QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non inquest findings into the death of KH**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/360
DELIVERED ON:	20 June 2017
DELIVERED AT:	Brisbane
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	Domestic violence, breach of bail conditions and protection order, response by agencies to violence, recommendations, 'Not Now, Not Ever'

Contents

Introduction

1. KH was 35 years of age when she died in rural Queensland. KH died at some time on the evening of 20 January or on the morning on 21 January 2012. KH's death was as a result of injuries inflicted by her de-facto partner C. The couple had been in a relationship for approximately two years. They initially lived in a caravan and travelled throughout rural Queensland. The couple commenced renting a property in rural Queensland on 28 August 2010. KH had a daughter from a previous relationship who was 15 years old at the time.

2. C had an extensive history of violent offences, both within Queensland and other Australian jurisdictions.

3. On 3 May 2010, C was charged with assault occasioning grievous bodily harm for punching KH in the face in late April. A protection order was issued under the then *Domestic and Family Violence Protection Act 1989.* C was granted bail to await trial. The bail and protection order conditions prohibited C from coming into contact with or approaching KH.

4. KH's death occurred three days before C was due to appear in court in relation to the assault charge. He was also due to appear in relation to subsequent charges of contravening his bail conditions and the protection order. The subsequent charges were laid after police became aware he had continued to live with KH.

Circumstances surrounding KH's death

5. The following sequence of events has been established based on documentation obtained during the police investigation. This includes witness statements, telephone data and CCTV footage. Where relevant, it incorporates the witnesses' own language.

6. On 17 January 2011, the couple completed and signed documentation to obtain a six month tenancy for another house in rural Queensland. The tenancy was to commence on 22 January 2011.

7. On 20 January 2011, KH worked until approximately 4:30pm. At approximately 6:30pm, KH spoke with her brother on the phone about providing a trailer to assist the move to their new property. KH's brother reported hearing C in the background, thanking him for his offer of assistance. At 9:34 and 9:35pm, KH's mobile phone called the mobile phone of her ex-partner. These calls were unanswered and no messages were left.

8. C and KH were drinking on the night of 20 January 2011 and C estimated KH to have consumed about 15 beers.

9. C said that he wanted to sleep but KH wanted to keep drinking, which caused them to have a "big fight". C reports that he went outside to cool down and upon re-entering the house KH accused him of being on the phone to another woman.

10. He told KH that he didn't want to drink anymore which made KH angry. KH reportedly grabbed a knife and he took it off her which caused her to sustain a cut on her hand which bled. C says that this caused KH to "lose the plot" and she started throwing stuff at him and breaking the TV.

11. C tackled KH into the corner but she was still "going off" and "losing it". He said that all he wanted was to keep her quiet, calm her down and get her hand seen to. C says that in the heat of the moment he cut KH's neck. He described himself as having no thought at the time and said it was drunkenness. C says it wasn't premeditated and if she hadn't picked up the knife in the first place it would never have happened. C says that he had put up with her for 18 months and he loved her but she wouldn't let go of her suspicions about him cheating on her.

12. C described cutting KH's throat as like "cutting a loaf of bread". KH died soon afterwards, estimated by C as a few minutes, probably less.

13. At 3:23am on 21 January 2011, an attempt was made to withdraw $1000 using KH's key card at an ANZ ATM. The initial attempt was unsuccessful as the incorrect PIN number was used. A subsequent attempt at 3:24am was successful. CCTV footage confirms C made the withdrawal. At approximately 3:54am, CCTV footage shows that C attended a BP service station and purchased fuel.

14. At approximately 5:00am, C phoned his sister. She says that C said something to the effect of: "She has hired two blokes to kill me, but I got them. One is gone and the other should be gone by now."

15. C's sister asked him where he was but he advised her that he did not want to tell her as he did not want to get her involved. He said that he was somewhere safe. He did not mention anything about hurting KH.

16. C's sister said that she thought he was overreacting, exaggerating because this was normal for him. She said that she did not know how to take it but was not concerned that he had done anything at that stage. She went back to sleep.

17. C's sister continued to text him during the day expressing her concern for him. He also text her on a phone number she did not know to say he had a new phone number.

18. At 8:07am, C presented to a police station to sign the bail register as part of the conditions of his bail order.

19. At 11:38am, CCTV footage from a hotel in New South Wales, shows C in the bar of the hotel. C booked a room for the night at this hotel using an alias.

