Domestic and Family Violence
Death Review and Advisory Board

Procedural Guidelines

Updated June 2025

Domestic and Family Violence
Death Review and Advisory Board

Queensland Government

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About the Board

Introduction

This document outlines the functions and procedures of the Domestic and Family Violence Death Review and Advisory Board (the Board). This document should be read alongside the *Coroners Act 2003* (Qld)[1] (the Act). These Procedural Guidelines will be reviewed annually.

Establishment of the Board

The *Special Taskforce on Domestic and Family Violence in Queensland*[2] (the Taskforce) was established in 2014 to examine Queensland's domestic and family violence (DFV) support systems, and to make recommendations to the Queensland Government on how the system could be improved and how to prevent DFV from occurring in the future.

The Taskforce delivered the *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*[3] report on 28 February 2015. The Taskforce recommended immediate steps be taken to enhance current review processes for DFV related deaths in Queensland, including:

- The Queensland Government immediately consider an appropriate resourcing model for the DFV Death Review Unit (DFVDRU) in the Office of the State Coroner to ensure it can best perform its functions to enable policy makers to better understand and prevent DFV (Recommendation 6);
- Protocols be developed with the DFVDRU to ensure that government departments with relevant policy development responsibilities have access to the research and resources available from the Unit (Recommendation 7); and

[1] *Coroners Act 2003 (Qld)*, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013

[2] https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/about/special-taskforce

[3] Special Taskforce on Domestic and Family Violence in Queensland, 2015, *Not now, not ever report*, https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/about/not-now-not-ever-report

- The Queensland Government, in consultation with key DFV stakeholders, immediately establish an independent Domestic and Family Violence Death Review Board (the 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. Be supported by and draw upon the information and resources of the DFVDRU (Recommendation 8).

Queensland Government accepted all Taskforce recommendations. The Board was established in late 2015.

The membership, functions and powers of the Board are legislated in Part 4A of the Act.

In addition to requirements for the Board to act independently and in the public interest, the legislation provides that the Minister, or anyone else, cannot direct the Board on how it is to perform its functions. While the Minister may direct the Board to carry out a review about a particular matter, the Board determines how the review is carried out and its outcomes.[4]

The Board membership also plays an important role in maintaining independence from government. The Chairperson and no more than 11 members[5] are appointed to the Board with representatives from government and non-government entities.

All resolutions (decisions) must be made by Board member majority vote.[6] This means government members do not hold majority voting powers and decisions.

Objective of the Board

The Board was established to:

- Identify preventative measures to reduce the likelihood of DFV related deaths in Queensland.
- Increase recognition of the impact of, and circumstances surrounding, DFV and gain a greater understanding of the context in which DFV deaths occur.
- Make recommendations to the Minister for implementation by government entities and non-government entities to prevent or reduce the likelihood of DFV deaths.[7]

[4] *Coroners Act 2003 (Qld)*, s 91H, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91H
[5] *Coroners Act 2003 (Qld)*, s 91J, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91J
[6] *Coroners Act 2003 (Qld)*, s 91V, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91V
[7] *Coroners Act 2003 (Qld)*, s 91A, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91A

Board functions

Functions of the Board

In performing its functions, the Board must act independently and in the public interest.[8] As such, the Board may do all things necessary or convenient to be done for or in connection with the performance of its functions, including engaging experts to conduct research and prepare reports to help the Board perform its functions.[9]

The Board's functions[10] are to:

a) Review DFV deaths in Queensland, including deaths that occurred before the Board was established, and deaths that are still being investigated under the Act.

b) Analyse data and apply research to identify patterns, trends and risk factors relating to DFV deaths in Queensland.

c) Carry out, or engage other persons to carry out, research to prevent or reduce the likelihood of DFV deaths.

d) Use data, research findings and expert reports to compile systemic reports into DFV deaths, including identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of DFV deaths in Queensland.

e) Make recommendations to the Minister about improvements to legislation, policies, practices, services, training, resources and communication for implementation by government entities and non-government entities to prevent or reduce the likelihood of DFV deaths in Queensland.

f) Monitor the implementation of recommendations made by the Board.

[8] *Coroners Act 2003 (Qld)*, s 91H, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91H
[9] *Coroners Act 2003 (Qld)*, s 91G, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91G
[10] *Coroners Act 2003 (Qld)*, s 91D, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91D

The chief executive must ensure the Board has the administrative support services reasonably required for the Board to perform its functions effectively and efficiently.[11] A Secretariat to support the Board has been established within the DFVDRU at the Coroners Court of Queensland.

