QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Teresa Bradford and David Bradford**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	15 June 2021
FILE NO(s):	2017/483, 2017/484
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	Coroners; Domestic Abuse, Domestic and Family Violence; Choking; Strangulation; Queensland Police Service; Specialist Services.

Contents

Introduction

1. Ms Teresa Bradford was born on 30 June 1976 and died on 31 January 2017, aged forty years old. Ms Bradford was violently killed by her husband, David Bradford, in the context of a pattern of intimate partner domestic abuse.

2. Ms Bradford was a caring and loving mother of four children and was the primary caregiver for her family after Mr Bradford suffered a stroke in 2015. Ms Bradford cared for Mr Bradford and her children while simultaneously balancing her employment and higher education commitments, in the context of significant and sustained coercive controlling violence perpetrated by Mr Bradford.

3. Mr Bradford's use of violence was prominent throughout the relationship, and his violence escalated in 2015 when he suffered a stroke, and again in 2016 when Ms Bradford decided to end the relationship. Ms Bradford sought support from multiple services to escape Mr Bradford's abuse; however, the support that was provided was not sufficient to protect her from Mr Bradford. Despite the positive efforts by some of those services, Mr Bradford violently killed and sexually assaulted Ms Bradford and then killed himself.

4. Throughout these findings I examine the response of services to Ms Bradford's help-seeking behaviours, and to Mr Bradford's domestic abuse. While there were numerous examples of positive support provided to Ms Bradford, unfortunately, there were also examples of concerning practice in response to Ms Bradford when she sought assistance.

Background

5. At the time of her death Ms Bradford lived with her four children, who were aged eight, twelve, fifteen and seventeen. Ms Bradford married David Bradford in 2001. Mr Bradford had a son from a previous relationship who was 28 years old.

6. Mr Bradford had a complicated medical history. In 2008 Mr Bradford was diagnosed as suffering from depression. He had a history of left medial cerebral artery stroke, lupus anticoagulant positive, low mood (medicated with anti-depressants), congenital kidney disease with right pelvi-ureteric junction obstruction and right pyeloplasty in 1999.

7. In May 2015 Mr Bradford had a left medial cerebral artery stroke that was managed acutely at Westmead Hospital in Sydney. The infarct was characterized by right sided facial droop and expressive dysphagia. MRI reported showing left sided corona radiata. In November 2015 Mr Bradford had a period of inpatient rehabilitation at Robina. During rehabilitation admission he had gait abnormality, left upper limb spasms and left hip-thigh pain. Due to the history of lupus anticoagulant positivity he required life long anticoagulation and

had been commenced on warfarin. He had a history of hypertension and cataract of the left eye, depression and frequent left shoulder dislocations.

8. On 30 January 2017 Mr Bradford hired a car and drove from his address in Brisbane to Bunnings at Oxenford where he purchased a hatchet. He then rented a hotel room a short distance from Ms Bradford's residence at Pimpama.

9. Between 12.30am and 6am on 30 January 2017 Mr Bradford drove to a street near Ms Bradford's home. He parked his car there and walked to her residence. A neighbour heard a noise at 2.10am.

10. Mr Bradford entered the house through a side window and went to the main bedroom where Ms Bradford was sleeping. He struck her numerous times to the head with the hatchet. When the hatchet broke he went to the garage and retrieved an axe and continued to bludgeon her. He then cut her throat with a knife he obtained from the kitchen. He placed her on the floor beside the bed. He removed her clothes and sexually assaulted her. He then inserted a phone into her abdominal cavity through her anus.

11. Mr Bradford then cut his wrists and torso with the knife, causing only superficial wounds. He then cut his throat.

12. Their two youngest children woke up at about 6am on 30 January 2017. They went to their mother's room but they were unable to open the door. They managed to open it slightly and saw blood on their mother's pillow. The son saw his father crouching near the end of the bed. He was still breathing at that time. They started screaming which woke their brothers. They left the house and ran to the neighbour's house. Neighbours called 000.

13. Queensland Ambulance Service paramedics attended and pronounced Ms Bradford deceased at the scene at 6.51am and Mr Bradford deceased at the scene at 6.53am.

14. Police found two knives at the scene, both of which were bloodstained. One was 320mm long with a blade length of 190mm and the other 245mm with a blade length of 125mm. Police also found a broken hatchet and an old axe with a rusted head.

Autopsies

Ms Bradford

15. An autopsy revealed that Ms Bradford died from head injuries. Ms Bradford had sustained at least eight chopping wounds to her head which had resulted in disruptive fractures of the calvarium and the skull floor. Those chopping wounds were consistent with having been made by the axe which was located at the scene.

16. She had an incised wound to her neck which was superficial and did not cause her death. It was consistent with having been made by a knife.

17. She had two stab wounds to her left upper arm which were consistent with having been made by the knife found at the scene and also consistent with “defensive wounds”.

18. Ms Bradford had minor incised wounds to her left upper back and extremities.

19. Ms Bradford had a mobile phone (iPhone) in her abdominal cavity which had been inserted through her anus causing injuries to the anal canal and rectum. The phone was inserted after she died.

20. Ms Bradford had no natural disease and was healthy apart from the injuries inflicted upon her.

21. Police determined that the iPhone belonged to Ms Bradford.

Mr Bradford

22. An autopsy performed on Mr Bradford revealed that he died from incised neck injuries.

23. Mr Bradford had multiple complex incised wounds in the front of the neck severing the left common carotid artery resulting in exsanguination and aspiration of blood. He had incisions on the cricoid cartilage (part of the Adam’s apple) and the strap muscles in the front of the neck. He had fresh incisions on the front of both wrists but there was no involvement of larger blood vessels. He had a single stab wound to the upper section of the middle section of his abdomen which did not involve any major structure within the abdominal cavity. He had minor tentative incisions or “hesitation marks” on the left side of his neck, left upper and lower chest including small nicks and minor superficial stab wounds confined to the subcutaneous tissues.

24. Toxicology was negative for alcohol but positive for tetrahydrocannabinol, amlodipine and atenolol (both anti-hypertensive drugs). Neuropathological examination showed complicated cerebrovascular disease including multiple old areas of lacunar-type white matter infarction involving right and left cerebral hemisphere white matter and pons; in a background of history of lupus anti-coagulant treated with warfarin and hypertension.

