



# ***COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE***

## **Members present:**

Ms LE Donaldson MP (Chair)  
Miss N Boyd MP  
Ms AM Leahy MP  
Mr MF McArdle MP  
Mr MJ McEachan MP  
Mr RJ Pyne MP

## **Staff present:**

Mr K Holden (Research Director)  
Ms L Manderson (Principal Research Officer)

## **PUBLIC BRIEFING—CORONERS (DOMESTIC AND FAMILY VIOLENCE DEATH REVIEW AND ADVISORY BOARD) AMENDMENT BILL 2015 AND CRIMINAL LAW (DOMESTIC VIOLENCE) AMENDMENT BILL 2015**

### **TRANSCRIPT OF PROCEEDINGS**

**FRIDAY, 18 SEPTEMBER 2015**

**Brisbane**

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Committee met at 9.00 am

**MACKIE, Mr David, Director-General, Department of Justice and Attorney-General**

**MOORE, Ms Victoria, Acting Director, Strategic Policy, Department of Justice and Attorney-General**

**PARKER, Ms Natalie, Acting Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General**

**CHAIR:** Good morning. I call this public briefing of the Communities, Disability Services and Domestic and Family Violence Prevention Committee to order. Thank you for your interest and attendance today. My name is Leanne Donaldson, the member for Bundaberg and chair of the committee. Mark McArdle, the member for Caloundra, is the deputy chair. The other committee members are Ms Nikki Boyd, the member for Pine Rivers; Ms Ann Leahy, the member for Warrego; Mr Matt McEachan, the member for Redlands; and Mr Rob Pyne, the member for Cairns. On behalf of the committee, I welcome officers from the Department of Justice and Attorney-General and the Department of Communities, Child Safety and Disability Services.

Today's public briefing is to assist the committee with our inquiry into the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015 and the Criminal Law (Domestic Violence) Amendment Bill 2015. The committee has advised the public of its inquiry into the bills by advertising on the parliamentary website and also by writing directly to a number of individuals and organisations. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. You have previously been provided with a copy of instructions to witnesses, so we will take those as read.

Hansard will record the proceedings and witnesses will be provided with a transcript. Today's proceedings are being broadcast live on the parliament's website. The media may also be present during this morning's briefing. The media will follow the conditions for broadcasters and guidelines for camera operators, which are available from one of the parliamentary staff. I ask witnesses to please identify themselves when they first speak and to speak clearly and at a reasonable pace. I remind all those attending the briefing today that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In this regard I remind members of the public that under the standing orders the public may be admitted to, or excluded from, the briefing at the discretion of the committee.

I remind committee members that officers from the department are here to provide factual or technical information. Any questions about government or opposition policy should be directed to the responsible minister or shadow minister or left to debate on the floor of the House. I also ask that if departmental officers take a question on notice today they provide the information to the committee by Tuesday, 22 September 2015. Before we commence, I ask that mobiles be turned off or switched to silent mode. I now call Mr David Mackie, Director-General, Department of Justice and Attorney-General, to brief the committee on the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015.

**Mr Mackie:** I would like to thank the chair, the deputy chair and committee members for giving us the time today to speak about the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015. The bill implements recommendation 8 of the report of the bipartisan [Special Taskforce on Domestic and Family Violence in Queensland chaired by the honourable Quentin Bryce. The task force report *Not now, not ever: putting an end to domestic and family violence in Queensland* was released on 28 February 2015 containing 140 recommendations to eliminate domestic and family violence and improve current responses.

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Amendment Bill 2015 and Criminal Law (Domestic Violence) Amendment Bill 2015

As the committee would be aware, the recommendations are comprehensive and cover all aspects of the way that 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. The task force undertook extensive consultations across the state, including regional and remote communities, to inform its work and recommendations. The Queensland government has accepted all of the task force recommendations and is now implementing 121 recommendations directed at the government.

The Department of Justice and Attorney-General is leading the implementation of over 30 of those 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. The scope of the work recommended by the task force and now being implemented through the department, legal profession—including the Queensland Law Society—and judicial officers provides an important context for this committee hearing on the bill that underpins the establishment of the proposed Domestic and Family Violence Death Review and Advisory Board. The board is a key element of the government's broader commitment to improve the current service system and justice system responses.

While I am not going to address all of the work that the Department of Justice and Attorney-General is undertaking in respect of implementing the recommendations, I did want to take this opportunity to outline to the committee the justice related work that is being prioritised. The department is strongly committed to ensuring our justice system works as effectively as possible to support and protect victims of domestic and family violence and to hold perpetrators accountable for that violence. In response to task force recommendations 96, 97 and 100, a specialist approach to how the courts deal with domestic and family violence proceedings, the trial of a specialist domestic and family violence magistrate has commenced in the Southport Magistrates Court. The trial is being used as an opportunity to implement several best practice court and registry procedures, including the fast-tracking of urgent applications for temporary protection orders and streamlined procedures for the engagement of interpreters. A dedicated registry has been created to complement the specialist court and provides clients with a single point of contact to specialised court staff who can offer support, referral, information and assistance regarding civil and criminal domestic violence proceedings.

The trial will be evaluated and it will assist in the development of future initiatives in this area of specialist court responses to domestic and family violence. Beyond that trial, throughout the state the department is working to ensure that court and registry staff receive training in responding to the needs of domestic and family violence clients as per recommendation 106 of the task force report. The department is participating in the development of integrated response models which are to be piloted in three locations in response to recommendations 9, 74 and 75 of the task force report. The locations will include a regional location with outreach to rural and remote communities and an Indigenous community. The department is also working with the Department of Communities, Child Safety and Disability Services on a review of the Domestic and Family Violence Protection Act 2012, implementing recommendation 140 of the task force report.

In addition, the department is continuing to review the Victims of Crime Assistance Act 2009 to ensure that all victims of domestic and family violence are able to seek financial assistance as per recommendation 95 and coordinating the justice reports for victims exposed to criminal proceedings as per recommendation 132. The Chief Magistrate has also recently finalised work on the *Domestic and Family Violence Bench Book*, which outlines the relevant law and suggested procedure for judicial officers who deal with applications under the Domestic and Family Violence Protection Act 2012 and a best practice report on the outcomes of a domestic violence best practice project to, amongst other things, identify elements of best practice for magistrates courts in Queensland to assist judicial officers, court staff and others involved in the court process to support the objectives of the act. Both publications are available on the Queensland courts website at [www.courts.qld.gov.au](http://www.courts.qld.gov.au).