Death review function

Without limiting the matters to which the Board may have regard in reviewing a DFV-related deaths, the Board must consider the following matters:

a. events leading up to the death;

b. any interaction with, and the effectiveness of, any support or other services provided to the deceased person and the person who caused the death;

c. general availability of services mentioned in paragraph (b); and

d. failures in systems or services that may have contributed to, or failed to prevent, the death.[12]

It is not a function of the Board to carry out an investigation of a death. Although the Board may examine individual case reports, this will only be for the purposes of its systemic review function.

When deciding which cases will be subject to review, the Board considers:

- emerging policy, practice and service issues where gaps in knowledge exist.
- data trends (including the prevalence of case types).
- the amount of information available in case files.
- the extent of service system contact.

These considerations allow the Board to select issues and cases that can contribute to making an important and potentially unique contribution to the body of knowledge. Prioritising cases where relevant information is available and there has been service system contact ensures the Board can examine service provision, interactions and information sharing between services and systems. Additionally, the Board can identify any missed opportunities for intervention, to inform the development of preventative, system-focused recommendations.

Relationship with the Coroners Court of Queensland

The Board may review a DFV-related death even though the death is, or may be, the subject of investigation by a coroner.

All reviews done by the Board are independent of, and separate to, the investigation by the coroner.[13]

[11] *Coroners Act 2003 (Qld)*, s 91I, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91I

[12] *Coroners Act 2003 (Qld)*, s 91E, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91E

[13] *Coroners Act 2003 (Qld)*, s 91F, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91E

Accessing information

Accessing information

Part 4A, Division 7 of the Act describes the Board's powers to request the information it needs to perform its functions.

Right to information

Section 91Y of the Act deals with information held by a prescribed entity, including:

- 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 DFV-related deaths; and
- an entity prescribed by regulation.

The Board may submit written notices to prescribed entities requesting information (including documents) within a stated reasonable period. The notice must state the purpose of the request. Prescribed entities must comply with these notices unless there is a reasonable excuse.

Arrangement with State Coroner

The Board entered an arrangement with the State Coroner in 2016 about the exchange of information between a coroner and the Board.[14] The arrangement provides:

- for the Board to be notified by a coroner that a reportable death is or is likely to be a DFV-related death by the DFVDRU.

[14] *Coroners Act 2003 (Qld)*, s 91Z, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91Z

- for coroners to give the Board access to an investigation document regarding the DFV-related death of a particular person or all investigation documents that relate to DFV-related deaths, for carrying out the Board's functions.
- for the Board to give coroners access to documents in the Board's possession or control that are relevant to an investigation.

The arrangement also provides for how, when and where documents may be accessed under the arrangement.

The State Coroner may give the Board access to an investigation document (which includes a document obtained under the Act that is similar in nature to an investigation document) under the arrangement. The arrangement is in effect until either party request its termination in writing. Other sections of the Act relating to accessing information do not apply.

For further information, or to request a copy of the agreement, please contact the DFVDRAB Secretariat at dfvdrab.secretariat@justice.qld.gov.au.

Information sharing with other jurisdictions

The Board may enter an arrangement with an entity (for example, an entity in another State that performs the same functions, or substantially the same functions, as the Board) about sharing or exchanging information held by the Board or the corresponding entity.

The Board may disclose information it holds unless the disclosure would prejudice a criminal investigation or an investigation by a coroner.

Before disclosing coronial information (that is, information in the Board's possession or under the Board's control that was given to the Board by the State Coroner) under the arrangement, the Board must consult the State Coroner about the proposed disclosure.[15]

Of note, a Memorandum of Understanding (MOU) was established between the Board and the Child Death Review Board (CDRB) with the Queensland Family and Child Commission in 2020. The arrangement is in effect until either party request its termination in writing.

For further information, or to request a copy of the MOU, please contact the DFVDRAB Secretariat at dfvdrab.secretariat@justice.qld.gov.au.