20. At around 3:00pm on 21 January 2011, C called his sister again and informed her that he had phoned the real-estate to tell them that he needed another day to move out of his house and that the owners were

coming to whipper snip the yard that day. He reported to his sister that he was worried that if the owners had a "sticky beak" in the kitchen window, they would see KH slumped over the kitchen cupboard.

21. C reportedly said to his sister that he had really hurt KH and "she is gone". C's sister says that he talked about changing his appearance and travelling around Australia. He advised her that he had $900 and KH's car as it was better on fuel than his. After the phone call, C's sister subsequently spoke to her daughter, boyfriend and best friend.

22. At 9:56pm, C's sister called her daughter and C's niece. She said that C was in trouble and had killed his girlfriend and two other people and that KH was still in the house. C's niece contacted police, who attended the address and discovered KH's body.

23. On 22 January 2012, at approximately 6:00am, C called his mother and said something to the effect of: "Mum I am sorry I have done something really bad, it is not your fault and I am handing myself into police." She did not ask him what he had done but said handing himself into police was the best thing he could do. C told her something to the effect of "I'm interstate at the moment but I'll hand myself in".

24. C presented at a police station in New South Wales on the morning of 22 January 2011 and disclosed that he had cut KH's neck with a kitchen knife. He was interviewed and provided police with an account of what happened leading up to KH's death as is reflected above.

Establishing the cause of death by autopsy

25. A full internal autopsy was conducted on 24 January 2011 by forensic and neuropathologist Dr Urankar. The autopsy report was finalised on 5 January 2012. Dr Urankar's findings were peer-reviewed by Professor Ansford.

26. The examination showed an incised wound to the throat comprising two, roughly parallel, horizontal incisions on the anterior neck. Both incisions were deep, leading to severe damage to all underlying neck structures. The major arteries and veins in the neck (carotid arteries and jugular veins) were incised on both sides of the neck as a consequence of the injury, thereby cutting off vital blood supply and hence oxygen supply to the brain, leading to massive and fatal blood loss. This, in turn, also allowed air to enter the circulation and the heart, leading to the development of an air embolism which also contributed to death.

27. The trachea (windpipe) was also severed as part of the injury. This injury contributed to death by preventing normal breathing. Damage to the vertebral bone in the neck was also noted beneath the incision, which implied that severe force was utilised in the infliction of the injuries. Dr Urankar concluded that, given the two main incisions, there were at least two separate applications of force to the neck.

28. Dr Urankar noted further, non-fatal injuries to the body as follows:

- Two stab wounds over the right shoulder which extended into subcutaneous fat only, and not damaging any vital structures;

- Incised wound on the right hand, involving the webbing between the thumb and first finger;

- Other minor bruises, abrasions and superficial incisions on the right hand; and

- Bruising to the left cheek and lip.

29. Toxicology testing revealed the presence of alcohol in the urine (313mg/100mL), vitreous humour (154mg/100mL) and the blood (148/100mL). Dr Urankar opined that the higher level in the urine indicated that the metabolism of alcohol occurred prior to the death, thus was not a result of post-mortem redistribution.

30. Dr Urankar concluded the formal cause of death was from the incised wound to the neck.

Police investigation and criminal proceedings

31. Following the discovery of KH's body a comprehensive police investigation ensued. C was subsequently charged with murder, and that charge proceeded to trial in the Brisbane Supreme Court in March 2014. C was found guilty by the jury. On 23 April 2014, he was sentenced to imprisonment for life. C appealed his conviction, and that proceeded to hearing in the Queensland Court of Appeal on 13 April 2016. On 21 June 2016, the Court of Appeal delivered its judgement dismissing the appeal.

32. A copy of the sentencing remarks, and the appeal judgement, have been placed on the court file.

Issues for review

33. At the time of KH's death, there was an outstanding charge of assault occasioning grievous bodily harm against C. There was also a current domestic and family violence protection order (Protection Order)[1] in place.

34. As such, the coronial investigation has been informed by the Domestic and Family Violence Death Review Unit (DFVDRU) within the Coroners Court of Queensland.

35. The purpose of the DFVDRU review (the 'Review') was to contextualise the nature, frequency and severity of the violence and provide advice on identified issues. These issues are addressed below.

[1] Pursuant to the *Domestic and Family Violence Protection Act 1989,* current at the time of the order.