I will now give the committee an overview of the Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Bill 2015. The review process for domestic and family violence related deaths was a specific area of focus by the task force as a mechanism to build a greater understanding of factors that may increase a person's risk of being killed in the context of domestic and family violence with a view to reducing the likelihood of future deaths. In Queensland nearly half of all homicides over the past eight years have been linked to domestic and family violence. While these figures are subject to change as the data includes open coronial cases, over the period 1 January 2006 to 30 June 2014, 187 deaths occurred in the context of domestic and family violence. Of these deaths where ethnicity was recorded, 26 deaths involved Aboriginal and Torres Strait

Islander domestic and family violence family related homicide, and of these in 25 cases the deceased was the victim of domestic and family violence. Based on earlier data recorded to 31 December 2013, approximately 56 per cent of these deaths occurred within an intimate partner relationship—that is, in circumstances where the victim or offender were current or former partners, married, de facto or girlfriend-boyfriend. A further 39 per cent of deaths occurred within a family relationship.

Domestic and family violence related deaths in Queensland are currently reviewed under processes established within the Office of the State Coroner. The Domestic and Family Violence Death Review Unit, which sits within the Office of the State Coroner, provides specialist advice and assistance to support the role of coroners in their investigations of domestic and family violence deaths. Whilst the task force recognised the important role of the unit, it was concerned about the lack of a comprehensive review structure to look at the system as a whole and identify any failures or gaps that may contribute to a domestic and family violence related death. The task force noted that, while the coroner through these inquests can consider the systemic failures that may have occurred and can make recommendations, the coroner does not undertake an inquiry on every death and generally considers each death in a discrete way. Taking into account its concerns, the task force recommended that the government immediately establish an independent board to identify common systemic failures, gaps and issues, and make recommendations to improve systems, practices and procedures.

The bill before the committee today establishes an independent body consisting of multidisciplinary experts separate from the coronial and criminal processes as contemplated by the task force. Having an independent body conducting systemic reviews is intended to support the identification of effective strategies to prevent and reduce the likelihood of domestic and family violence deaths in the future. The board will draw upon the important work of the Domestic and Family Violence Death Review Unit in order to make recommendations to government and non-government agencies for the improvement of systems and practices.

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. Enhancing the Domestic and Family Violence Death Review Unit in the Office of the State Coroner and establishing the board will promote the sharing of information with a view to identifying where system changes are needed. The model for the board as reflected in the bill is based on the task force recommendations and 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. This approach of allowing the board to consider open cases will ensure the board can provide timely advice and recommendations to government and non-government agencies without needing to wait until the coronial investigation process has been concluded.

The board will also be able to review deaths that occurred prior to its establishment such as the tragic recent deaths of Tara Brown and Karina Lock on the Gold Coast. The focus of the board will be on reviewing domestic and family violence deaths to identify common systemic failures, gaps and issues and make recommendations to improve current responses, thereby contemplating the existing coronial processes and investigations of domestic and family violence related deaths. We will shortly inform you of the proposed functions, powers and membership of the board as part of the clause-by-clause analysis.

Other related task force recommendations 6 and 7 are that the government consider an appropriate resourcing model for the Domestic and Family Violence Death Review Unit in the Office of State Coroner to ensure it can best perform its functions and that protocols be developed within the unit to ensure government departments have access to important research and resources available from the unit. An assessment of the resourcing needs for the unit has now been finalised, and government has announced it will provide \$2.1 million from 2015-16 over four years to support the operations of the board and enhanced unit. Recruitment for the enhanced death review unit has commenced, with a manager of the unit recently having been appointed to commence duties in October 2015. An additional senior adviser and a new coronial support officer position are currently being created, and they will be filled as a matter of urgency. The Queensland Police Service will also provide an officer to be co-located within the unit to support its effective operation. At this point I would like to hand over to Natalie Parker, Acting Assistant Director-General, Strategic Policy and Legal Services, who will take you through the bill clause by clause.

**Ms Parker:** I thought the way that I would take you through the clauses is to pick out the key clauses rather than every single clause, because some just build on the next clause. Does that suit the chair, the deputy chair and the committee?

**CHAIR:** That is fine.

**Ms Parker:** The first key clause is clause 2, which states—

This Act commences on a day to be fixed by proclamation.

That ensures that, if the parliament passes the bill, there is time for the board to be established with appointments made. That is why the act is going to commence on proclamation.

The next key clause amends the Coroners Act—all of these next clauses are to amend the Coroners Act—and includes a new object of the act. Currently the Coroners Act has several objects, and that is to establish the position of the State Coroner, to require the reporting of certain deaths and categories of deaths, to establish procedures for investigations and inquests into deaths, and also to help prevent deaths by allowing coroners to comment on matters relating to the reportable deaths and deaths that they investigate and take to inquest. Based on those objects, there is going to be another object inserted into the act, and that is to establish the Domestic and Family Violence Death Review and Advisory Board with the purpose of reviewing deaths related to domestic and family violence to prevent or reduce the likelihood of those deaths. This is squarely putting in the Coroners Act this new important object and function.

There are a lot of proposed new sections included in clause 5—basically the entire amendments that are being developed as part of the bill. A new part 4A is to be inserted into the act through clause 5, and that is the Domestic and Family Violence Death Review and Advisory Board. Proposed new section 91A through to proposed new section 91ZF set out the provisions relating to the board, so it is all in one part. It is very handy and very easy for people who are going to want to know about the board to have everything in one place. I will now refer to the proposed new sections. As I said, they are all in clause 5.

Proposed new section 91A sets out the specific purposes of the board. David Mackie in his speech has set out those purposes, so I will not talk about them again. They are, as David said, to identify preventative measures to reduce the likelihood of domestic and family violence deaths; to increase the recognition of the circumstances surrounding those deaths so that we can get a greater understanding of the context of the deaths; and, importantly, to make recommendations to the minister for implementation by government entities and non-government entities to prevent or reduce the likelihood of those deaths. So the board will have a very important function of making recommendations to the minister on these deaths.