[15] *Coroners Act 2003 (Qld)*, s 91ZA, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91ZA

Board membership

Board membership

The Minister must appoint the State Coroner or the Deputy State Coroner as the chairperson of the Board, and not more than 11 other persons that the Minister considers appropriate as members.[16]

The chairperson is responsible for leading and directing the activities of the Board to ensure functions are performed appropriately. The chairperson holds office for the term stated in the person's instrument of appointment as chairperson.[17]

The Minister may appoint a member of the Board to be the deputy chairperson, who acts as the chairperson when the chairperson is absent from their duties or for another reason cannot perform the duties of the office.[18]

The Minister must ensure that the Board includes government and non-government members, reflects the diversity of the Queensland community, and includes at least one member who is an Aboriginal or Torres Strait Islander. The Minister must also ensure that members have appropriate experience, knowledge, or skills relevant to the Board's functions and in accordance with the Act's requirements.[19]

A person may not be appointed as a member if the person is an insolvent under administration under the *Corporations Act 2001* (Cth), section 95(A)[20], has a conviction, other than a spent conviction, for an indictable offence or is a member of the Legislative Assembly.[21]

Conditions of appointment

Non-government members are paid a daily fee of $300 for their attendance at a meeting. A member who is a Queensland Government employee is not entitled to be paid remuneration for holding office as a member.[22]

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[16] *Coroners Act 2003 (Qld)*, s 91J, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91J
[17] *Coroners Act 2003 (Qld)*, s 91K, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91K
[18] *Coroners Act 2003 (Qld)*, s 91M, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91M
[19] *Coroners Act 2003 (Qld)*, s 91L, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91L
[20] *Corporations Act 2001 (Cth)*, s 95A, https://www5.austlii.edu.au/au/legis/cth/consol_act/ca2001172/s95a.html
[21] *Coroners Act 2003 (Qld)*, s 91L, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91L
[22] *Coroners Act 2003 (Qld)*, s 91N, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91N

Terms of appointment

Members are appointed for the term of not more than three years. However, members may be reappointed for a further term.[23]

Vacation of office

A member's appointment ends when the member is not reappointed on the completion of their term; resigns from their position; is an insolvent under administration; is convicted of an indictable offence; becomes a member of the Legislative Assembly; is absent from three consecutive meetings without the Board's permission or reasonable excuse; or is removed from office by the Minister.[24]

Disclosure of conflict of interests

If a member has a direct or indirect financial 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 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. The Board must record the particulars of a disclosure in a register of interests kept for that purpose.

The member (following disclosure of the interest in a matter) must not be present during a deliberation or decision of the Board about the matter unless the Board otherwise decides.[25]

Psychological safety

It is acknowledged that the work of the Board and the material the Board considers represents a risk of vicarious trauma. The psychological safety of Board members is of paramount importance. It is critical that Board members are safe and look after themselves whilst reviewing case and other Board materials. Most Board members have extensive history in working within the DFV environment. Nevertheless, reviewing coronial death cases is heavy work and may be distressing for some. The information provided can be confronting and it is important that all Board members feel safe in doing this work.

It is also important that Board members are culturally safe when reviewing case material. If approaches to case reviews or the presentation of material should be changed due to cultural reasons, Board members are encouraged to speak to the Chair and Secretariat.

TELUS Health

Board members have access to the Department of Justice and Attorney-General's Employee Assistance Program provided by TELUS Health. The program is designed to help enhance employee's individual health and wellbeing, and supports employee's work, health, and life journey. Access is free and confidential for Board members and their immediate family members. Counselling sessions are generally limited to four sessions per year, per person; however, the human resources branch can approve additional sessions if requested by TELUS Health, for a particular individual.

TELUS Health is available 24 hours a day, 7 days a week. They can be contacted on 1800 604 640.

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[23] *Coroners Act 2003 (Qld)*, s 91O, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91O

[24] *Coroners Act 2003 (Qld)*, s 91P, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91P

[25] *Coroners Act 2003 (Qld)*, s 91X, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91X

Proceedings of the Board

Meetings

The Board may hold its meetings when and where it decides. The chairperson may at any time call a meeting of the Board and must call a meeting if asked by at least three other members.[26]

A quorum for a meeting of the Board is at least half of the members.[27]

Presiding at meetings

The chairperson presides at all meetings of the Board at which the chairperson is present. If the chairperson is not present at a meeting, the deputy chairperson is to preside. If neither the chairperson nor the deputy chairperson is present at a meeting, the member chosen by the members present is to preside.[28]

Conduct of meetings

The Board may conduct its proceedings, including its meetings, as it considers appropriate. The Board may hold meetings in person or virtually.

A question at a meeting of the Board is to be decided by a majority of the votes of the members present at the meeting. If the votes are equal, the member presiding has a casting vote.

A resolution is a valid resolution of the Board, even though it is not passed at a meeting of the Board, if at least half the members give written agreement to the resolution and notice of the resolution is given under procedures approved by the Board.[29]

Minutes and other records

The Board must keep minutes of its meetings and a record of any decisions and resolutions.[30] The minutes are circulated to members no later than one week after the meeting.