History of domestic violence

36. Based on analysis and review of the available documentation, the Review concluded that C exhibited a pattern of behaviour consistent with coercive controlling violence. He displayed ongoing and often relentless conduct designed to induce fear, intimidation and submission in a victim[2]. The Review found that C used tactics such as social isolation, belittling, threatening behaviour, restricting resources as well as verbal and physical violence in an attempt to control KH.

37. There was evidence of significant non-physical forms of control being perpetrated by C. This included limiting KH's ability to contact friends, monitoring phone conversations, sitting outside her work during lunch breaks and yelling from the vehicle if she was not ready to be picked up.

38. Police first became aware of this violence when they intercepted KH on 3 May 2010 in the course of routine duties. KH was intoxicated and visibly upset, disclosing that her partner had physically assaulted her on or around 21 April 2010. She told police that within a few months of living together, C started to physically assault her. She reportedly said:

> *He can be perfectly fine one minute and he snaps the next, throwing things and stuff like that. It happens about every two weeks. As soon as one bruise heals, he gives me another one. I've always had black eyes*.

39. KH further described to police a number of assaults from as early as 2009. In describing one occasion, she said words to the following effect:

> *He dragged me out and started kicking me all over, stomping on me and told me I was going to die and this was the best place for it, cause we were in a national park*.

40. The Review ultimately concluded that there were some 16 risk factors in place between KH and C indicative of a heightened risk of lethal violence within the relationship.

41. I accept the findings of the Review that KH was routinely victimised by C and that his use of controlling tactics and isolation of KH was a significant barrier to interventions, both by formal and informal support mechanisms.

Family and friends as informal supports

42. KH's friends, colleagues and family members all reported their concerns about the relationship. They often saw KH with black eyes or bruises to her body. KH commonly minimised the severity of these assaults or would deny C committed these acts.

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[2] Fisher, S. (2011). *From Violence to Coercive Control: Renaming Men's Abuse of Women.* White Ribbon Policy Research Series No.3.

43. The Review found that it is clear that efforts were made by friends and family members to intervene at various points. However KH stated that she loved C and wanted to stay in the relationship.

44. KH's brother acknowledged that it seemed to him, and he believed the entire family, that the violence was increasing:

> *I know I thought a few times if we don't get her out of there he would kill her and I know as a family we talked about it and did everything we could, but we couldn't get her to leave*.

45. The Review highlighted that unfortunately, this experience is not uncommon. Recent reform (identified below) has identified the important role that family and friends can play in supporting victims of domestic and family violence.

46. The Review identified shortly before her death, KH had experienced a shift in her thinking and began to disclose her desire to end the relationship with C. She told several colleagues that she intended to end the relationship and move into the new rental property on her own. There is no evidence to confirm whether or not KH communicated this to C. However it is salient to note that while leaving a violent relationship may seem the safest solution, there is research to suggest the very opposite to be true. Namely, that post-separation violence significantly elevates the risk of dangerous violence and lethality[3].

Identifying domestic and family violence in the workplace

47. In the months preceding her death, KH's colleagues report that they had seen her with bruises and cuts and some had spoken to her about their concerns and suspicions of domestic and family violence being perpetrated by C against her. Colleagues also witnessed examples of C's non-physical controlling behaviour.

48. A colleague reported that KH took some unplanned time off work before Christmas, shortly prior to the death. This was because she had an argument with C, became scared and fled to her brother's house, returning to her home three days later. When a graze was noted on the side of her face, KH reportedly attributed it to her dog dragging her down her brother's driveway and maintained that everything was fine with C.

49. Another colleague reported that some time in the weeks immediately prior to the death, KH came to work with a black eye. When she asked what happened, KH apparently reported "you don't want to know".

50. Research demonstrates that most victims disclose their experience of domestic violence to co-workers (64%), followed by immediate supervisors (29%), non-immediate supervisors (21%) and others in the

[3] Anderson, D.K and Saunders, D.G. (2003) *Leaving an Abusive Partner: An empirical review of predictors, the process of leaving and psychological well-being.* Trauma, Violence and Abuse 4(2), 163-191.

workplace (21%)[4]. In this case, KH's family and colleagues appear to have been among the only people aware of the assaults in December 2010 to January 2011.

51. Recent reform in this area (discussed below) has identified the need to improve opportunities for intervention in the workplace.

Access to services/service provision in rural and remote communities

52. The Review found there was no evidence that KH made any contact with formal specialist services, either directly or with the support of others, about ending her relationship with C. The Review suggested this may have been because of her reluctance to engage with services or her fear of reprisal.