Proposed new section 91B sets out some key definitions. I thought I would just take you through the most important of those definitions which is the definition of 'domestic and family violence death'. This is quite a broad definition, as you read through this definition. A domestic and family violence death 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. So it is a very broad definition. It is to pick up that often we have to have a good look at all of these complexities in relation to these deaths. So we think this will pick up quite a broad definition for these deaths. You might see that throughout that definition we are scoping the relationships through the term 'relevant relationship'. That picks up all of the relationships covered under the Domestic and Family Violence Protection Act 2012. There is a handy note in the bill in italics, as an editor's note, of exactly what those relationships are.

I will now take you to another key new section, which is proposed new section 91D, which sets out the functions of the board. This now drills down to the very specific functions that the bill is stating that the board can do. The key elements are that the board can review deaths that occurred before the board commences and also deaths that occurred after the bill is passed. The board can also consider current deaths and investigations by the coroner, as David was saying previously. To do that, the board, under paragraph (b), can analyse data and apply research to identify patterns, trends and risk factors. The board can compile systemic reports on the key learnings and elements of good practice to prevent DV. As I have said previously, the board can make recommendations to the minister about improvements for government and non-government entities across a range of areas

such as legislation, policies, practices, service delivery and training. This section also clearly sets the limits of the board's functions. It is not to carry out an investigation of an individual death. That is the role of the coronial system.

The next section I would like to take you through is proposed new section 91F. This section sets out how the board relates to the coronial jurisdiction. This section says that the board can review a death that is subject to a coronial investigation and also that the review is independent to the investigation by a coroner. This is backed up by proposed new section 91H in terms of the independence of the board. This section says that, in performing its functions, the board must act independently and is not subject to the direction of the minister. So we have a very independent board that can do as it is required under its functions.

The key sections then go into new division 3, which sets out the membership of the board. In proposed new section 91J the provision says that the board is to consist of the chairperson and then not more than 11 members, and they are all to be appointed by the minister. Under that provision, there may be 12 members or there may be fewer than 12 members, as the minister decides. Proposed new section 91K sets out that the minister must appoint either the State Coroner or the Deputy State Coroner as the chairperson of the board. This provision makes sure that there are clear linkages between the coronial jurisdiction and the functions of the board and that we have, as I take you further through the provisions, a good transfer of information from the Office of the State Coroner to the board. This position, as the State Coroner, is an independent judicial officer leading the board who has at their disposal all the information about the coronial system. This section makes that role clear—that the chair is responsible for leading and directing the activities of the board to ensure the board performs its functions appropriately.

Proposed new section 91L provides direction on the rest of the board members and their qualifications. This section says that the minister must ensure that the membership of the board reflects the diversity of the Queensland community so that we can make sure there are members from a cross-section of the community and, importantly, that at least one person is an Aboriginal and Torres Strait Islander person. The section also provides that the membership is to be mixed—both government and non-government entities—and also that the members are to have experience, knowledge or skills that the minister considers relevant to the board's functions, with some examples given. The section then gives some exclusions for membership, and that is either an insolvent under administration or if the person has a conviction, other than a spent conviction, for an indictable offence. The rest of that part sets out the procedures of the board. I was not going to go into that in too much detail if the committee agrees.

Interestingly, in division 5, proposed new section 91T sets out the quorum for the board—

A quorum for a meeting of the board is at least half of the members.

That is important. Under proposed new section 91S, the chairperson may decide to call a meeting of the board and also must call a meeting of the board if asked by at least three other members. That is an important provision as well.

I also draw the committee's attention to proposed new section 91X, which is where board members must disclose a conflict of interest. You can see in that provision that they must disclose the conflict. Subsection (3) states—

After a member has disclosed the nature of an interest in a matter, the member must not be present during a deliberation of the board about the matter, unless the board otherwise decides.

So the board will consider the conflict and determine, based on the conflict, if the member should leave.

Division 7, which is proposed section 91Y through to proposed section 91ZA, provides very broad powers for the board to access information from government, police and service providers relating to persons affected by DV. The board will be able to get all that information in proposed subsection (5) with the usual limits on the ability to obtain that information so that individuals are protected where information might tend to incriminate them, where they might be the subject of legal professional privilege, where there is a criminal investigation going on, or endangering a person's life or prejudicing another prosecution.

You can see with 'prescribed entity' where the information to be shared is specifically set out in proposed subsection (9). Previously I generalised the sources of the information, but they are specifically set out in proposed subsection (9)(a), (b), (c) and (d). If any have been missed out, there is an ability to prescribe more by regulation, but you can see the broad scope of where information can be gathered from the other subsections.

I would now like to take the chair to the next important sections which are under division 8, 'Reporting'. Proposed section 91ZB provides that each year the board is to give an annual report to the minister about their performance and information about the progress to implement recommendations made by the board during that year or previous financial years. That report must be tabled by the minister, so it will be a very important report. Any recommendations that are made will be tabled in the parliament, and there will be an assessment of whether those recommendations have been implemented.

Proposed section 91ZC provides further reporting abilities. It states—

The board may prepare a report about a matter arising from the performance of the board's functions.

That might be about systemic matters. Under this provision if the board chooses to provide this report to the minister there may be tabling of the report, but the report cannot have any identifying information in it if it is tabled on an individual or systemic group of matters. This proposed section goes into a lot of detail which I have not teased out. If you want more information, I can provide it. For example, the board can make a recommendation that the report not be tabled, but the minister may decide that it is in the public interest for that report to be tabled.

In proposed section 91ZD there are the usual confidentiality provisions for board members or for people who get access to material of the board, and there are penalties. In proposed section 91ZE there are the usual provisions dealing with protection from liability for members or persons helping the board perform their function. In proposed section 91ZF there are protections from liability for providing information to the board. That is to protect the entities that provide the information. That is a run-down of the key sections of the bill.

**CHAIR:** Thank you. I will invite questions from committee members.

**Miss BOYD:** Thank you very much for that thorough briefing. I have a question for Mr Mackie. Are you aware of how many domestic or family violence matters are currently underway before a coronial inquiry?

**Mr Mackie:** I am not sure whether we have that information on us at the moment. If we do not, I will take it on notice.