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[26] *Coroners Act 2003 (Qld)*, s 91S, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91S
[27] *Coroners Act 2003 (Qld)*, s 91T, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91T
[28] *Coroners Act 2003 (Qld)*, s 91U, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91U
[29] *Coroners Act 2003 (Qld)*, s 91V, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91V
[30] *Coroners Act 2003 (Qld)*, s 91W, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91W

Media or public statements

The chairperson of the Board is the appointed media spokesperson for all Board matters. Proactive media or public statements must be approved by a quorum of the Board.

Any media requests are to be directed to the Chairperson, through the Secretariat, in the first instance.

Quorum

A quorum for a meeting of the Board is at least half of the members.[31]

Proxy

Government Board members unable to attend a meeting may send a proxy in their place to provide information to the Board on their behalf, as Government members are appointed by virtue of their position in their organisation. The Chair must be informed in writing that the member cannot attend and that a proxy will be attending prior to the meeting. A proxy representative for a Government member will count towards the meeting quorum but may not vote in decisions and resolutions.

A proxy may be granted access to documentation relating to that meeting only, with the expectation that Board materials and discussions will remain confidential. Board members are required to ensure the proxy is aware of their responsibilities in this regard and the behaviours Board members have agreed they expect of each other.

As non-government members are appointed to the Board as individuals, they cannot send a proxy in their place if they are unable to attend a meeting.

Expert advisors

The Board has powers to engage persons with appropriate qualifications and experience to undertake research and prepare reports to help the Board perform its function. These expert advisors may attend meetings and provide advice and share research findings. Expert advisors may be granted access to documentation relating to the research they have been asked to undertake or to meetings, with the expectation that materials and discussions will remain confidential.[32]

Observers

There may be circumstances where it is appropriate to have observers attend Board meetings. Attendance of observers is to be arranged and approved through the Chairperson. Board members will be made aware when an observer is in attendance. Observers may be granted access to documentation relating to the meeting, with the expectations that materials and discussions will remain confidential.

Behaviours Board members expect of each other

- Demonstrate honesty and authenticity – choosing to speak our minds.
- Respectfully engage in robust discussions – particularly where members may not agree. Respect is demonstrated by active listening, considering tone and body language, and giving adequate time for hearing properly, including not speaking over each other.
- Bring optimism – to harness collective wisdom to make positive change.
- Respect the expertise – each Board member brings to the group.

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[31] *Coroners Act 2003* (Qld), s 91T, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91T

[32] *Coroners Act 2003* (Qld), s 91G, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91G

- Acknowledge that the collective wisdom shared amongst the Board also impacts on individual Board members' work in their organisations.
- Respect confidentiality – what is discussed at Board meetings, stays in these confines.
- Come prepared – Board members are to be well prepared, as a sign of respect to the lives that have been lost.
- Bring a mindset of professional curiosity – demonstrate a spirit of continuous improvement. Maintain an open mind and recognise things can be better. Avoid defensiveness and give grace to those who are responding defensively.

Reporting and recommendations

Annual reporting

The Board must give the Minister an annual report describing the performance of the Board's functions during the previous financial year by 30 September. The report must include information about the progress made that year to implement recommendations made by the Board during that year or previous financial years. The Minister must table a copy of the report in the Legislative Assembly within one month of receiving it.[33]

Systemic reporting

Section 91ZC of the Act describes the Board's ability to prepare a report about a matter arising from the performance of its functions. The Board may, if it considers it appropriate, give a copy of the report to the Minister.

The Board must not include information adverse to a person in the report unless, before the report is prepared, the Board gives the person an opportunity to make submissions about the information. If the person makes submissions and the Board still proposes to include the information in the report, the Board must ensure the person's submissions are fairly stated in the report.

If the report includes information relating to a death that is still being investigated by a coroner, the Board must provide a copy of the report to the coroner. Further, if the Board intends to provide a copy of the report to the Minister, the Board must ensure the report is given to the coroner prior to providing it to the Minister.

If the report is provided to the Minister, the Board must make a recommendation about whether the report should be tabled in the Legislative Assembly. The Board may recommend that a report be tabled in the Legislative Assembly only if it does not contain information in a form that identifies or may identify an individual in the individual's private capacity.

If the Board recommends the report not be tabled in the Legislative Assembly, the Minister may table the report only if the Minister is satisfied the public interest in tabling the report outweighs any other considerations. If the Board recommends the report be tabled in the Legislative Assembly, the Minister

[33] *Coroners Act 2003 (Qld)*, s 91ZB, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91ZB

must table a copy of the report within five sitting days after receiving it, although may choose to table the report earlier than this.

