation of the recommendations; and
- requiring the Board to report to the Minister annually, and otherwise at the Board's discretion.

The amendments in the Bill are discussed in more detail below.

New Part 4A

- The Bill amends the *Coroners Act 2003* by introducing a new Part 4A to establish the Domestic and Family Violence Death Review and Advisory Board. Independent to the Office of the Coroner, the purpose of the Board is to review deaths related to domestic and family violence to help prevent or reduce the likelihood of those deaths.

Key terms relevant to the Board's powers and functions

- The new section 91B defines key terms that are relevant to the Board's powers and functions.
- The term 'domestic and family violence death' is defined in section 91B to include the death of a person caused by a person (the second person) if both people were in, or had been in a family relationship that involved domestic and family violence. It also includes deaths where the deceased person was a witness to or sought to intervene in domestic and family violence.

Establishment, functions and powers of the Board

- The new Part4A, Division 2 establishes the Board and sets out its functions and powers.
- The new section 91D provides that the functions of the Board are to:

  - review domestic and family violence deaths in Queensland, which include deaths that occurred before the Board was established, and deaths that are still being investigated;
  - 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 and reduction in the likelihood of domestic and family violence deaths in Queensland;
  - 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 in Queensland; and
  - monitor the implementation of the recommendations.
- Under the new section 91E the Board must consider:
  - the events leading up to the death;
  - the effectiveness of support or other services provided to the deceased person and the person who caused the death and the general availability of those services; and
  - failures in systems or services that may have contributed to, or failed to prevent, the death.
- The new section 91F states 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 review is independent of, and separate to, the investigation by the coroner.
- The new section 91G provides the Board can do all things necessary or convenient to be done for or in connection with the performance of its functions, including to engage persons with appropriate qualifications and experience to conduct research relevant to the Board's functions and prepare expert reports to help the Board carry out its functions.
- The new section 91H provides that the Board must act independently and in the public interest in performing its functions. In performing its functions the Board is not subject to the directions of the Minister.

Membership of the Board

- Division 3 of the new Part 4A establishes the Board's membership. The new section 91J provides that the Board will consist of a chairperson and not more than 11 other persons appointed by the Minister.
- The new section 91K states the Minister must appoint the State Coroner or the Deputy State Coroner as the chairperson of the Board.

- The new Section 91L provides that in appointing the other members of the Board, the Minister must ensure the membership of the board: reflects the diversity of the Queensland community and includes at least one member who is an Aboriginal or Torres Strait Islander person; includes representatives of government entities and non-government entities; and that members have experience, knowledge or skills relevant to the Board's functions.
- 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.
- The new section 91L also provides that certain people are excluded from being Board members. For example a person who has a conviction for an indictable offence, other than a spent conviction. The Minister can access criminal history reports to determine if a person cannot be appointed or continue to be a Board member.
- The new section 91N sets out provisions regarding the remuneration available to a member of the Board and provides that, for matters not provided for by the *Coroners Act 2003*, a member holds office on the terms and conditions decided by the Minister.
- The new section 91O provides that members are to be appointed up to three years and can be reappointed.

Proceedings of the Board

- The new Part 4A, Division 5 sets out provisions about how the Board is to function.

Disclosure of Conflict provisions

- Part 4A, Division 6 inserts a new section 91X to provide for the disclosure of conflicts of interest of Board members.
- The new section 91X provides that if a member has a direct or indirect pecuniary or other interest in a matter being considered or about to be considered at a meeting of the Board and the interest appears to raise a conflict with the proper performance of the member's duties, the member must, as soon as practicable disclose the nature of the interest at a meeting of the Board. Unless the Board otherwise decides, the member must not be present during a deliberation of the Board about the matter.
- The new section 91X also sets out the provisions regarding the recording of the particulars of a disclosure, and deliberations by the Board about matters where a conflict of interest is registered. Section 91X provides that a contravention of the section does not invalidate a decision of the Board, but if the Board becomes aware a member has contravened the section, then the Board must reconsider a decision made by the Board in which the member took part in contravention of the section.

Information sharing provisions

- The Bill inserts a new Part 4A, Division 7 to provide the Board with the ability to access information, including confidential information, it needs to perform its functions.
- The new section 91Y provides that the Board has a right to all information to perform its functions in the custody or under the control of a prescribed entity. A prescribed entity includes:
  - the chief executive of a department;
  - the Queensland Family and Child Commission;
  - the commissioner of the police service;
  - 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.
- The Board may by written notice require a prescribed entity to give information to the Board.
- The prescribed entity must comply with the notice, unless the person has a reasonable excuse - for example, in circumstances where the information may

  tend to incriminate the individual or endanger a person's life or physical safety.