53. I consider that fear of C was likely a significant barrier. KH told police on one occasion that she was terrified that he would kill her if he discovered she was speaking with them.

54. Despite her earlier admissions about the violence, KH became reluctant to pursue the matter soon after charges were laid. KH approached police officers several times in the months after to have the charges withdrawn. For example, the police records of 19 May 2010 state:

> *KH's partner is an unwilling complainant in this matter. She has attempted on a number of occasions to have this matter withdrawn. Despite bail and DV Order conditions prohibiting it, it is strongly suspected that C and KH are residing together. KH will lie to protect C KH has been assaulted on numerous occasions by C and is currently suffering from a fractured cheekbone (subject in this matter).*

55. I note also that in May 2010, police did issue an alert to all officers in the station of the continued safety concerns regarding the potential risk that C posed to KH.

56. The Review also considered access to resources and services for those who live in remote and rural communities, as KH did. The Review noted that service provision in rural communities can be limited by a lack of resources, restricted access to professional development opportunities and difficulties with the recruitment and retention of qualified staff. The Review highlighted that in the absence of dedicated, resourced and accessible services to support victims or educate perpetrators of domestic and family violence, it is more likely that opportunities for intervention may be missed. Victims who are attempting to leave relationships may not be able to access the necessary support in a timely manner.

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[4] Swanberg, J., Logan, T. and Macke, C. (2006*) Intimate partner violence, employment and the workplace: consequences and future directions.* Trauma, Violence and Abuse, Vol. 6, No. 4, pp236-312.

57. I accept the Review's suggestion that these issues were further compounded by the transient nature of the couple's lifestyle which would have disrupted or impeded any attempts to provide ongoing health or other support services to KH.

58. I accept that KH came into contact with agencies on only a small number of occasions prior to her death, which limited the potential opportunities for risk assessment and intervention prior to her death.

Information sharing/opportunities for intervention in health settings

59. The Review found that KH had limited contact with health services in the years preceding her death. However she did present to a hospital on at least two occasions (24 April 2010 and 3 May 2010) in relation to abuse-related injuries she sustained on or about 21 April 2010.

60. Whilst it is apparent that KH's injuries were identified as assault-related during her second admission, it appears the focus was limited to the provision of medical treatment. No referrals or additional support appear to have been offered. However, I note that KH was reluctant to engage with staff and did not return for follow-up appointments

61. There is no legal obligation incumbent upon health practitioners to mandatorily report domestic and family violence related matters to police.

62. This issue was considered by Coroner Hutton in the inquest into the death of Noelene Buetel. Coroner Hutton supported legislative review to allow general practitioners to make a confidential intelligence submission to police. This would allow health practitioners to provide important information to police, however transfers the responsibility to manage risk to police officers by way of their response.

63. Reform that has occurred in relation to information sharing and intervention in the health care setting is discussed below.

Protection orders and bail conditions

64. Final issues that were raised during this investigation were C's breaches of the Protection Order and his bail conditions.

65. The documentation provided indicates that in May 2010, police opposed bail following C's initial arrest for his assault against KH in April 2010. They were concerned of the risk of continued violence in the relationship and his extensive history of violent offending.

66. The *Bail Act 1980* (Qld) outlines basic principles and provides discretionary authority to the court in granting or refusing applications for bail. At the time, there was a general presumption that bail should be granted in Queensland. There were no provisions which specifically

accounted for domestic and family violence cases, unlike in some other states and territories[5].

67. Pursuant to the *Bail Act 1980*, the court may refuse to grant bail to the defendant if '*there is an unacceptable risk'* that the defendant, if released on bail, would, while released on bail, endanger the safety or welfare of a person who is claimed to be the victim of the offence with which the defendant is charged or anyone else's safety or welfare[6].

68. Magistrates have additional powers to impose special conditions on any bail grant if the conditions are considered necessary to ensure protection of any individual, and to ensure the defendant appears before the court and does not seek to interfere with witnesses[7].

69. Despite their objection to bail, C was ultimately released from custody under conditions of bail which included that he not make contact (either directly or indirectly) with KH.

70. In May 2010, police also made an application under the *Domestic and Family Violence Protection Act 1989* for the Protection Order on the basis it was thought necessary to protect KH. The Protection Order also stipulated (inter alia) that he was not to contact KH or come within 100 metres of her residence or workplace.

71. C did continue to have contact with KH. On 19 May 2010, when police were conducting bail checks in the local area, C was found in the company of KH. C was therefore charged with breaching his bail conditions and the Protection Order.