25. Mr Bradford died from the wounds to his neck which resulted in exsanguination of blood, acute aspiration of blood and possible air embolism. All of his wounds were consistent with being self-inflicted. The wounds to his neck, wrists and abdomen were consistent with being caused by a serrated knife which was found near him.

Relationship History

26. Ms Bradford met David Bradford in March 1999 when both were working for City Rail in Sydney. They moved in together and Ms Bradford fell pregnant with their first child to whom she gave birth in December 1999.

27. They married in 2001 and had three more children who were born in 2001, 2004 and 2008 respectively.

28. The family moved to Queensland in 2004 and lived at Nerang and then Proserpine.

29. In October 2006 Mr Bradford was charged with Possession of Cannabis and a Pipe. He was drug diverted instead of facing criminal charges. Shortly after that the family moved back to New South Wales.

30. During this time Ms Bradford came to believe that Mr Bradford was having extramarital affairs and described him as being emotionally abusive, jealous and controlling.

31. Mr Bradford's father died in 2008 and he began to suffer depression.

32. In May 2015 Mr Bradford suffered a stroke which resulted in some physical and intellectual impairment. His speech became slurred, he required a cane to walk and suffered sexual dysfunction. He was prescribed numerous medications.

33. In August 2015 the family moved back to Queensland. Mr Bradford suffered several further strokes. Ms Bradford became his carer. He struggled with his physical and mental health and alleged that Ms Bradford was not looking after him or the children appropriately. Ms Bradford felt that the marriage was over. They slept in separate rooms. Mr Bradford was noted to have suicidal thoughts.

34. In September 2016 Ms Bradford told Mr Bradford that the marriage was over and she wished to leave him. In October 2016 she met a man (Mr D) with whom she commenced a relationship soon after.

35. In October 2016 Mr Bradford was admitted to a mental health facility to deal with depression and suicidal ideation. He was an inpatient for nine days.

History of Domestic Abuse

36. Mr Bradford isolated Ms Bradford from her family. She had no contact with her mother from the time they commenced their relationship in 1999 until December 2016. She had very little contact with other members of her family. Her eldest son states that Mr Bradford prohibited the family from having any contact with

Ms Bradford's family.

37. Mr Bradford was physically abusive to his eldest son who sought psychiatric treatment due to the abuse. His youngest child referred to him by derogatory names.

38. On 28 November 2016 Mr Bradford assaulted Ms Bradford in their living room. He punched and choked her, causing her to black out and lose control of her bodily functions. She was eventually able to calm him down.

39. Mr Bradford had paid for his eldest son to go to Sydney to visit friends shortly before the assault and the son believes that he did so with the intention of attacking Ms Bradford and killing her.

40. Police from Coomera Station attended their residence and Mr Bradford went to the Gold Coast University Hospital (GCUH) mental health unit. He was charged with Common assault and a Police Protection Notice (PPN) was served on him including standard good behaviour conditions only.[1] Police officers referred Ms Bradford to the Domestic Violence Protection Centre (DVPC).

41. DVPC contacted Ms Bradford on 29 November 2016. She met with Centre staff at Beenleigh.

42. After that meeting Ms Bradford attended the Coomera police station and provided a statement about the attack the day before. She gave police some rope, plastic tubing and tape which she said that Mr Bradford was going to use to tie her up.

43. The PPN was lodged in the local Magistrates Court and police requested additional non-contact conditions in response to Ms Bradford's statement. A Temporary Protection Order (TPO) was issued and that order prohibited Mr Bradford from approaching Ms Bradford or contacting her. The application was served on Mr Bradford whilst he was an inpatient at GCUH.

44. On 30 November 2016 Mr Bradford was interviewed by police and charged with Assault Occasioning Bodily Harm, Choking, suffocation or strangulation in a domestic setting and Deprivation of Liberty. He was refused bail by police and remanded in custody at the Arthur Gorrie Correctional Centre.

45. Whilst he was in custody Mr Bradford posted his phone to his family. His sons looked through the phone and found photos of their mother sleeping and of her underwear.

[1] A Police Protection Notice is a type of domestic violence order that is made by police in response to an event where domestic violence is occurring or has occurred. If the respondent is present, police can issue the PPN to the respondent. After the police protection notice is made, a copy of the notice must be filed by the police officer at the local Magistrates Court. Filing of the notice is taken to be an application for a domestic violence order made by a police officer. Where a notice has been issued and an order is then made in the court, the notice remains in force until the order is served on the respondent and becomes enforceable.

46. On 12 January 2017 Mr Bradford was granted bail in the Magistrates Court at Southport conditioned that he:

47. reside at a hotel in Brisbane;
48. not approach within 100 metres of Ms Bradford;
49. report every Monday to the Brisbane City police station.

50. Ms Bradford became aware of Mr Bradford's release from prison on 13 January 2017 after she contacted the prison and was advised he had been released. She then contacted services such as Rent Connect to discuss relocating.

51. On 16 January 2017 Mr Bradford moved to permanent accommodation in East Brisbane.

52. On 17 January 2017 police flagged Ms Bradford's residence as "treat all calls as urgent".

53. On 29 January 2017 Ms Bradford told her daughter that she wanted to move to a new house so that Mr Bradford could not find her as she was scared of him.

54. Ms Bradford was seeing Mr D at the time of her death. He told police that Ms Bradford was scared of Mr Bradford. She found out that he'd been released from prison when she phoned the prison. She requested assistance from DV Connect to find another place to live but received no assistance from that service. He said that he last saw Ms Bradford at 2pm on 30 January 2017 after they spent the morning together and had lunch and she was in good spirits at that time. His last communication with her was by text message at 8.30pm on 30 January 2017.

55. Ms Bradford's brother, Darren O'Brien, told police that the children spent two nights at his residence after Mr Bradford assaulted Ms Bradford in November 2016. She was scared when she found out that Mr Bradford had been released from prison and the children spent the night at his house while she stayed with Mr D.

30 and 31 January 2017

56. At 10.30am on 30 January 2017 Mr Bradford attended a car hire business and rented a white Corolla for two days. At 5.25pm that afternoon he went to the Bunnings Warehouse at Oxenford where he purchased a small axe. At 5.55pm he booked into the Coomera Motor Inn. He left there in the hire car at 12.30am on 31 January 2017.