Making recommendations

The Board draws on evidence from case reviews of DFV-related deaths in Queensland, data from the Queensland DFV-related Homicide and Suicide databases, and research to inform the development of recommendations.

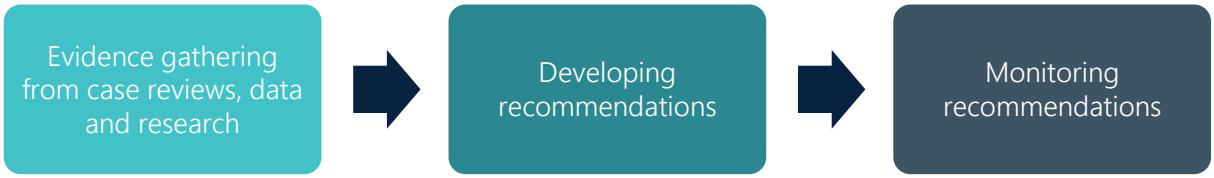

Figure 1: Overview of the Board's recommendation development and monitoring process.

The Board takes an ongoing, iterative, and reflective process to the development and monitoring of recommendations. The process described in Table 1 supports the Board when considering relevant matters and ensuring the recommendations made are clear and actionable.

Table 1: The Board's recommendation development process.

Step in development	Key activities

Describe the problem
 	
Provide a clear explanation of the problem or the gap that needs to be addressed.
	• Consider and name the relevant stakeholders who experience the defined problem, including the victims, persons using violence, kinship structures, services, and systems.
	• Consider factors that contribute to the problem at the:
	  ○ individual or relationship level.
	  ○ organisational and community level.
	  ○ system and institutional level.
	  ○ societal level.
	• Identify the implications for victims and other stakeholders of not acting to address the problem.

Define the desired outcomes Define desired outcome(s) of addressing the problem, the ideal state.	• Identify performance measures to monitor implementation and contribute to evaluations (if relevant).

Confirm the most appropriate mechanism to drive change
 	
Consider legislative remit and role of stakeholders to confirm whether a recommendation is the most appropriate mechanism to achieve the desired outcome(s).
	• Confirm that a recommendation is the most appropriate mechanism to drive change by considering whether:
	  ○ the Minister is the appropriate respondent to the recommendation.
	  ○ there is value in the Board having oversight of implementation.
	  ○ the delay between making a recommendation and implementation commencing is an acceptable risk.
	• If the issue is not best addressed by a recommendation, consider advocacy options.

State the recommendation Provide a single statement that expresses the intent,	• Confirm wording, direction, and intent of recommendation. • Ensure the recommendation statement is specific, targeted, and meaningful (refer to the Double SMART recommendation model).

Step in development	Key activities
audience, and primary outcome.	
Identify the evidence base Articulate a clear evidence base for the recommendation.	• Confirm which case(s), data and/or research the recommendation stemmed from. • Consider the relevance of the recommendation to previous Board work and how these insights can inform implementation. • Identify and discuss any relevant work underway within member agencies and across the sector that are relevant to the recommendation to avoid duplication, and identify opportunities for collaboration, including enhancement of existing activity. • Describe the relationship or dependencies of the recommendation with existing strategies, policies, projects or legislation, and the associated implications.
Set implementation activities Set clear, distinct action points to guide implementation.	• Discuss considerations for the approach to implementation. • Confirm whether agency feedback is required to understand potential implementation barriers. • Define outcome implementation progress measures. • Define supporting agency actions with timeframes (short-, medium-, and long-term). • During the Annual Report review meeting, the Board must confirm Steps 1–6 to provide clarity about the problem, desired outcomes, and suggested implementation approach (including suggested outcome measures, implementation activities and timeframes) to support implementation.
Confirm the monitoring process Confirm the process for monitoring implementation.	• Monitor the implementation of recommendations through updates provided though the Department of Justice reporting processes, the Board's legislative powers to request information and any other monitoring activities.

Double SMART recommendation model

The Board may choose to enhance recommendations by drawing on elements from the Double SMART recommendations model used by the Queensland Child Death Review Board (QCDRB) to develop its recommendations (see Appendix C).

The guidelines provided by the QCDRB state that the quality and usefulness of recommendations can be considered against the ten inter-related and mutually reinforcing criteria. While recommendations may not meet all criteria, maximising compliance makes them much more effective.