**Ms Parker:** We have some statistics here.

**Mr Mackie:** I might take it on notice if that is possible.

**Miss BOYD:** The reason that I ask is I wonder whether there could be an element of risk in the board reviewing or examining and particularly making recommendations around items that are open before the Coroners Court. For instance, if the Coroners Court did not have all of the information available to it, I wonder whether there could be an element of risk that sits within the board looking at something that is currently the subject of a coronial inquiry. Is this something that the department has looked at or examined in any fashion?

**Mr Mackie:** Yes. I will find the area, but I think there is a reference in the bill itself that any of those investigations cannot impinge upon other proceedings or jeopardise other proceedings, and I think an assessment would be made at the time as to what the circumstances were.

**Mr McARDLE:** I will use the terms 'unit' and 'board' instead of the full title. Can you explain where the unit stops and the board commences? It is not quite clear as to where their roles differ. I know there are jurisdictional issues contained in the bill per se, but what does the unit do now that the board is going to enlarge on that could not be done by the unit?

**Ms Parker:** The DV Death Review Unit was established in 2011 within the Office of the State Coroner. It was established following the recommendations of the Death Review Panel in 2010 as a result of a report that was developed by the group headed up by Betty Taylor at the time. It was specifically set up to provide advice on the coronial processes and to identify barriers preventing domestic and family violence related deaths. Its role currently is to provide that expert assistance in the investigation of homicides, murder-suicides and suicides identified as being related to domestic and family violence to the coroners. So that is what it is doing now.

The unit will assist the coroner by ensuring that the information about the broader context within which the death occurred is gathered and examined. The death review unit supports the coroner in investigating deaths that proceed to inquest and maintains a dataset of all homicides identified relating to domestic and family violence and assists in monitoring and identifying those patterns. That is the role now. What will happen with the DV death review unit is that that capability can now be used to support the board as well. That is my understanding; is that correct, Victoria?

**Ms Moore:** That is right. The secretariat of the board will sit within that unit, so the unit will continue to provide support to the coroner's office in its investigations and assist in collecting the information and inform any assessment of domestic and family violence related deaths, but at the same time it will also be the conduit of information between the coroner's office and the board, and will provide secretariat support to the board. The board's focus will be much more on looking collectively at cases rather than individual cases to identify systemic issues. Its broader focus will be on those systemic issues and making recommendations for improvements to policies, legislation and practice rather than supporting the coroner's office in its role in investigating those individual deaths.

**Mr Mackie:** I think another significant difference is that the board itself and its constitution is made up of a broader reflection of the community in terms of giving meaningful advice and relevant information as recommendations. It obviously also will have greater powers to access information than what the unit has at this point in time. So it is a dedicated body to focus on this particular area of domestic violence deaths with a really meaningful and relevant composition of members, including what information they can sequester.

**Mr McARDLE:** You indicated that the unit advises the coroner. To do that they would need to have an understanding of systemic issues to advise the coroner, which is what the board is going to do as well: look at systemic issues. Just to clarify, I get the sense that the unit will consider systemic issues and so will the board, so where are they different? If it is looking at systemic concerns, either for the coroner or for the board, but the board will do the same thing, where is the difference between the two? I am not trying to be smart; I am trying to understand where they are distinct.

**Ms Parker:** The unit is made up of public servants who are part of the Office of the State Coroner—

**Mr McARDLE:** Does there need to be two bodies? Can the unit become the board? My question is: do we need to have the unit, the board and the coroner? There may be very good reasons as to why that is the case. They are looking at the same thing, as I understand what you said here today: systemic issues regarding domestic violence.

**Ms LEAHY:** I suppose the question is: can the unit be refocused at all?

**Ms Parker:** I gave you a run-down of the provisions in the bill in relation to the appointment of members. It is a matter for the Attorney as to the members she appoints, but we are anticipating these members will have critical knowledge of areas and be experts in their areas which the board of the death review unit do not have because they are made up of public servants who are being directed to do certain tasks for the coroner. So we are giving them a new community driven, expert driven focus to analyse and consider domestic and family violence deaths.

**Mr McARDLE:** I agree with that. I do not question the feeling behind it. But if the unit became a board with a secretariat you could still maintain the board membership as contained in the bill. I am just trying to drill down into this. If they are looking at the same things, systemic domestic violence issues, where are they different? They could morph into one.

**Mr Mackie:** One of the key dichotomies in the context of the unit is really providing operational support for matters that are going through the coroner's office, whereas this board would have a broader holistic focus around the service sector and all sorts of other things around that as well. It would also have different powers to the unit in terms of how they can do their work and make their recommendations whilst there are other proceedings on foot such as criminal proceedings. They do not have to wait. They can be doing their work while those things are in play, which I think would be different from the accountability of the unit.

**CHAIR:** I have a question about when the envisaged time frame would be for the board to be up and running.

**Ms Parker:** This is a matter for the Attorney, as the Attorney will need to appoint the members under the bill. For appointments to be made we must have the bill passed and then the Attorney will appoint those members.

**Mr McARDLE:** Under proposed new section 91Y 'Right to information', the board has the right to call for information from the entities contained in subsection (9). Do you see a need for the board to call a person to give information to it? For example, a CEO on receipt of notification may simply mail the information to the board. I would have thought that the board may want to hear from the CEO or relevant officer as well. I just do not pick up in proposed new section 91Y a right to call a person. That may be something that might be of importance to the board, to get someone to elaborate on the content of information or for it to be explained as well.

**Ms Parker:** Is that a comment?

**Mr McARDLE:** I suppose it is a comment and a question. Is it viable?

**Mr Mackie:** As to whether or not it is expressed in there and, if not, is it something that we could look at as part of it?

**Mr McARDLE:** Is it needed? I will put it that way.

**Ms Parker:** I will pass that over to Victoria Moore as to whether it is covered now or whether we will continue to look at it.

**Ms Moore:** We are happy to have a look at it. We did have a look at the current provisions in the New South Wales Coroners Act 2009, and it was very much focused on the provision of information rather than calling for individuals to provide information. So the approach that we took was to follow, where we could, the New South Wales model with some modifications. But we are happy to look at that further.