57. Between 12.30am and 6am Mr Bradford parked the car on Imelda Way, one street over from Ms Bradford's residence.

58. Mr Bradford walked to her house and entered it through an open but screened

window in the lounge room. He went to the main bedroom where Ms Bradford was sleeping. He used the axe to kill Ms Bradford and then sexually interfered with her body before killing himself.

59. At 6.15am their youngest child awoke and went to his mother's bedroom. He was only able to open the door a little due to something being behind it but he looked in and saw blood on the bed. He awoke his siblings who also tried to enter the bedroom. They called neighbours who called 000.

60. Police were called at 6.26am and attended the address (under lights and sirens) at 6.36am. One of the officers found the bedroom door barricaded. He could hear an unidentified sound from inside. He tried to call Ms Bradford's phone but there was no answer. Upon instruction from his Senior Sergeant he forced the door and found Ms and Mr Bradford lying on the floor.

61. Ms Bradford was lying naked on her stomach. Her lower body was covered by a blue sheet and her upper body by a pink bathrobe. She had blood on her head and arms.

62. Mr Bradford was lying on the bedroom floor. He had clumps of hair in his right hand. He had a deep laceration to this throat. He had wounds to his stomach, legs, and wrists.

63. Neighbours found a notebook in a drain nearby Ms Bradford's residence and provided it to police. Mr Bradford had written his thoughts in the book including the following:

> *I sat in a cell regretting not what I did but why I stopped – should have planted a tomahawk in her spine and had some good ol play time.*

He also wrote:

> *And if this gets read by a coroner – the systems fucked but it won't change*

64. Mr Bradford blamed Ms Bradford for his assault on her in November. He wrote in the book that she "played a very active role", "pushed all the buttons and waited for me to implode tick tick."

65. Mr Bradford's reference to a coroner reveals that he intended to kill Ms Bradford when he entered her house on 31 January 2017. The notebook corroborates Ms Bradford's fears that he also intended to kill her on 28 November 2016 and "regretted" that he "stopped" before doing so.

Domestic and Family Violence Death Review Unit (DFVDRU)

66. The DFVDRU considered the circumstances surrounding Ms Bradford's death at the hands of her husband and his subsequent suicide, in the context of the

history of domestic abuse in the relationship and produced the following report.

Context and circumstances of the death

Teresa Bradford was the victim of a severe and prolonged physical assault perpetrated by her husband, David Bradford, on 28 November 2016, after she had expressed a desire to end the relationship several weeks earlier. The assault involved acts of non-lethal strangulation (the severity of which caused loss of consciousness and residual memory loss), deprivation of liberty and threats to kill if Ms Bradford were to attempt to seek help. Ms Bradford believed this episode of violence was a premeditated attempt to take her life by Mr Bradford considering his deliberate behaviours immediately prior to the assault, including removing the children from the home, locking all exits, and pre-preparing lengths of rope and other weapons which were either used, or present, during the assault.

Mr Bradford was subsequently arrested and remanded in custody for 44 days until he was released on bail on 12 January 2017 with a two year Domestic Violence Order prohibiting him from contacting or approaching Ms Bradford, and bail undertakings requiring him to reside at a specified location and report to police weekly.

Ms Bradford expressed frustration with the system for failing to advise her of Mr Bradford's release from custody during a time of significant safety concerns for her and her children. She further disclosed two days prior to her death that she felt unsafe to return to the family home now that she knew Mr Bradford was living in the community, and was intending to move to a new rental and relocate her children to an alternate school in the coming weeks.

On the morning of 31 January 2017, police received a call for assistance from one of the couple's children stating that Mr Bradford had attended the house with a knife, was in a room with Ms Bradford and there was a significant amount of blood observable on the floor of the room.

Police arrived to discover the door of the bedroom was barricaded with a wooden framed double bed. On entry, police observed Mr Bradford and Ms Bradford naked and unresponsive on the floor with two knives located near the bodies; one positioned in Mr Bradford's hand and the other on the floor underneath his body.

Prior history of domestic and family violence

Ms Bradford and Mr Bradford were in a marital relationship for approximately 17 years and shared four children together.

The family resided in New South Wales (NSW) and operated a small business up until May 2015, when Mr Bradford suffered a stroke, leading to the deterioration of his physical function and mental state, and the collapse of the business after the family filed for bankruptcy. This loss of income and an inability to sustain housing and living expenses in Sydney at the time precipitated the family's decision to relocate to Queensland in August 2015.

Mr Bradford experienced a further five strokes over the course of 18 months between May 2015 and October 2016. He suffered from multiple physical issues in the aftermath of these acute crises, including stroke related symptoms of limb weakness, facial sensation change, speech impairment and partial loss of cognitive awareness; with accompanying health concerns of impaired sleep, fatigue, mood instability and signs of depression emerging concurrently.

Mr Bradford often spoke to formal service providers in the primary healthcare setting about his lowered quality of life and mood fluctuation in the wake of dealing with life post-stroke. He perceived himself to be 'inadequate' following this adverse life event and described an overall 'loss of dignity' and sense of loneliness despite living in a house with five other people. He also reported feelings of frustration and irritability regarding the physical limitations his condition had imposed on him, which he believed had inhibited his mobility and threatened his independence.

This perceived diminishment in his quality of life appeared to be associated with presenting symptoms of depression and suicidal ideation, including negative thoughts such as 'it would have been better or easier if he had died'. Although, it is apparent that Mr Bradford exhibited symptoms of depression which were underlying, but undiagnosed, since 2008 following the death of his father, there was a clear escalation in the presence of depressive symptoms in the wake of Mr Bradford having suffering a stroke.

Due to the increased level of care necessary as a result of the complexities evolving from Mr Bradford's physical limitations, Ms Bradford was required to take up the role of primary caregiver to Mr Bradford and the children. Ms Bradford was forthcoming in disclosing her struggles to cope with life post-stroke and the increased burden of care that accompanied this. The heavy demand associated with caregiving while simultaneously trying to balance employment and higher education commitments, in the absence of strong external supports, was thought to place a significant strain on Ms Bradford's wellbeing and, in 2015, it was reported that she was on the verge of a mental breakdown.