Applying a risk lens

The Board is committed to ensuring its recommendations are contextual and impactful.[34] Applying a risk lens when developing recommendations enables the Board to critically assess and reflect on the intended impact of its recommendations in the current environment.

[34] Australian Risk Management Principles and Guidelines (IS0 31000:2018 Risk Management Principles and Guidelines).

Advocacy options

In lieu of making a recommendation, the Board may consider other advocacy options to raise awareness of problems or gaps it has identified, and advocate for change. For example, the Board may consider corresponding with entities to share its evidence or findings, and advocate for change, or to seek information to inform Board functions. The Board may also consider alternative communication strategies to reach diverse audiences.

Monitoring recommendations

Government agencies provide both an initial whole-of-government response to all recommendations made by the Board, and then regular progress updates throughout implementation. All responses are published on the Board's webpage.

Updates from lead agencies about implementing Board recommendations are collected by a team within the Department of Justice at least once per year. These updates are published on the Board's website.

The Board maintains independence in exercising its monitoring function and assessing implementation progress.[35]

Four step monitoring process

Without duplicating the coordination and reporting role of the Department of Justice, the Board undertakes routine monitoring across all recommendations, and may seek further information about specific recommendations.

The Board undertakes four steps in its monitoring process:

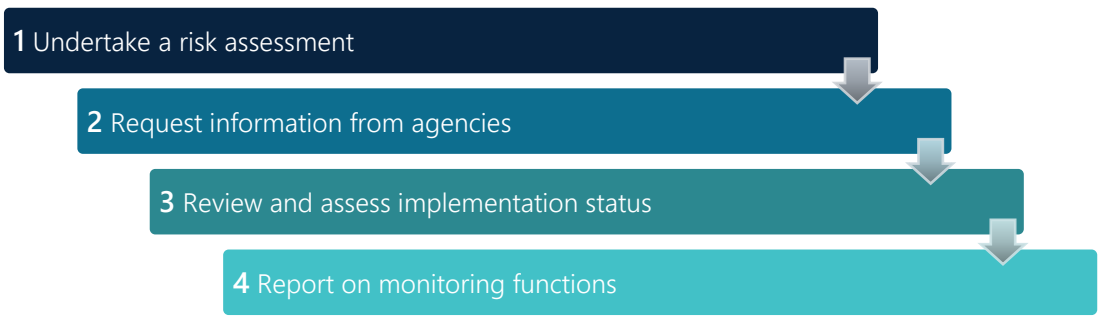

Figure 2: The Board's four step monitoring process.

1. Undertaking a risk assessment

The Board identifies new and emerging challenges and barriers impacting on the delivery of open recommendations. Risks change over time and hence risk management will be most effective where it is dynamic, evolving, and responsive. Monitoring and review is integral to successful risk management.[36]

2. Request information from agencies

The Board may request material from agencies including updates of deliverables (for example, strategies, frameworks, improved processes, and procedural and governance changes), implementation plans/measures and evaluation outcomes.

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[35] *Coroners Act 2003 (Qld)*, s 91H, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91H

[36] Australian Risk Management Principles and Guidelines (ISO 31000:2018 Risk Management Principles and Guidelines).

Agencies may also be asked to provide status updates or information directly to the Board.

3. Reviewing and assessing implementation updates

The Board reviews and assesses the information provided by agencies to understand implementation status and identify any further action required by the Board. The Board identifies cases where implementation has been delayed or differs significantly from the intent of the recommendation and/or Government response.

If the Board identifies that implementation is not consistent with recommendation intent, the Board will write to lead agencies to clarify intent and may offer to work with a lead agency (or agencies) to confirm understanding. The implementation status of each recommendation is coded into the following categories based on those used by the New South Wales Domestic Violence Death Review Team:[37]

Table 2: Recommendation implementation status

Implemented	The required work to implement this recommendation has been completed. If a recommendation was comprised of multiple parts or is led/supported by multiple agencies, all elements of the recommendation must be completed before it is coded as implemented.
Implemented – alternative approach to meet intent adopted	The intent of this recommendation has been implemented; however, the work completed was an alternative approach to what was initially recommended or accepted. This includes when a recommendation is implemented through the completion of superseding recommendations or activities.
In progress	Work has commenced to implement the recommendation in line with intent. This includes recommendations that comprise multiple parts and/or are led or supported by multiple agencies.
In progress – alternative approach to meet intent adopted	Work is underway, however the lead agency has adopted an alternative practice approach to the action outlined in the recommendation which still fulfills the intention of the recommendation. This can occur in circumstances where subsequent policy changes have superseded the recommendation, unforeseen policy changes have affected the initial implementation approach, or new evidence emerges.
In progress – alternative approach not supported	Work is underway, however the lead agency has adopted an alternative practice approach to the action outlined in the recommendation. In this case, the overall intent of the recommendation is not being met by implementation activities and the Board may work with the lead agency (or agencies) to understand the challenges or lessons from implementation.
In progress – at risk	Work had initially progressed towards implementing the recommendation, but there is no current action or plan to complete the work. This includes multi-staged recommendations where one component appears to have stalled indefinitely or one (or more) agency has not provided an update on progress.
Awaiting response	No practical steps have been taken since Government acceptance. This includes when no updates have been provided.