72. Further bail and temporary protection order conditions were imposed. Again, these conditions included that C not make contact or approach KH. His bail also required him to present personally to a police station every Monday and Friday. Following his release from custody on 13 July 2010 and the murder on 20/21 January 2011, C was therefore in contact with police twice every week.

73. It is not clear whether further bail checks or monitoring were carried out by police in relation to C. However it is clear that C continued to live with KH during this period. The documentation indicates they entered into a joint lease agreement commencing 28 August 2010.

74. Had further bail checks and/or monitoring been carried out, it is possible that C would have been found to be in further breach of his bail and protection order conditions.

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[5], For further information refer to the Australian Law Reform Commission. Australian Law Reform Commission. (2010). *Family Violence: A national legal response, ALRC Report 114*. Australian Government

[6] Section 16(1)(a)(ii)(B), *Bail Act 1980* (Qld).

[7] Section 11(2), *Bail Act 1980* (Qld).

75. I acknowledge the barriers imposed when victims, for whatever reason, are reluctant to engage with formal support services including police officers.

76. The coronial jurisdiction is not an appellant jurisdiction. It is therefore not within the scope of a coronial investigation to examine the appropriateness of the decision to grant bail.

I note however that some reforms in relation to bail have occurred since KH's death.

Recent reform in relation to domestic and family violence

77. Since KH's death, there has been significant reform across Queensland in relation to domestic and family violence. In particular, the Special Taskforce on Domestic and Family Violence in Queensland, chaired by the Honourable Quentin Bryce AD CVO, former Governor-General of Australia, was established on 10 September 2014.

78. The Taskforce was requested to examine Queensland's domestic and family violence support systems and make recommendations to the Premier on how the system could be improved and future incidents of domestic violence could be prevented.

79. On 28 February 2015, the Taskforce released its report: *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* (2015) ('the Report').

80. The Report's 140 recommendations for reducing domestic and family were all accepted by the Queensland Government for implementation. The recommendations are extensive and encompass a whole-of-system response to domestic and family violence which includes health, justice and social services, and the community.

81. A significant proportion of these recommendations, when implemented, are likely to improve outcomes for victims of domestic and family violence similar to KH.

82. Recommendations 31 through to 49 are aimed at improving opportunities for intervention in the workplace. In particular Recommendation 32 suggests that the Queensland Government fund development of a training program for employers and businesses on building workplaces supportive to victims of domestic and family violence that includes skills on identifying and responding to domestic and family violence.

83. I understand that the Queensland Government has enacted Recommendation 32 through the development of an e-learning program, 'Recognise, Respond, Refer: Domestic Violence and the Workplace'. This is available to the Queensland Public Service and offered to businesses to purchase.

84. Recommendations 55 through to 63 are aimed at improving hospital and health service's responses to domestic and family violence and child harm. The Report highlighted that hospital staff are in a critical position to provide support and referral to victims presenting with assault-related injuries. The Report also noted that when individuals have been physically abused by their partners and require immediate medical treatment, a hospital emergency department is where the victim will seek help.

85. Recommendation 59 suggests that that the Queensland Government work in partnership with DV Connect to develop a model to provide immediate access to specialist domestic and family support referral services within public and private maternity hospitals and emergency departments.

86. Recommendation 61 is aimed at ensuring the continuing professional development and accreditation requirements of health practitioners includes education components on recognising and responding to domestic and family violence.

87. Recommendations 71 through to 89 are aimed at enhancing funding for specialist domestic and family violence services. This includes perpetrator intervention initiatives, specialist shelters and improving responses to high risk clients. They are also aimed at improving service system integration, information sharing and providing more support for victims trying to leave domestic and family violence.

88. Recommendation 78 recommends that the Queensland Government introduce enabling legislation to allow information sharing arrangements between agencies within integrated responses, with appropriate safeguards. This would include legislative protection for the sharing of information without consent, if a risk assessment indicates it is for the purpose of protecting the safety of the victim and their immediate family.

89. Recommendation 79 suggests that the Queensland Government develops and shares with all relevant service providers, clear guidelines to facilitate information sharing within an integrated response, with a continued focus on obtaining consent unless a high risk threshold has been met.

90. Recommendations 96 100, 118, 120-123, and 126 are aimed at improving court responses to domestic and family violence. This includes a focus on increased perpetrator accountability and the implementation of specialist domestic and family violence courts.