Broader psychosocial stressors such as social isolation and financial hardship (whereby the family had limited social supports in Queensland and were unable

to meet basic living necessities such as food, electricity, or school supplies) further compounded the issues felt within the familial setting.

The culmination of these stressors was noted to place increased strain on familial relationships in the years preceding the deaths.

While records indicate that Mr Bradford had always been prone to anger easily, the onset of a chronic physical health problem with associated functional impairment and psychological distress was noted to heighten Mr Bradford's level of aggression and 'shortness of temper' towards his family.

Mr Bradford's relationship with his oldest son, in particular, was noted to be entrenched in conflict of an escalating nature and was described as the catalyst to the son's admission to hospital for mental health concerns in late 2016, shortly prior to this fatality. A significant breakdown in the communication and intimacy between Ms Bradford and Mr Bradford was also identifiable in the records and expressed by Mr Bradford to several service providers in the two years preceding the deaths.

A strong pattern of domestic and family violence is evident when analysing Ms Bradford's accounts of the relationship dynamics within the familial setting over the course of the marriage.

Coercive controlling behaviour, in particular, was prevalent in the familial setting and included the use of tactics such as:

- *Excessive control where Mr Bradford treated Ms Bradford like 'he owned her';*
- *Monitoring her contact with other people by going through her computer and mobile phone and checking up on her when she attended social outings;*
- *Continually interrogating her regarding his suspicions of infidelity;*
- *Isolating her from social supports such as friends and family in which she only recently reconnected with her mother and her wider family following 16 years of minimal contact due to Mr Bradford's controlling behaviour;*
- *Maintaining adherence to strict traditional gender roles within the relationship to set hierarchical dynamics; and*
- *Threatening to kill her, stating he would find her and kill her if she were to attempt to seek help.*

Mr Bradford's use of physical violence, particularly towards his eldest child, was also identifiable within the records; although, it was often minimised as either

an 'accidental' event or appropriate actions that were within the scope of parental responsibilities to discipline a child.

Ms Bradford reported Mr Bradford's use of physical violence towards her involved pushing and shoving, and, on one instance, she reported he punched her while in bed which he claimed was an accident in his sleep.

While the couple's children were all suspected to have been subject to physical abuse at the hands of Mr Bradford (including punching and kicking predominantly within the last five years), the eldest son was reportedly the primary target of Mr Bradford's violence perpetration. At one stage in February 2016, reports of suspected child abuse were reported to statutory authorities after it was alleged that Mr Bradford had physically assaulted his son on two separate occasions.

The couple's children also appear to have exhibited signs of psychological trauma within the familial setting as a result of their exposure to domestic and family violence, among other psychosocial stressors. The eldest son reportedly experienced suicidal ideation, anxiety and poor socialisation skills over the course of several years, while the couple's seven year old son, expressed a desire to kill himself in or around late-2016.

Mr Bradford largely blamed Ms Bradford for the deterioration of the home environment. In November 2016, when Mr Bradford was referred to mental health services for presenting issues of suicidal ideation, he voiced high frustration with his wife's behaviours, stating she was 'responsible for all his problems' and the deterioration of their relationship because she had neglected her duties as a wife and homemaker since commencing her studies in nursing earlier that year. He stated the children were suffering because the house was in squalor and smelt like 'piss', the housework was not getting done, and there was no food in the fridge due to Ms Bradford spending most of her time studying or out with friends.

This expectation to adhere to rigid gender roles, and male proprietary attitudes towards women, sets hierarchical dynamics and correlates highly with intimate partner violence perpetration.

Ms Bradford never reported any of the earlier episodes of violence to formal authorities as she stated she did not (at the time) consider Mr Bradford's actions to be acts of domestic and family violence, nor did she recognise herself and her children as victims.

As briefly mentioned above, in or around October 2016, the eldest son was admitted for inpatient treatment for nine days at the Logan Hospital Child and

Youth Mental Health Services (CYMHS) after expressing suicidal ideation in the context of a history of trauma associated with physical and psychological abuse perpetrated by Mr Bradford.

It is following this event that Ms Bradford returned home from hospital, held Mr Bradford's hand and told him she could not do this anymore and was ending the relationship.

Following the dissolution of the relationship, Ms Bradford and Mr Bradford continued to reside together under the same roof in the absence of sufficient financial means to acquire alternate accommodation.

Mr Bradford expressed suicidal ideation post-separation due to the prospect of having to start life over again with a disability. He also expressed high levels of stress related to his suspicions that Ms Bradford was cheating on him (despite having separated several weeks earlier).

Records suggest that Ms Bradford had indeed commenced a new intimate partner relationship with a friend around the same time as the marital breakdown, although, it is unclear whether this information was known to Mr Bradford. In consideration of Mr Bradford having previously exhibited sexual jealousy and obsessive, controlling behaviours towards the deceased, it is apparent that Ms Bradford was at a high risk of harm during this post-separation period.

Service system contact

While reported acts of domestic and family violence were minimal, the couple were engaged with multiple service providers in Queensland up until the time of the deaths, predominantly in relation to Mr Bradford's complex care needs.

Following Mr Bradford's stroke and relocation to Queensland in August 2015, he was supported by an integrated care team for rehabilitation and ongoing management. This involved input from a multidisciplinary team under a Team Care Arrangement providing Mr Bradford with physical rehabilitation, pain and medication management, counselling, and psychological support aimed at improving his functional outcomes and quality of life.

In particular, Mr Bradford, often in the company of Ms Bradford, was well supported by their General Practitioner at a nearby family practice in the two years preceding the deaths. The primary focus of the clinical care provided to Mr Bradford in this forum was centred on the management of post-stroke complications, including Mr Bradford's ongoing mental health concerns.

While undertones of family conflict were reported to their General Practitioner during limited consultations over the course of their engagement, this was often in the context of the relationship breakdown secondary to ongoing stressors associated with the increased demands of life post-stroke; and did not ever extend to exploration of whether the relationship was characterised by domestic and family violence, or whether Ms Bradford was at potential risk of harm.