**Mr McARDLE:** Again, under proposed new section 91Y(9), a 'prescribed entity' includes NGOs and other organisations of that nature. You then say in the bill later on that recommendations will be looked at down the track to see how they are enforced. How do you do that with an NGO? You can do it with a department, but how do you get into an NGO down the track and say, 'Now you must say to us what you have done and provide me with the data.' How does that work?

**Ms Moore:** There is no requirement for non-government entities to respond or to comment on how they are implementing the recommendations. However, the board will produce an annual report and will be reporting back to the minister and those reports will be tabled. 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, given the strong commitment of many NGOs to tackling issues of domestic violence, they would be cooperative and will provide that information.

**Mr McARDLE:** They would see sense.

**CHAIR:** The explanatory notes on page 5 state that 'key legal and domestic and family violence support services and stakeholders will be consulted prior to debate on the bill'. Has the department started this consultation and, if so, who has been consulted and have there been any issues?

**Ms Parker:** As you know, the bill was introduced on Tuesday, so we are planning to have that consultation and we will be making contact with key stakeholders this afternoon or on Monday on those issues.

**Mr McARDLE:** I just go back to that point again about NGOs. Take, for example, a contact centre that is not funded by the government—by either federal or state governments—where the parents exchange the child at the end or the start of contact. They can be independent bodies. That could well be a spot where a domestic violence situation could occur and violence could happen. In fact, a lot of organisations keep their locations secret for that particular reason. If that body is then given recommendations as to what they should be doing based upon the board's determination of a systemic issue, you cannot enforce that against that body, can you? No-one can enforce that against that body. So you do not have any capacity to make an assessment as to whether or not the recommendation was successful or could have been successful. How do you make certain that the actual recommendations are going to be successful? I understand the issue about the report. I get that. But this is about putting in place platforms and protections now. How do we assess that NGOs which have not put in place recommendations have actually failed in regard to the protection of women, men and children?

**Mr Mackie:** It probably goes back to the comments that were made earlier. 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, I think. Through the reporting, we would obviously seek some information from NGOs at the time we report about reporting against that. Again, we cannot force them to adopt the recommendations or give us information around that, but you would like to think in this particular environment, in this particular space, there would certainly be a focus by those NGOs to comply.

**Mr McARDLE:** Thank you very much. That is much appreciated.

**CHAIR:** We have a couple of more minutes to ask questions before we move on to the next bill.

**Miss BOYD:** There was a response relating to one of the questions that the deputy chair asked where, Ms Moore, you indicated that you looked at New South Wales to gather some information. I am wondering whether a board such as the one that is being proposed actually exists already in any other jurisdiction. Is that something that you have looked at? Are there similarities or differences between what has been proposed before the committee today and what is running in different jurisdictions?

**Ms Moore:** The model, as I said, that we have most closely looked at is the New South Wales model, which is a legislative model and is similar but different in some respects to what is proposed in this bill for Queensland. New South Wales has a Domestic Violence Death Review Team, which is established. Its membership is listed under section 101E of that act. It only looks at closed cases—that is, cases where the coronial investigation has concluded. So it is different in that respect from the model proposed under this Queensland bill.

Other models that we have looked at include non-legislative models. Victoria has a Victorian Systemic Review of Family Violence Deaths, which has a reference group which has quite a broad membership. But my understanding is that that has not been established in New South Wales. That is simply an advisory group. There are other models that exist such as in New Zealand, where they have family violence death review committees with members appointed by the Health Quality and Safety Commission. So there are a range of models that we have looked at, but most significantly the New South Wales model has been the one that stakeholders have raised with us previously.

**CHAIR:** Before we move on, I would like to invite to the table Megan Giles, the Executive Director of Legislative Reform in the Department of Communities, Child Safety and Disability Services.

**GILES, Ms Megan, Executive Director, Legislative Reform, Department of Communities, Child Safety and Disability Services**

**MACKIE, Mr David, Director-General, Department of Justice and Attorney-General**

**MOORE, Ms Victoria, Acting Director, Strategic Policy, Department of Justice and Attorney-General**

**PARKER, Ms Natalie, Acting Assistant Director-General, Strategic Policy and Legal Services, Department of Justice and Attorney-General**

**RYLKO, Ms Julie, Acting Director, Strategic Policy, Department of Justice and Attorney-General**

**CHAIR:** I now call Mr David Mackie to brief the committee on the Criminal Law (Domestic Violence) Amendment Bill 2015.

**Mr Mackie:** I will move on to the Criminal Law (Domestic Violence) Amendment Bill 2015. For this bill I am also joined by Megan, as you have already pointed out. Megan is the Executive Director of Legislative Reform in the Department of Communities, Child Safety and Disability Services. Thank you again for the opportunity to speak to the committee today on this bill. I will provide an overview of the reforms in the bill and then hand over to Natalie Parker to discuss the detail again of the clauses falling within the justice portfolio. Ms Parker will then defer to Ms Giles, who will discuss the clauses for the amendments to the Domestic and Family Violence Protection Act 2012, which fall within the communities portfolio.

Similarly to the previous bill, this bill also implements three recommendations made by the Special Taskforce on Domestic and Family Violence in the report *Not now, not ever: putting an end to domestic and family violence in Queensland*. The reforms in this bill will enable notations to be made on charges for criminal offences to indicate that they have occurred in a domestic violence context and provide that subsequent convictions for domestic violence offences be noted on a person's criminal history. It will ensure the availability of protections for special witnesses apply to all victims of domestic violence, and it will increase the maximum penalties for breaches of domestic violence orders. These key reforms are part of a package that the government has decided to fast-track to increase accountability of perpetrators of domestic and family violence and to increase protection for the community and victims of domestic and family abuse, following the very recent public and horrific domestic violence incidents that recently occurred.

Recommendation 119 is that this Queensland government make provision in legislation for domestic and family violence related convictions to be recorded consistent with the approach adopted in New South Wales. Currently in Queensland convictions for criminal offences which have been committed in the context of domestic and family violence are recorded like any other crime, not recognising the specific nature of the abuse. For example, a common assault committed by a husband against a wife will only be recorded as a common assault on charge sheets, indictment if indicted and the offender's criminal history. The fact that the offending occurred in a domestic violence context is not obvious in the recording of the offence. Should the offender subsequently appear before the court on another criminal offence which occurs in a domestic and family violence context, the prosecutor and court are unlikely to be aware of that context of the offender's previous offending.

