Terms of Reference

Independent and timely reviews of police-related deaths and domestic and family violence deaths with prior police involvement

Background

On 22 January 2021, in making findings with respect to the Inquest into the death of Cindy Leigh Miller, Mr Terry Ryan, State Coroner, recommended the Government consider commissioning an independent review of the current arrangements for the investigation of police-related deaths on behalf of the coroner and the oversight of those investigations (**Recommendation 2**). Although the State Coroner made no adverse comment against any police officer or member of the watchhouse staff in relation to the conduct of the police investigation into Ms Miller's death, it was acknowledged that community confidence in the independent investigation of police-related deaths is a matter of significant public interest.

The Palaszczuk Government is committed to ensuring public confidence in the thoroughness, transparency and independence of investigations into police-related deaths.

Similar to police-related deaths, the Palaszczuk Government recognises the public interest in ensuring that prior police involvement in domestic and family violence deaths should be subject to independent review in a transparent and timely manner.

There are already a number of mechanisms to investigate and review police-related deaths and, domestic and family violence deaths with prior police involvement, including but not limited to:

(a) coronial processes which facilitate operational arrangements for the independent and impartial investigation of police-related deaths by the Ethical Standards Command, with oversight by the Crime and Corruption Commission;

(b) the Domestic and Family Violence Death Review and Advisory Board; and

(c) the Child Death Review Board.

Appointment of an independent reviewer

The Palaszczuk Government has accepted **Recommendation 2** of the State Coroner's *Findings of Inquest into the death of Cindy Leigh Miller*.

These Terms of Reference implement **Recommendation 2** by requiring an independent reviewer to examine and make recommendations in relation to deaths in police custody or in the course of, or as a result of, police operations. The review is to also examine the mechanisms for undertaking and overseeing reviews of prior police involvement in domestic and family violence deaths.

Scope

The reviewer will broadly examine and make recommendations with respect to the following:

1. current arrangements for the investigation and oversight of police-related deaths; and.

2. the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to timely, independent and transparent review.

A ***police-related death*** refers to reportable deaths that are, consistent with terminology in the *Coroners Act 2003* (Coroners Act), either:

(a) a death that has happened in the course of, or as a result of, police operations; or

(b) a death in custody, to the extent the deceased was in the custody of the Queensland Police Service.

*A **domestic and family violence death with prior police involvement*** refers to a domestic and family violence death where police had been involved prior to the death. For the purposes of the review, a ***domestic and family violence death*** is defined consistently with section 91B of the Coroners Act.

The reviewer will undertake independent consideration of issues within the scope of the review and make recommendations to the Premier and Minister for Trade, the Attorney-General, and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence, and the Minister for Police and Corrective Services and Minister for Fire and Emergency Services.

Recommendations

Having regard to the current arrangements for the investigation and oversight of police-related deaths, the reviewer will make recommendations providing for the most effective mechanism for the investigation and oversight of police-related deaths.

While remaining mindful of the relationship with existing oversight mechanisms that have similar review functions, such as the Domestic and Family Violence Death Review and Advisory Board, the reviewer will make recommendations providing for the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to independent, timely and transparent review.

The reviewer will consider:

(a) the public interest in ensuring that investigations into police-related deaths and domestic and family violence deaths with prior police involvement are independent, transparent, and undertaken in a timely manner;

(b) the most appropriate agency or independent body to conduct investigations into police-related deaths;

(c) the most appropriate agency or independent body to provide oversight of investigations into police-related deaths and, the most appropriate mechanism to conduct reviews of police involvement into domestic and family violence deaths with prior police involvement;

(d) the extent to which any recommended investigative and oversight framework, including associated investigative powers, should be provided for in legislation;

(e) the approach taken when investigating and reviewing police-related deaths and domestic and family violence deaths with prior police involvement in other jurisdictions;

(f) the appropriate reporting requirements for investigations into police-related deaths and reviews of prior police involvement in domestic and family violence deaths, including minimum timeframes;

(g) the resourcing impacts of any proposed recommendations, particularly in regional areas;

(h) the need to ensure any related proceedings are not prejudiced; and

(i) any other related matters.

With respect to any recommendations made, the reviewer is to consider the need to protect and promote human rights, including the rights protected under the *Human Rights Act 2019*.

Consultation

The reviewer's examination and recommendations should be informed by consultation with Government agencies. The reviewer is to undertake targeted consultation with key legal and community stakeholders, including relevant unions.

Timeframe

A report will be provided on the findings and recommendations of the review, to the Premier and Minister for Trade, the Attorney-General and Minister for Justice and Minister for the Prevention of Domestic and Family Violence, and Minister for Police and Corrective Services and Minister for Fire and Emergency Services by 12 July 2022.