Mr Bradford first reported 'family drama and poor family interactions' on 2 March 2016. The clinical notes do not provide further detail around the context of this disclosure and simply state that Mr Bradford was experiencing fluctuating moods, loss of motivation and energy, and negative thoughts triggered by frustrations associated with his physical limitations. Mr Bradford received counselling around life changes post-stroke and was referred to a Psychologist under a Mental Health Care Plan (MHCP) for more intensive psychological intervention pertaining to the presenting concerns of depression and adjustment issues.

The General Practitioner followed up with Mr Bradford on two separate occasions subsequent to referring him to a Psychologist, to which Mr Bradford advised he was yet to engage with the service.

One month earlier, on 2 February 2016, Mr Bradford was investigated by QPS and the Department of Children, Youth Justice and Multicultural Affairs in relation to child protection concerns received from an unidentified notifier regarding suspected physical violence against his eldest son. Two Child Protection Notification reports were referred to police by Child Safety Services with information alleging that:

- *during one incident on or around 20 October 2015, Mr Bradford struck his son with a stock whip and threw a cup at his head; and*
- *during another incident dated 12 January 2016, Mr Bradford punched his son in the jaw.*

The son was interviewed by police at the family home on 3 February 2016 and advised responding officers that the incident involving the whip was unintentional after he inadvertently moved into its path while his father was simulating a cattle muster. He further advised that he could not recall any incident involving a cup striking his head, and reported that the punch to the jaw was actually a smack to the back of the head as a result of him 'being cheeky' towards his father. The son stated he felt he deserved the smack because of his attitude towards his father at the time.

The extent of the information provided to police was evidently an underestimation of the magnitude of the abuse in the family setting. Indeed, Ms Bradford later reported to DV Connect that the son had 'downplayed the abuse

to protect his father', and there is indication that she, too, may have minimised the severity of the violence at the time by suggesting to police that Mr Bradford's actions had not exceeded reasonable parental discipline.

Minimising, denying or refusing to talk about abuse is a common behaviour seen in victims of domestic and family violence and their children. This may occur due to any number of reasons, including for fear of making the abuse worse or to protect the abuser from criminal consequence in circumstances where the victim only wants the abuse to stop. Police and child safety were unable to proceed without further information and the police investigation was subsequently finalised as unfounded and no further intervention was deemed necessary.

Throughout 2016, Mr Bradford continued to engage with healthcare providers for after-care support with respect to his physical and psychological recovery. This included interactions with the Gold Coast Integrated Care (GCIC) program[2] for integrated case management, including social worker support.

Periodically, Ms Bradford would also link in with community support services in her role as carer, but was notably less connected to the system.

In October 2015, a referral to The Benevolent Society identified that Ms Bradford was struggling to cope with the family's complex issues and needs, and was reportedly on the verge of a mental health breakdown. The referral recommended the need for financial, respite and mental health supports, including:

- *counselling for Ms Bradford and the children; and*
- *in-home nursing support for the care of Mr Bradford.*

The Benevolent Society ultimately assessed that the family did not meet the criteria for Intensive Family Support and, instead, would be best placed to receive support from Family and Child Connect (FaCC). A referral was completed and the matter was transferred to FaCC provider, Acts for Kids.

Acts for Kids[3] received the referral on 5 November 2015 and made contact with Ms Bradford one week later to schedule a face to face appointment with Ms

[2] The Gold Coast Integrated Care program is a program led by general practitioners and health specialists in the Gold Coast region, supported by the Gold Coast Hospital and Health Service, aimed at ensuring patients and practitioners work in partnership to create the best possible outcomes for patient care. The program aims to reduce unplanned hospitalisations by sharing knowledge and linking services for people with chronic and complex health issues. A single shared care health plan for each identified patient is developed and monitored by the patient's treating GP with the support of the local health system (including input from specialists, allied health providers and community health services). The patient consents to, and actively participates in, the development of the healthcare plan.

[3] The aim of FaCC is to identify concerns or issues that are present in a family and identify appropriate referral pathways or services to address those areas of need. The intervention period with families is very short and consists primarily of meeting with a family to complete an initial needs identification for the purpose of onwards referral and connection to appropriate services.

Bradford and Mr Bradford for the purpose of discussing the needs of the family and appropriate referral pathways.

The presence of domestic violence, among other harm indicators, was canvassed during intake assessment on 25 November 2015, in which a Structured Decision Making Safety Assessment was completed, and no safety risks/concerns were identified based on the available information at hand. It is noted that the screening assessment was not specific to domestic and family violence and encompassed a range of broader psychosocial factors considered in the family and environmental setting.

While there is a paucity of information pertaining to the discussions held between Acts for Kids and Ms Bradford and Mr Bradford at the time, it is evident that, in response to the family's identified areas of need, the following supports were provided:

- *financial assistance for educational resources; and*
- *information on referral pathways into:*
- *parenting programs;*
- *school holiday activity programs; and*
- *a counselling service.*

It would appear that no direct referrals were made by Acts for Kids, but rather, brochures and/or contact details were provided to the couple as options for them to consider if they wanted further engagement. The case was closed to FaCC on 16 December 2015.

The available records suggest that this was the last known instance in which Ms Bradford was linked in with community service supports prior to circumstances reaching crisis point in November 2016 following the couple's separation.

On 18 November 2016, Mr Bradford attended a neurology appointment at the Gold Coast University Hospital (GCUH) and expressed vague thoughts of suicidal ideation in the context of feeling overwhelmed by his physical impairment and the accompanying impact it was having on his family which had led to the breakdown of his marriage. It became apparent during this conversation with the Neurologist that Mr Bradford had ceased his medication regime a week earlier as he felt it was contributing to his weight gain. While no suicidal plan or intent was identified, Mr Bradford did disclose thoughts of overdosing on his medication and, at the conclusion of the consultation, the Neurologist referred Mr Bradford to the Emergency Department (ED) for a mental health review.

When Mr Bradford did not present to the ED for review, the Acute Care Team (ACT) spoke to Ms Bradford over the phone who advised that the couple had left the hospital to collect their children from school. The benefit of an urgent review was explained to Ms Bradford, however, it was concluded that given Ms Bradford felt Mr Bradford was not currently at risk of harm to himself and was being monitored closely, a referral for ACT community follow up was appropriate.

Mr Bradford was assessed at this stage as low risk of suicide, self-harm and aggression, but moderate risk of vulnerability given his physical impairments, limited supports and marital breakdown.