The bill overcomes this by ensuring that the domestic and family context of criminal offending is evident on the face of charges and in criminal histories. This recognises that, to enhance the safety of victims, information must be available to the court, police and other supporting agencies to know if there is an ongoing pattern of domestic and family violence. It enables the courts and the police to be armed with information to take appropriate action against the offender. The bill also implements part of the government's response to the task force's recommendation 133. That recommendation was that the Attorney-General, in consultation with the Chief Magistrate and Chief Judge, implements alternative evidence procedures for victims of domestic and family violence providing evidence in related criminal matters to reduce the trauma of this experience, including legislative amendment and/or procedural changes.

In considering the complexities of pursuing criminal prosecutions for domestic and family violence related incidents, the task force report identified that victims are often traumatised by having to repeatedly retell their stories. When criminal charges are laid, police report that there is often a difficulty in pursuing the prosecution given a reluctance of the victim for fear of continuing with the

criminal prosecution. Section 21A of the Evidence Act 1997 sets out a range of measures that can be instituted by the court in order to support and enhance the giving of evidence of certain defined vulnerable or special witnesses. These measures include giving evidence from another room, giving evidence via a videotaped recording and the ability to have another person present in the court to provide emotional support while the witness gives evidence.

Like the last bill, the reforms in this bill build on the work which has already commenced to deliver better decisions and outcomes for victims including the new specialist family violence court trial in Southport and the new court bench book to support every magistrate in Queensland by providing a clear judicial and procedural framework for dealing with family violence matters so they can deliver a high level of consistency in how the law is applied statewide. The reforms in this bill are part of the government's response to recommendation 133, but there is more work to be done in the space of reducing the trauma for victims in giving evidence.

Finally, the bill implements task force recommendation 121 for the Queensland government to consider the sufficiency of penalties to hold perpetrators to account for repeat contraventions of domestic violence orders. Specifically, the bill will increase maximum penalties from two to three years imprisonment for a breach of a domestic violence order. The maximum penalty for a subsequent breach will increase from three years to five years imprisonment. The changes reinforce the community's view that domestic violence is unacceptable and perpetrators will be held accountable for the use of such violence. The increase also brings maximum penalties closer into line with those applying in some other Australian jurisdictions such as Victoria, Tasmania and the Australian Capital Territory. I will now hand over to Natalie Parker to go through the clauses.

**Ms Parker:** In going through the clauses of this particular bill, I will go through the clauses relating to the acts within the administration of the justice portfolio. Megan Giles, who represents the Department of Communities, Child Safety and Disability Services, will go through the clause related to the amendment of the Domestic and Family Violence Protection Act. In going through these provisions, I am going to clump some together because with these provisions some clauses flow on to other clauses later on in the bill, and the clauses relate to amendments in the Criminal Code which relate to indictable offences and procedures for prosecuting indictable offences. There are also some amendments to the Justices Act because that provides for the procedure of less serious offences—summary offences—and then there are also amendments to the Penalties and Sentences Act because that is providing the sentencing regime. So they all link into each other, and for that reason it would be too confusing to take you through clause by clause and I am going to clump some of them together.

As David said, this bill implements recommendation 119 to provide for notations of domestic and family violence offences in the Criminal Code, the Justices Act and also the Penalties and Sentences Act. Firstly, I will take you to clause 4. Clause 4 amends section 564 of the Criminal Code, and this allows an offence charged on indictment—that is, offences in the Criminal Code—to be noted as a domestic violence offence. The sister clause is clause 14. If you go to clause 14, this is an amendment to section 47 of the Justices Act to allow an offence to be noted on a complaint as a domestic violence offence. For both charges under the code and under the Justices Act, we are going to have the ability to note these as domestic violence offences. That is in the charges provision. Clause 18 amends the Penalties and Sentences Act in that, where the offender is found guilty or pleads guilty to such an offence and the court is satisfied the offence is a domestic and family violence offence, the court must order that the offence is noted on the offender's criminal history as a domestic violence offence. So that is how we get to the notation.

To assist with the process of identifying domestic violence offences, the court will have power under clause 18 of the bill to order that previous criminal offences—for example, assault occasioning bodily harm—be noted on a person's criminal history as a domestic violence offence. With regard to clause 18, I would like to point out to the committee that it potentially infringes the fundamental legislative principle that legislation should not adversely affect the rights and liberties or impose obligations retrospectively. However, any potential breach must be balanced against the community interest, ensuring that an offender's pattern of domestic violence behaviour is identifiable on a person's criminal history and in the interests of justice in ensuring that offenders are to be sentenced in the context of accurate and pertinent information. As per the explanatory notes, we think that potential FLP breach is considered and justified.

I want to specifically point out that the amendments to set out this notation of the domestic violence offence on the criminal history does not interfere with the court's discretion as to whether to formally record a conviction against an offender or where an offender's criminal history can be taken

into account. So the court still has that discretion to not record a conviction. In summary, as David said, these amendments send a clear message to offenders who continue to commit domestic violence that constitutes a criminal offence that all of these can now be considered by the court and police officers to inform future criminal justice outcomes for the offender, as the history will all be notated as it occurs.

Before I finish and hand over to Megan, I thought I would take you through the new special witness provisions. I take you to clause 11 of the bill, which is an amendment to the Evidence Act, and specifically section 21A, which is about the evidence of special witnesses. The bill amends this section to automatically recognise that for criminal matters where an accused is being prosecuted for a DV related offence the victim of the domestic violence will automatically be recognised as a special witness. Currently under 21A of the Evidence Act it is not automatic in that the victim has to apply and demonstrate that they will suffer trauma or they have been traumatised, and I will get the specific provisions while Megan is speaking to clarify that. Once a victim of domestic violence is automatically considered as a special witness, what that will trigger is the court being able to make a direction or order for one of the measures available under section 21A that is appropriate in the circumstances. This includes videotaped evidence and other things which David mentioned such as excluding the accused from the courtroom, obscuring the view of the accused from the special witness, allowing support people to be present in the court, allowing for rest breaks for the witness, stating that simple questions must be used for the witness and limiting the number of questions.