  Failure to comply with a written notice is an offence with a maximum penalty of 100 penalty units.
- The new section 91Z in Division 7 provides that the Board may enter into an arrangement with the State Coroner about the exchange of information between a coroner and the Board, including notification by a coroner that a reportable death is or is likely to be a domestic and family violence death. The arrangement may provide for coroners to give the Board access to an investigation document that relates to the domestic and family violence death.
- The new section 91ZA provides that for its functions, the Board may enter into an arrangement with an entity in another State that performs the similar domestic and family violence death review functions.

Board's Reporting obligations

- The reporting arrangements for the Board are set out in the new Part 4A, Division 8. The Board is required under the new section 91ZB to report annually to the Minister in relation to the performance of the Board's functions, and the Minister must table the report in the Legislative Assembly. The annual report must include information about the progress made during the financial year to implement recommendations made by the Board during that year or previous financial years.
- The new section 91ZC 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 carried out by the Board, or making

recommendations to the Minister about any other matter likely to prevent or reduce domestic and family violence deaths. The Board may, if it considers appropriate, give a copy of the report to the Minister and make a recommendation about whether the report should be tabled in the Legislative Assembly (in which case the Minister must table it within 5 sitting days after receiving it). Such a recommendation may only be made if the report does not contain information in a form that identifies or may identify an individual in their private capacity. However, the Minister may table the report if the Board does not recommend this if satisfied the public interest outweighs any other considerations.

The section also requires, in circumstances where the Board proposes to include information in a report adverse to a person (which, in accordance with section 32D of the *Acts Interpretation Act 1954*, includes a corporation), to give the person an opportunity to make submissions. If the Board still proposes to include the information, the Board must ensure the person's submissions are fairly stated in the report.

Protection of information

- The new section 91ZD in Division 9 provides that a person who is or was a member of the Board or a person engaged to help in the performance of the Board's functions must not disclose confidential information, unless lawful to do so. A breach of this requirement is an offence with a maximum penalty of 200 penalty units.

Questions on Notice

Q: *How many domestic and family violence cases are currently before the coronial courts?*

A. There are 65 open coronial cases (cases to which a coronial investigation are yet to be finalised by the coroner) that have been identified as domestic and family violence related since 2011 when the Domestic and Family Violence Death Review Unit commenced operation.

These cases may include those that have occurred within the context of domestic and family violence or the deceased and/or perpetrator had an intimate partner or family relationship.

All of these 65 deaths were linked to interpersonal violence (homicide/manslaughter) and there are 14 other relevant cases (which may include suspected suicides or deaths in custody).

The Domestic and Family Violence Death Review Unit is currently assisting the coroner with a coronial investigation which will shortly be proceeding to inquest in relation to one of these deaths. The Domestic and Family Violence Death Review Unit is investigating the domestic and family violence context of the death.

The Domestic and Family Violence Death Review Unit has reviewed a significant proportion of the 65 deaths or is in the process of completing a full review for others to inform the coronial investigation.

Q: *Please provide further information about the application of the Right to Information Act 2009 (RTI Act) to the Domestic and Family Violence Review and Advisory Board (the Board) and potential use by the Board of exemptions under the RTI Act.*

A. The Bill does not include any specific exclusion from the usual provisions and operation of the *Right to Information Act 2009* or the *Information Privacy Act 2009.*

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.

Some examples of the types of documents, or information, that are exempt, excluded or factors favouring non-disclosure under existing right to information legislation that relate to the Board's proposed operation include:

- a document of an agency that is a coronial document, other than certain documents specified, while a coroner is investigating the death to which the document relates;
- a document created for a root cause analysis of a reportable event under the *Ambulance Service Act 1991 part 4A,* or the *Hospital and Health Boards Act 2011*, part 6;
- information the subject of legal professional privilege;
- information, disclosure of which would be a breach of confidence;
- information if its disclosure could reasonably be expected to prejudice an investigation of a contravention of the law, enable identification of a confidential source related to law enforcement, or endanger a person's life or physical safety; and
- personal information of individuals.