A follow up telephone call to Mr Bradford on 19 November 2016 identified that Mr Bradford was feeling 'a bit brighter today', his mood had lifted since recommencing his medication and he denied any current suicidality.

Three days later, on 22 November 2016, Mr Bradford was seen by ACT during a home visit in which he reported there was no risk of suicide due to his children being strong protective factors who would deter him from carrying out any thoughts of suicide. He disclosed that his rumination about overdosing on medication was in the context of feeling as though he was discharged prematurely without warning during his last medical discharge (presumably in reference to Mr Bradford's most recent admission to hospital following a stroke in September 2016).

When asked about violence during the Consumer Assessment, Mr Bradford 'spontaneously denied any issues with physical violence in his home' and was 'adamantly stating he has had nil physical altercations with family'.

Based on information only collected from Mr Bradford, with no collateral information gathered to assess the accuracy of the claims, the clinician assessed Mr Bradford as being 'At risk of domestic/family violence' at the hands of his eldest son and 'At risk of being financially abused by others', namely Ms Bradford, after he reported:

- *his son had threatened to punch him during a prior incident; and*
- *He believed Ms Bradford was siphoning money into a hidden shared account, but was continuing to report the family had no money.*

At the conclusion of the intake, Mr Bradford's risk of suicide and self-harm was assessed as low, although, it was noted that this might fluctuate based on his situation at home.

Mr Bradford was referred to a General Practitioner for ongoing monitoring of his mental state, with a recommendation that his General Practitioner should maintained Mr Bradford's current medication and dosage. The matter was then closed to ACT community with no further action.

Mr Bradford presented to his General Practitioner on 24 November 2016 and reported that he felt if he had received counselling earlier in the year, 'things wouldn't be like this'. Mr Bradford reported escalating family problems in the home, including that his eldest son was displaying difficult behaviours at home and in school, and that Ms Bradford was agitated at home due to stressors associated with struggling to maintain work, study and home life.

Mr Bradford was subsequently re-referred to the same Psychologist under a MHCP and was advised of social support options, including Anglicare, to assist in financial, accommodation and adjustment support. A GP follow up for two weeks later was scheduled, but did not eventuate as Mr Bradford physically assaulted Ms Bradford four days after this GP consultation, resulting in his arrest.

On 28 November 2016, Mr Bradford woke up early, prepared the children for school and got them to leave the house early. The couple's daughter advised she was feeling unwell that morning and wanted to stay home from school, however, Mr Bradford reportedly forced her to go and threatened her by stating if she told the school she was sick, nobody would collect her from school and she would be in serious trouble when she got home. Mr Bradford then provided the children with money and instructed them to visit McDonald's after school, which was reported to be out of character. It was Ms Bradford's belief that Mr Bradford did this so he would 'have enough time to follow through with his plan to murder her'.

After the children had left for school, Ms Bradford stated that Mr Bradford tried to lure her into the bedroom and she felt a sudden rush of panic and refused to go into the room with him. Ms Bradford stated that this was when the assault began, whereby Mr Bradford:

- *punched her in the face;*
- *placed gaffer tape over her mouth;*
- *dragged her by the hair; and*
- *non-lethally strangled her until she lost consciousness and control of her bladder and bowel function.*

Ms Bradford regained consciousness to find Mr Bradford sitting on top of her. She attempted to calm him down over the next 30 minutes as he maintained

his position sitting on her body. He eventually stood up and agreed to let Ms Bradford call an ambulance to seek mental health support for Mr Bradford.

Two ambulances and four police crews attended the residence shortly thereafter and took Mr Bradford under an Emergency Examination Order (EEO) to the GCUH for mental health review. Ms Bradford was not taken to hospital despite her injuries, as she reported:

- *Mr Bradford 'downplayed' the episode of violence to emergency services; and*
- *she was unable to provide an accurate account of what had transpired to inform QAS and QPS assessment due to residual dizziness and shock she was experiencing following the assault.*

Ms Bradford later advised DV Connect that responding officers 'didn't treat her very well and told her to have a shower' due to being covered in urine and faeces.[4]

It is apparent that, in response to the assault, police issued Mr Bradford with a Police Protection Notice (PPN) stipulating one standard good behaviour condition and charged him with the offence of Common assault. Responding officers also contacted the Department of Children, Youth Justice and Multicultural Affairs in relation to child protection concerns regarding the children's exposure to domestic violence, the unkempt state of the home, and the lack of food in the fridge.

When Ms Bradford later presented to the children's school to collect her kids, she was approached by a staff member who saw 'the state she was in' and was referred to the school's guidance officer. The guidance officer spoke to Ms Bradford and contacted DV Connect to request safe accommodation for Ms Bradford and three of her children (eldest child was currently interstate) as, although Mr Bradford had been taken to hospital under police escort, it could not be confirmed whether he would be returning to the family home later that afternoon.

DV Connect advised Ms Bradford a counsellor would call her back and that if she hadn't heard from them in approximately an hour, she should call them

[4] The QPS narrative initially stated (prior to Ms Bradford providing an addendum statement which initiated additional charges) that at *'approximately 09:30am on the 28th day of November 2016, the respondent has received a phone call in relation to a medical condition. This has upset the respondent who was already stressed in relation to the aggrieved wanting to leave him. The respondent also believed the aggrieved was cheating on him. The respondent has then taken a knife from the bedside table and given it to the aggrieved who was in the lounge room. The respondent then tried to drag the aggrieved into the bedroom. The aggrieved resisted so the respondent slapped the aggrieved in the face with an open hand twice. The respondent then said he will kill himself and mumbled a comment about harming the aggrieved. The respondent went into the bedroom with a rope where he remained until Police arrived. Police have then transported the respondent to the Gold Coast University Hospital to speak with the mental health team. Based on the evidence provided, the attending Police have filled out a PPN and served it on the respondent'.*

back to follow-up. While it is clear that DV Connect did indeed recontact Ms Bradford as advised, requiring the victim to follow-up with a service following a traumatic crisis event opens up opportunities for the victim to fall through the cracks where she may disengage from accessing appropriate supports when adequate follow-up is not provided.