I have that section here, so I want to clarify for the committee that currently for a victim of domestic violence section 21A(1)(b)(ii) and (iii) is the specific provision that currently applies. It states that the witness—

- (ii) would be likely to suffer severe emotional trauma; or
- (iii) would be likely to be so intimidated as to be disadvantaged as a witness;

Under this new provision, the witness does not have to demonstrate those two factors or one of those two factors. I would now like to hand over to Megan Giles from the Department of Communities, Child Safety and Disability Services to take you through the amendment related to the Domestic and Family Violence Protection Act.

**Ms Giles:** Good morning, chair, deputy chair and members of the committee. As David already outlined in his overview, recommendation 121 from the special task force report called for the consideration of increasing penalties to hold perpetrators to account for repeat contraventions of domestic and family violence orders. Clause 7 of the bill amends section 177 of the Domestic and Family Violence Protection Act 2012 to increase maximum penalties for criminal offences for a breach of a domestic violence protection order. Currently the maximum penalty for a breach of a domestic violence order under section 177 is, if the respondent has in the last five years previously been convicted of breaching a domestic violence order, a police protection notice or release conditions, three years imprisonment or 120 penalty units; or, if the person is otherwise convicted of an offence under the act, two years imprisonment or 60 penalty units.

Clause 7 of the bill increases these maximum penalties as follows: if the respondent has previously been convicted in the last five years of an offence under the act or another domestic violence related offence, five years imprisonment or 240 penalty units. The reference in that amendment to another domestic violence offence relates to the Criminal Code amendment and Justices Act amendment that Natalie has just taken you through in terms of notations on offences. If a person is otherwise convicted of an offence under the act, the penalty will be increased to three years imprisonment or 120 penalty points. The increased maximum penalties otherwise constitute a potential infringement of the fundamental legislative principle that legislation has sufficient regard to the rights and liberties of an individual. However, this is similarly justified in the community interest in ensuring that there are effective and appropriate sanctions in place for patterns of behaviour that underpin domestic and family violence.

Clauses 8 and 9 make amendments to deal with procedural matters relating to the increased penalties. Specifically, an offence carrying five years as a maximum penalty would be classified as an indictable offence. However, there will be provision for the Magistrates Court to hear and determine offences unless, because of the nature or seriousness of the offence or another relevant consideration, the defendant may not be adequately punished on summary conviction or if satisfied that, because of exceptional circumstances, the charge should not be heard summarily. It will be a matter for the magistrate to make that decision. The maximum term of imprisonment which can be imposed in a summary conviction by a Magistrates Court is three years imprisonment. My colleagues and I are happy to clarify any matters that you might have or answer any questions as far as we can.

**Mr McARDLE:** When you go to clause 7 and the increase in penalties, do you have information, or can you take on notice, on how many applications have been made to the court for a breach of domestic violence orders in the last two financial years and this financial year as well and what other types of orders have been made? For example, it is currently three years and two years. Has anybody been sentenced to three years or two years, or has it been probation or community service orders or the like? How many applications have been made to the court for a breach of a domestic violence order in the past two financial years and the current financial year to date, and what has been the range of penalties issued for that broken down into the headings of probation et cetera? I accept that you cannot do it now.

**Mr Mackie:** I will take that on notice, if I may.

**Mr McARDLE:** Yes, that would be good. With regard to the changes to the Evidence Act, it has only been two days since the bill was introduced into the House. Have the Bar Association and the Law Society agreed with the proposal in these circumstances with regard to giving evidence?

**Ms Parker:** We have not consulted specifically at the moment.

**Mr McARDLE:** I understand that, but you will?

**Ms Parker:** Yes, we will make sure we do.

**Mr Mackie:** Prior to debate, yes.

**Mr McARDLE:** Fine. Thank you.

**CHAIR:** I have a question about special witnesses. Although my question is not about special witnesses within the courtroom, I am aware that particularly in regional courthouses it is difficult for victims who are special witnesses to be separated, so they may sit in a waiting room with the perpetrator or an offender. Is any consideration being given to rectifying this?

**Mr Mackie:** Yes, there is. Even prior to the DV issue becoming more apparent to the community due to recent events, we very much understand this issue. We have 80-odd courthouses around the state, all built at different times and certainly many of them built when things like domestic violence or child witnesses, for that matter, were not at the forefront of the criminal justice system. So we have a steady program that we already had in place in terms of going through and looking at these facilities in terms of what is needed to be done. This government when it came in also asked for an audit of a similar nature, so we are going through that process now. We certainly understand that some of the facilities, particularly in many regional courthouses, need to be upgraded in that regard. Even in Southport where we are doing the DV trial we have some designs going forward about how we can make the accommodation and facilities better. So we understand that. That is at the forefront of some of the changes that we are looking at bringing forth for our courtrooms.

**CHAIR:** Thank you.

**Miss BOYD:** I have a question in relation to clause 18, which inserts proposed new section 12A, 'Convictions for domestic violence offences'. The conversation that we had earlier was about the principle of retrospective documentation and notation around offences. I was wondering whether in the research that has been done this has happened before and, if so, in what instances.

**Ms Parker:** I might hand that over to Julie Rylko.

**Ms Rylko:** Those provisions that amend the Penalties and Sentences Act are based on similar provisions that the task force report recommended from New South Wales. There are provisions in the Crimes (Domestic and Personal Violence) Act 2007 in New South Wales that contain those similar provisions. When it is a domestic violence offence and a person is convicted before the court, there is some scope for the court to be able to consider criminal offences that they may have been convicted of in the past and whether they occurred in a domestic and family violence context.

**Miss BOYD:** How long has that New South Wales act been in place?

**Ms Rylko:** My understanding is that it is a 2007 act. I am not sure whether the relevant section, which is section 12, existed at the time it was introduced, but the act is from 2007.

**Miss BOYD:** Are you able to take on notice to provide us with some detail around that: firstly, what year that came in and, secondly, for how many instances the retrospectivity has been applied?

**Ms Rylko:** Certainly.

**Miss BOYD:** Thank you.

**CHAIR:** How is the department ensuring both victims and perpetrators of domestic violence will be aware of the proposed changes in the bill?