[37] New South Wales Domestic Violence Death Review Team (2021), *Report 2019–2021*, pp.192–193, https://coroners.nsw.gov.au/documents/reports/2019-2021_DVDRT_Report.pdf

4. Reporting of monitoring functions

The Board provides an update on its monitoring functions in its Annual Report. This includes, but is not limited to, the number of recommendations in each category, a summary of the Board's monitoring activities, and assessments of progress made to date. Agencies will have an opportunity to respond to any adverse comments in the Annual Report regarding monitoring of recommendations.

Confidentiality of information and liability

Confidentiality

Confidential information is information that is not publicly available, that is in a form that identifies or may identify an individual, and was acquired by, or may be accessed by, a person in the person's capacity as a member of the Board or a person engaged by the Board to help the Board perform its functions.[38]

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 to anyone else other than to the extent the disclosure is permitted under section 91ZD of the Act.

A breach of this requirement is an offence with a maximum penalty of 200 penalty units. Section 91ZD(3) of the Act sets out the circumstances where confidential information may be disclosed. The person cannot be compelled to disclose the confidential information, including giving evidence in relation to the confidential information, in any proceeding.

Protection from liability

A member of the Board or a person engaged to help in the performance of the Board's functions (other than a member or person who is a State employee) is not civilly liable for an act done, or omission made, honestly and without negligence under section 91ZE of the Act.

If this provision prevents a civil liability attaching to a member or other person, the liability attaches instead to the State.[39]

Protection from liability for providing information

An entity that gives information to the Board as required by a notice under section 91Y of the Act is not liable civilly, criminally or under an administrative process for giving the information.[40]

[38] *Coroners Act 2003 (Qld)*, s 91ZD, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91ZD
[39] *Coroners Act 2003 (Qld)*, s 91ZE, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91ZE
[40] *Coroners Act 2003 (Qld)*, s 91ZF, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91ZE

Access to information from courts

Under the doctrine of the separation of powers, the judiciary operate independently of the legislative and executive arms of government. Consistent with this principle, the only mechanism for review of decisions made by courts is through current appeal processes. It would therefore not be appropriate for the Board to review decisions made by a court in individual cases or in relation to specific actions taken by a court.

It is recognised that the circumstances leading up to a DFV-related death may often involve an individual's interaction with courts, such as with the family law courts and magistrates' courts. This broader context and circumstances may highlight potential issues with the current operation of the legal system suggesting a potential need for legislative or administrative reform.

Appendices

Appendix A: Definitions

DFV means domestic violence within the meaning of the *Domestic and Family Violence Protection Act 2012 (Qld)*, section 8.[41]

DFV death means the death of a person (the *deceased person*)—

a) caused by another person (the *second person*) if:

   i. the deceased person was or had been in a relevant relationship with the second person that involved domestic and family violence; or

   ii. at the time of death, the deceased person was in a relevant relationship with a person who was or had been in a relevant relationship with the second person that involved domestic and family violence; or

   iii. at the time of death, the second person mistakenly believed the deceased person was in a relevant relationship with a person who was or had been in a relevant relationship with the second person that involved domestic and family violence; or

   iv. at the time of death, the deceased person was a witness to or present at, or attempted to intervene in, DFV between the second person and a person who was or had been in a relevant relationship with the second person; or

   v. at the time of death, the deceased person was a witness to or present at, or attempted to intervene in violence between the second person and a person who the second person mistakenly believed was in a relevant relationship with a person who was or had been in a relevant relationship with the second person that involved domestic and family violence; or

b) by suicide or suspected suicide if the person was or had been in a relevant relationship with another person that involved domestic and family violence.