Ms Bradford later self-presented to the Robina Hospital for assessment of her injuries after DV Connect urged her to seek medical treatment for her injuries after she described experiencing residual dizziness and blackouts in the hours following the assault. She then made attempts to recontact police to provide additional details about the assault which she was unable to recall at the time of police attendance (possibly due to the severity of the strangulation and the loss of consciousness). After initially being unable to make contact with the investigating officer, Ms Bradford attended the Southport Courthouse to apply for a private application for a protection order requesting additional conditions, including an ouster condition, be placed on the order.

She was assisted by a DV Court Support worker from the Domestic Violence Prevention Centre (DVPC) who advised her to immediately attend the police station to provide an addendum statement to police which would inform the police application. Ms Bradford subsequently attended the Southport Police Station as directed, and based on the supplementary information provided by Ms Bradford, police upgraded Mr Bradford's charges to Assault occasioning bodily harm, Deprivation of liberty and Choking, suffocation, strangulation (domestic relationship).

Ms Bradford was also referred to DV Connect and the DVPC for financial and accommodation support, and counselling.

Decision-making around this police response was reviewed by the Gold Coast Domestic and Family Violence Taskforce during an audit on 15 December 2016 and was deemed appropriate with no further action necessary at this time.

During assessment while at the GCUH MHU, Mr Bradford minimised his use of violence by stating this episode of domestic violence simply involved him hitting his wife out of frustration when he "blew the switch" at the state of the house. While it was noted in the records that Mr Bradford exhibited some degree of regret about the escalation of events, the overarching impression was that Mr Bradford demonstrated limited remorse or insight into his actions. He continued to ruminate about Ms Bradford's lack of involvement with the family in the months leading up to the incident and her neglect of her responsibilities as a parent and a wife.

Mr Bradford was described as 'violent' and a risk to his wife and children during risk assessment. Clinicians even reported that he was smiling when he showed them a photo of the black eye he had given his wife. It is of considerable concern to identify that, despite evidence of severe physical violence and the evaluation of Mr Bradford as a risk to the safety of his family, the treating team contacted Ms Bradford to request she attend a family meeting to 'clear the air' with Mr Bradford. Ms Bradford denied this request and stated she did not feel safe with Mr Bradford, citing his actions were premeditated and he was a volatile and angry person.

Mr Bradford was assessed at this time as low risk of suicide, self-harm and absconding, but high risk of aggression and vulnerability.

The records indicate that, within hours of his admission, Mr Bradford was requesting discharge from hospital as he felt he would function better with his son, who lived in Newcastle, rather than in hospital. The treating team subsequently contacted Mr Bradford's son, who initially agreed to the plan, but later refused as he felt Mr Bradford's mental health needed attention due to the risks he posed to himself and others.

Mr Bradford remained in the care of the MHU until his release two days later on 30 November 2016 for the purpose of appearing before the court in relation to a police application for a protection order. The treating team failed to inform police or Ms Bradford of Mr Bradford's release and, upon arrival at court, Ms Bradford found Mr Bradford had positioned himself in the entrance of the domestic violence courtroom preventing her entry.

The investigating officer contacted Ms Bradford while she was in attendance at the court and, upon hearing of the situation at hand, coordinated a response by CIB Coomera to intercept Mr Bradford and apprehend him in relation to the additional criminal charges yet to be addressed.

Mr Bradford was in attendance during the domestic violence hearing, in which a Temporary Protection Order[5] was granted by the Court, and he was then remanded in custody.

When Mr Bradford did not return to the mental health ward at 2:30pm as directed following his five hour leave, the hospital contacted the family home and spoke with the couple's 12 year old daughter, advising her that Mr Bradford's whereabouts was unknown and questioned whether she knew where he was. Ms Bradford subsequently reported that the children were

[5] A Temporary Protection Order was granted by the Court stipulating 10 conditions which prohibited Mr Bradford from contacting or approaching Ms Bradford and the children, and the matter was adjourned until 14 December 2016.

terrified. Upon contacting Ms Bradford and being advised about the situation, the DVPC worker advised Ms Bradford to act as though Mr Bradford was not in custody until it was confirmed that he was and to arrange for the children to attend the neighbour's house up the street where Ms Bradford could collect them and take them to a new location. It was later confirmed by the QPS DV Taskforce that Mr Bradford was, indeed, in custody and an objection to bail had been submitted.

The case was closed to the MHU on 1 December 2016 when it was assessed that Mr Bradford did not need to be under the Mental Health Act as an inpatient (informed largely by their understanding that he was in custody and could be treated by the Prison Mental Health Service if necessary) and it was suitable for the case to be closed.

Mr Bradford was transported from the Southport Watchhouse to the Arthur Gorrie Correctional Centre on 2 December 2016 and remained in custody for the next 44 days.

During this period, Ms Bradford was supported by specialist domestic violence support services. The DVPC maintained contact with Ms Bradford up until the time of her death and were responsible for providing high risk case management via risk assessment, safety planning, court support and counselling services. Concurrently, DV Connect provided intermittent support to Ms Bradford during this time around emergency accommodation options and referral to the Pets in Crisis program.

In the following weeks, Ms Bradford began exhibiting symptoms of Post-Traumatic Stress Disorder (PTSD) concurrent to suicidal ideation, for which she sought support from several healthcare services.

In December 2016, Ms Bradford presented to the GP on three occasions and disclosed detailed accounts of the physical assault that had transpired and the emotional impact it had had on her. While this was Ms Bradford's first point of contact with the treating doctor, it is apparent that this GP was also the primary practitioner responsible for coordinating the provision of medical and mental health service support to Mr Bradford both prior to, and after, the assault. Ms Bradford continued her engagement with this GP in relation to trauma related symptoms over the course of the next six weeks, while Mr Bradford simultaneously received support from the same GP recommencing in January 2017.

On 6 December 2016, Ms Bradford presented to CYMHS with her eldest son, to see his case manager and was observed to be distressed. She reported experiencing PTSD like symptoms such as flashbacks, hypervigilance and poor

sleep in the wake of the assault, and disclosed suicidal ideation with intent, stating she had intended to overdose on her prescription medication the day prior due to feeling overwhelmed with the seriousness of the incident and the risk to her life. Ms Bradford had presented to her GP that same day, but the records suggest that the focus of the consultation was around domestic violence counselling (unspecified) with no suicidal thoughts, plan or intent identified as having been detected (although, it is unclear whether the treating doctor screened for suicidality on this occasion). A psychology referral under a MHCP was discussed during this consultation, but did not eventuate at this time.