**Mr Mackie:** In the lead-up before its passage we would be looking at website presence and writing to NGOs advising NGOs of that. I think there will obviously be media statements relating to it, so we are very aware and conscious that it needs to be publicly out there well prior to these laws coming in.

**Miss BOYD:** I have another question in terms of retrospectivity. Is there a mechanism for appeal or will the retrospectivity be based on the previous criminal history and it is assumed that there is an appeal component in that?

**Ms Rylko:** The provision will not interfere with the court's ability to appeal a decision in relation to a conviction or a sentence. In terms of correction of an error, there is provision in the section itself in subsection (8) that if a court is satisfied an error has been made in the recording or entering of an offence as a domestic violence offence the court may, on application or its own initiative, correct that error. So there is some provision in the section itself to correct any technical errors or so.

**CHAIR:** Are there any further questions from committee members? If not, I am aware that the deputy chair has further questions regarding the coroners amendment bill.

**Mr McARDLE:** Thank you, Madam Chair. Under the terms of the bill, is the information and the discussions contained within the board structure RTI-able or not? Can I RTI the board documentation? The reason I pose that question is this: if you are going to obtain information from the department of communities, it would be very sensitive information that will be before the board. It could well be about a family or it could well be about a large scope and that information is exceptionally delicate. Is this safe from RTI or not? The board's deliberations will also contain—the minutes will contain—information that I thought could be equally sensitive.

**Mr Mackie:** I would imagine that everything is RTI-able at the end of the day. Obviously the RTI Act would be applied though in terms of any of those requests, so I would imagine much of that information would probably fall within exclusion zones as part of that RTI application. But we can get you a little bit further information if you would like around the provisions and how that would apply.

**Mr McARDLE:** Thank you. The other thing, too, is that the information you are going to gather, as I said, will be very sensitive information. The Auditor-General recently put out a report regarding Child Safety information in which he was quite concerned about information not being securely placed or being accessible by people who should not have access to it. How do we secure that information within the board structure to make certain that the information is received in a form that it needs to use but is also secure in that it cannot be then left lying around somewhere, because, again, the data is exceptionally delicate?

**Mr Mackie:** Yes, and that would be something we would have to certainly specifically look at in the lead-up to the board being established if the bill goes through.

**Mr McARDLE:** The other point, too, is that when we talk about 91ZC we talk about making adverse comments about persons and 91ZC(3) relates to information about a person. The board may want to make an adverse comment about a department as well. There is nothing in here to say that the department has the right to make a submission about that or an NGO for that matter as well—a right of reply. That is the first point, and I think it might be worthwhile considering it. Some of the reports that come down also by the Auditor-General actually have as an appendix the submissions made by the relevant authority against which the comment is made as part of the report. Is that going to happen here? You say here that the submission will be referenced appropriately in terms of the final report. Will it be a full insertion of the submission by the person or entity that you made adverse comment against or just a synopsis of what they are saying?

**Ms Parker:** I think that will be a matter for the board as to how they will structure their reports, but I think it is a good issue that they will take into consideration. In terms of that comment about adverse comments about persons, I think we will consider that matter but also have a look at the Acts Interpretation Act and the definition of 'person'. That probably does cover any legal entity, but we will take that point into consideration as we are finalising before debate of the bill.

**Mr McARDLE:** I have one final point. A death or a suicide occurs and it falls into the terms of the bill. How does the board's jurisdiction get enlivened? It will go through the coroner's office per se. Is it then a reference by the coroner to the board so that the board then has a jurisdictional issue to deal with the matter?

**Ms Parker:** I will hand you over to Victoria Moore for that one. We have considered that issue.

**Ms Moore:** Under the proposed new section 91Z, which is on page 20 of the bill, you will see there is a fairly detailed provision there about entering into an arrangement with the State Coroner about the exchange of information and also under subsection (3) that the State Coroner may give the

board access to an investigation document. What we envisage happening is that that arrangement would detail a lot of those sorts of administrative aspects of how the board is notified and at what point in the investigation the board is notified. We did not want to go into too much detail about how that would happen in the bill itself because we thought that that should be something that was negotiated between the board, once established, and the Office of the State Coroner to determine what those arrangements would look like. All that detail about when would be something that would be detailed in that arrangement. Does that clarify your question?

**Mr McARDLE:** Okay. With regard to proposed section 91E, the review function of the board, subsection (a) states 'the events leading up to the death', but you cannot investigate the death itself as I understand the terms of the bill. What is the break between the events leading up to the death and the actual passing away of a person? Where is the difference?

**Ms Moore:** This provision, as I understand—and I will check this—was based on the New South Wales equivalent provision. So your question is about the events leading up to the death and—

**Mr McARDLE:** For example, someone is killed. Where do the events leading up to the death under the review function of 91E(a) stop and the inability to carry out an investigation of a death under 91D(3)? I just do not quite see where they are different. I would have thought the events of the death must in part be an investigation of a death and it might be—

**Ms Parker:** I suppose this goes back to the purpose and functions of the board as compared to the purpose and functions of the coronial system.

**Mr McARDLE:** I agree with you totally. That is the point of my question.

**Ms Parker:** The board's focus will be systemic issues. We will have a look at how that section is drafted, but it is definitely going to be finding the learnings from what has happened in particular deaths but not needing to make findings or investigate as the coroner would. We will check the way that the provision is drafted, but that is really the delineation of the two roles.

**Mr McARDLE:** I just wonder whether the functions in that regard are blurred because of the language used. The language here is quite clear—'the events leading up to the death' but cannot 'carry out an investigation of a death'. I am just not clear on the wording. It might well be a New South Wales proposal that their case law has devolved as to what that does mean.

**Mr Mackie:** We will certainly have a look at that. Obviously 91E(a) though is just bringing it up to the point where there is no overlap with the coroner's function, but we will have a look at the wording. I understand what you are saying.

**Mr McARDLE:** Thank you.

**CHAIR:** As there are no further questions from the committee, I want to thank everybody for your time here this morning and for the information you have provided and the time you have taken. I declare the public briefing closed.

**Mr Mackie:** I just want to thank the committee for its hospitality in having us here and thank you very much for raising issues for two really important bills for the community.

**Committee adjourned at 10.29 am**