[41] *Domestic and Family Violence Protection Act 2012 (Qld)*, s 8, https://www.legislation.qld.gov.au/view/html/inforce/2023-10-10/act-2012-005#sec.8

Expert reports see section 91G(2)(b) of the Act.[42]

Member means:

a) the chairperson; or

b) a member of the Board appointed under section 91J(b) of the Act.[43]

Relevant relationship see the *Domestic and Family Violence Protection Act 2012*, section 13.[44]

Note: In the *Domestic and Family Violence Protection Act 2012*, section 13, a relevant relationship means an intimate personal relationship, a family relationship or an informal care relationship.[45]

[42] *Coroners Act 2003 (Qld)*, s 91G, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91G ,

[43] *Coroners Act 2003 (Qld)*, s 91J, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91J

[44] *Domestic and Family Violence Protection Act 2012 (Qld)*, s 13, https://www.legislation.qld.gov.au/view/html/inforce/2023-10-10/act-2012-005#sec.13

[45] *Domestic and Family Violence Protection Act 2012 (Qld)*, s 13, https://www.legislation.qld.gov.au/view/html/inforce/2023-10-10/act-2012-005#sec.13; *Coroners Act 2003 (Qld)*, s 91B, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2003-013#sec.91B

Appendix B: Relevant legislation and governing documents

Relevant legislation:

Coroners Act 2003 (Qld)

https://www.legislation.qld.gov.au/view/whole/html/inforce/current/act-2003-013

Domestic and Family Violence Protection Act 2012 (Qld)

https://www.legislation.qld.gov.au/view/whole/html/inforce/2023-10-10/act-2012-005

Governing documents:

Welcome Aboard: A guide for members of Queensland Government Boards, Committees and Statutory Authorities[46]

https://www.premiers.qld.gov.au/publications/categories/policies-and-codes/handbooks/welcome-aboard.aspx

Identifying, Disclosing and Managing Personal Interests: A Guide for Multi-Member Decision-Making Bodies[47]

https://www.integrity.qld.gov.au/assets/document/catalogue/resources/multi-member-decision-making-bodies.pdf

Charter of Victims' Rights

https://www.victimscommissioner.qld.gov.au/Charter-of-Victims-Rights

[46] This Department of the Premier and Cabinet Queensland guide describes the role of government boards and those who serve the community as members, including board member obligations and responsibilities.

[47] This Queensland Integrity Commissioner guidance provides a framework to multi-member decision-making boards and bodies about managing personal interests of members of Queensland boards or bodies.

Appendix C: Double SMART recommendations model[48]

Criterion	Description
Specific	• Each recommendation should address one specific issue only. • Each recommendation should be simple, sensible, and significant. • Each recommendation may also propose one or more specific actions (however these should each be clearly defined and separated).
Measurable	• A recommendation should be meaningful and motivating. • A recommendation should be formulated in a way that allows the evaluation of progress to be made in an easy way. • Agencies and monitoring bodies should be able to unequivocally assess whether a recommendation is being implemented and to what extent.
Achievable	• A recommendation should seek to be feasible in practical terms.
Results oriented	• The actions suggested in the recommendation should be designed to lead to a specific result or state of affairs. • This desired situation may be implied and explicitly stated in the recommendation.
Time-bound	• Recommendations should be time-bound: – time-based – time-limited – time/cost limited – timely – time sensitive. • Timeframes for implementation of recommendations should be realistic and clear. Such timeframe assists agencies to prioritise their response, leads to meaningful change and enhances accountability.
Solution suggestive	• Generic recommendations that call for 'change' or 'improvements' are insufficient. • Credible recommendations must include credible solutions.
Mindful of prioritisation, sequencing, and risks	• Crucial in the implementation of any recommendation is the focus on: o the most important and urgent recommendations first o the logical sequencing of dependent recommendations, and o a risk-based approach to implementation, particularly in terms of unintended consequences by specific implementation actions.
Argued	• Recommendations should be based on high quality objective evidence and analysis gathered during the monitoring cycle and systematically detailed in the body of the report.
Root-cause responsive	• Recommendations (and their subsequent monitoring) should be directed at addressing the root-causes of problems (rather than the symptoms of problems) or the systems/processes needed to mitigate risk factors.
Targeted	• Recommendations should correctly identify the relevant agencies that can legally and practically implement the recommendation. • This assists the process of assigning actions and responsibilities, increasing accountability and facilitating progress follow-up.

[48] Sourced from Appendix B (pp 43–46) of Queensland Family and Child Commission. (2023). *Child Death Review Board Procedural Guidelines*. https://www.qfcc.qld.gov.au/sites/default/files/2024-10/Child%20Death%20Review%20Board%20CDRB%20Procedural%20Guidelines.pdf

Queensland Government