Q: *New section 91E of the Coroners Act 2003 would provide that the Board must, when reviewing a domestic and family violence death, consider the events leading up to the death. However, new section 91D(3) would prohibit the Board investigating the actual death. Please could you clarify the intended interaction between these two provisions, including the respective roles of the Board and Coroner?*

A. The Board's primary purpose is to review deaths related to domestic and family violence to prevent or reduce the likelihood of those deaths. The Board's functions under the new section 91D support the Board's death prevention role, including by providing for the Board to make recommendations to the Minister about improvements to legislation, policies, practices, services, training and communication by government and non-government entities to prevent future deaths and to compile reports

identifying key learnings and elements of good practice in preventing domestic and family violence deaths.

Section 91D(3) distinguishes the Board's functions from that of the coroner as it is not a function of the Board to *carry out an investigation of* a death, but rather, in accordance with sections 91D(1) and 91E, to *review* domestic and family violence deaths and, in doing so, *consider* events leading up to a death (such as contact of those involved with support services).

Under the *Coroners Act 2003*, the role of coroners is to investigate the circumstances leading up to the incident in which a person died. Under section 45(2) of *Coroners Act 2003*, 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. The sequence of events in an individual case may or may not involve the victim having had service or system contact.

In contrast, the Board's review function, which under section 91E allows it to consider the events leading up to the death, will not be focused on investigating and making findings about the particulars of a person's death (such as the person's identity, medical cause of death and how the death occurred) but rather examining and making recommendations in relation to the supports and services provided that preceded that death with a view to preventing future deaths.

It is envisaged that the Board will rely to a significant extent on the investigation documents held by the Office of the State Coroner to support its review function. Section 91Z provides for the Board and the State Coroner to enter into an arrangement about the exchange of information between a coroner and the Board to support the provision of this information occurring.

While a power exists under section 46 of the *Coroners Act 2003* for a coroner to make preventative recommendations in relation to systemic issues, this only applies to the small number of matters that proceed to inquest. Also, in cases where a person has been charged in respect of the death (as in the case of many domestic and family violence related deaths), the coroner is prevented by section 29 of the *Coroners Act 2003* from holding or continuing an inquest until the criminal process (including appeals) has exhausted; this may take several years.

The Board's role and functions will allow it to review and examine the events leading up to all death and family violence related deaths and to make recommendations to the Minister to prevent such deaths from occurring without the need to wait until any criminal proceedings have been finalised and relevant appeal periods expired. 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).

Even in cases where there is no barrier to an inquest being held more immediately (e.g. where a violent partner has committed suicide), inquests are

only held into a small percentage of the total number of reportable deaths each year. Unless the death also falls within one of the criteria under the Act which require that an inquest must be held (deaths in custody, deaths in care and deaths during police operations), the decision about whether to hold an inquest under the Act is made by reference to whether this is considered to be in the public interest. The decision to hold an inquest in the public interest is made at the discretion of the investigating coroner, who is an independent judicial officer. Chapter 9 of the State Coroner's Guidelines provide guidance to coroners about the factors to be considered when making this assessment.

The Board will be able to review and make recommendations about domestic and family violence deaths that do not proceed to inquest.

Consultation

The Taskforce undertook extensive consultation in preparing its report. The consultation process included meeting with 367 different groups of victims, service providers and community leaders. This consultation informed the Taskforce recommendations, which are being implemented through this Bill.

The State Coroner and officers from the Office of the State Coroner have been consulted and their views have been taken into account in preparing the Bill.

Since introduction, the heads of court jurisdictions, the Queensland Law Society, Bar Association of Queensland, other legal stakeholders, and key domestic and family violence organisations have been provided with a copy of the Bill for comment.

In addition, key legal and domestic and family violence support services and stakeholders will be consulted prior to debate on the Bill to identify and resolve any operational and/or technical issues.

Fundamental Legislative Principles

The Committee is referred to pages 3-4 of the Explanatory Notes to the Bill where potential breaches of the fundamental legislative principles are identified and justified.

Costs

As noted in the Explanatory Notes to the Bill, the Queensland Government has committed $2.067 million over four years for the enhancement of the Domestic and Family Violence Death Review Unit in the Office of the State Coroner, and the establishment and operation of the Board.

Once established, the Board will have the benefit of sharing the resources and expertise with the DFVDRU. As secretariat support will be provided by the DFVDRU, information, research and analysis prepared and developed by the Unit will be available to the Board.

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.*

Expert consultants who may be engaged by the Board from time to time will be paid out of the allocated funding for the Board's operation referred to above.