91. Recommendation 96 suggests that the Queensland Government establishes specialist domestic violence courts in legislation with jurisdiction to deal with all related domestic and family violence and criminal/breach proceedings. To that end, I understand that a Specialist Domestic Violence Court is being trialed in Southport, and this model will be refined and other specialist courts established throughout the State.

92. Recommendation 101 suggests that the Chief Magistrate reviews and completes the domestic and family violence 'Bench Book' in consultation with relevant stakeholders (Women's Legal Service, North Queensland Women's Legal Service, Queensland Domestic Violence Services Network, Queensland Association of Independent Legal Services, Queensland Indigenous Family Violence Legal Service and Legal Aid Queensland).

93. I understands that this bench book for Magistrates is aimed at guiding their decision making with respect to the new domestic violence legislation. It also suggests procedures to help streamline responses and aid consistency across the courts.

94. Recommendations 132, 134, 135 and 138 are aimed at improving policing responses to domestic and family violence including a review of training and the adoption of a pro-active investigation and protection policy that considers the safety of the victim as paramount.

95. I understand that a state-wide training program for Queensland police officers is currently being rolled out, named the 'Vulnerable Persons Training' package. This is a two day package aimed at equipping police officers with a knowledge and skills to work within the new legislative framework for domestic violence and mental health.

96. Since KH's death, the *Domestic and Family Violence Protection Act 1989* has been modified and updated to the current *Domestic and Family Violence Protection Act 2012* (the Act). The Act was passed on 16 February 2012 and commenced on 17 September 2012. Amendments to the Act include a broader definition of domestic and family violence, greater police powers when investigating a domestic or family violence incident, improved grounds and immediate protection for the aggrieved when making a Protection Order application, and increased penalties for breaching a current Protection Order.

97. I further note the recent amendments to the *Bail Act 1980* with the introduction of the *Bail (Domestic Violence) and Another Act Amendment Bill 2017.* The new provisions reverse the onus of proof for bail for an alleged offender charged with a relevant domestic violence offence. A suite of other strategies aimed at strengthening the management and monitoring of parole and bail orders with respect to domestic and family violence offenders have also been introduced.

Conclusion

98. Between the evening of 20 January and early hours of 21 January 2011, KH was killed by her partner, C at their residence. KH died as a result of severe violence inflicted upon her by C. C cut the major arteries and veins in KH's neck thereby cutting off vital blood supply and hence oxygen supply to the brain, leading to massive and fatal blood loss.

99. These injuries allowed air to enter the circulation and the heart, leading to the development of an air embolism which also contributed to death. The trachea (windpipe) was severed as part of the injury, which contributed to death by preventing normal breathing.

100. I note that in addition to inflicting other non-life threatening injuries on KH, C cut KH's throat with such force it caused lacerations to her vertebral neck bone.

101. Reform surrounding domestic and family violence is an urgent prevalent national issue of high importance. Significant reform has occurred in Queensland since this death that is intended to improve the safety and protection of victims of domestic and family violence.

102. In deciding whether to hold an inquest into KH's death, I have considered the recent recommendations made in the Report. The Queensland Government has committed to the implementation of all recommendations. I am also conscious of the recent legislative amendments to remove the presumption for bail for high-risk offenders who commit relevant domestic and family violence offences. I have also considered the finalisation of the criminal proceedings brought against C in relation to the death.

103. Ultimately, I have decided that holding an inquest is unlikely to provide any new information, or result in any useful recommendations being made over and above those already discussed above. I am unable to make any further preventative recommendations on anything connected with the death, with respect to matters of public health and safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

104. It is therefore my view that it is not in the public interest to hold an inquest into this death.

105. The findings are published on the Queensland Coronial website. The dissemination of information in this way is the most appropriate and likely means to raise awareness of such an shocking domestic violence death and the continuing need for the community and all health, support, police and justice services to speak out and act against this appalling crime.

Findings required by s. 45 of the *Coroners Act 2003*

Identity of the deceased - KH

How she died KH suffered domestic violence at the hands of her de-facto partner C. At the time of her death, C was awaiting trial in relation to charges for grievous bodily harm against KH. He had also been charged with breaching a protection order and his bail conditions that he not have contact

with the deceased. KH died at their residence as a result of severe violence inflicted upon her by C. The injuries were inflicted by a knife.

Place of death – Rural Queensland, Australia

Date of death– 20 January 2011 – 21 January 2011

Cause of death – 1(a) Incised wound to neck

Christine Clements
Brisbane Coroner
Brisbane