Ms Bradford was referred to the Gold Coast Mental Health Service (GCMHS) by the CYMHS that same day subsequent to her disclosures outlined above. On intake on 7 December 2016, she reported feeling much better following the mental health crisis the day prior. The service noted Ms Bradford reported she was well supported by specialist domestic violence services and was planning on attending her GP to obtain a referral to a psychologist under a MHCP. This informed their decision to close the matter to the Acute Care Team accordingly with no further action taken or any specific discharge planning.

Ms Bradford presented to her GP on 14 December 2016 where a referral to a Psychologist (the same psychology service that Mr Bradford was referred to) was initiated and a three week follow up was scheduled to review and discuss her progress.

A two year Domestic Violence Order (DVO) was granted on 14 December 2016 naming Mr Bradford as the respondent, Ms Bradford as the aggrieved and the couple's four children as named persons. The order stipulated 10 conditions which prohibited Mr Bradford from contacting or approaching Ms Bradford and the children, and the criminal proceedings pertaining to assault occasioning bodily harm, deprivation of liberty and non-lethal strangulation were adjourned until 21 March 2017.

On 5 January 2017, Ms Bradford re-presented to her GP and disclosed she was trying to get her life back together, was trying to move into more affordable accommodation, and was receiving financial assistance and counselling support from multiple services.

Mr Bradford was released from prison on bail on 12 January 2017 despite police objections.[6] *Bail undertakings stipulated that Mr Bradford was required to*

[6] A QPS Objection to Bail Affidavit submitted to the Court on 1 December 2016 supported Mr Bradford's remand in custody due to the unreasonable risk of harm he posed to himself and others as a result of his 'fragile mental state' and the likelihood he would commit further offences.

reside at a specified location[7] and report to police weekly. This information was not relayed to Ms Bradford during a time of significant safety concerns for her and her children and she later voiced her frustrations with the system for not recognising the risk of harm they had placed her in. She stated if she had not called the prison herself to confirm Mr Bradford's status, she would never have known he was out in the community subsequent to his release.

Following Mr Bradford's release, the DVPC discussed safety planning with Ms Bradford, including accommodation support options, and received consent from Ms Bradford to generate a high risk referral for Rent Connect. This was completed on 23 January 2017 and outlined Ms Bradford's high risk assessment and a request to prioritise assistance for immediate accommodation relocation support.

On 13 January, Mr Bradford telephone the GCIC to advise that he was released from custody yesterday and was residing at a hotel in Brisbane. A summary of the context circumstances surrounding Mr Bradford's custody were noted by the Social Worker, including the episode of domestic violence and Mr Bradford's prior history of neurological impairment post-stroke. The Social Worker discussed with Mr Bradford accommodation support options on the Gold Coast, including information about homelessness services, and advised Mr Bradford to re-contact the service if any health concerns arose. The Social Worker scheduled a one week follow-up with Mr Bradford, however, based on the records available, there is no indication that the service was in further contact with Mr Bradford following this point of engagement.

It was suspected that Mr Bradford may have breached the conditions of the order when, on 13 January 2017, Mr Bradford contacted his son in relation to attending the family home to collect his personal belongings. Ms Bradford was encouraged by the DVPC to seek advice from police as to whether this correspondence constituted a breach of the conditions of the order given Mr Bradford had inferred that he would potentially be attending the residence.

Ms Bradford spoke to Policelink on 16 January 2017 and a police crew was sent to her house to investigate the report of a breach. On viewing the text messages, responding officers were of the opinion that the correspondence did not contravene the conditions of the order; presumably because Mr Bradford was permitted to return to the home to collect personal property (in the company of police) pursuant to a recovery condition stipulated on the order. Decision-making around this police response was reviewed and authorised by the District Duty Officer as 'No DV' that same day.

[7] A residential condition was imposed on Mr Bradford stipulated that he must reside at a specified address in Brisbane (nominated as a hotel by his son, as a temporary address). An additional feature was added to the condition which offered Mr Bradford the ability to alter the address by notifying the Officer in Charge at the Southport Police Station to assist him in finding more stable and long term accommodation.

When speaking to Policelink, Ms Bradford disclosed feeling that she was 'in the dark' and 'no one is helping her', stating she did not feel safe in her current rental accommodation and had nowhere to go as a result of being unable to afford rent at current market prices. In response to the concerns raised by Ms Bradford, referrals were generated to:

- *Victims Assist QLD - to determine whether she may be eligible for financial support;*
- *Legal Aid QLD – to provide legal advice regarding the pending divorce and Ms Bradford's suspicions Mr Bradford may attempt to take advantage of her financially; and*
- *DVConnect – to assist in accommodation support.*

That same day, on 16 January 2017, Mr Bradford attended a consultation with his GP (the same one that Ms Bradford had been seeing who was aware of the prior episode of non-lethal strangulation) and disclosed the recent acute deterioration which resulted in his admission to hospital and arrest for 'domestic issues'. The records do not demonstrate that the treating doctor attempted to understand or further explore the contextual circumstances surrounding Mr Bradford's arrest, nor is there any evidence to indicate that safety or risk assessment tools were utilised during consultation to assess safety and risk levels. During this consultation, Mr Bradford reported experiencing fluctuating moods and sensitivity, but denied any thoughts of self-harm. He requested another psychologist referral, stating he had not engaged with the service previously because 'his ex-wife didn't take him'.

The GP contacted GCUH to advise Mr Bradford was back in the community. The treating team advised the GP that Mr Bradford had been discharged and was no longer in their care in the absence of any current (reported evidence of) deterioration. The medical records do not include a discharge summary for the previous admission and there is no indication of any ongoing treatment plan, with records citing that Mr Bradford was deemed suitable for discharge into the care of Watchhouse staff.

On 20 January 2017, Ms Bradford attended a consultation with her GP with presenting issues of back pain. The records do not document any attempts by the GP to follow up with Ms Bradford about how she was progressing since their last consultation, nor were attempts made to assess the unmet needs and vulnerabilities of the victim (particularly with respect to safety planning) now that Mr Bradford was living in the community.

On 26 January 2017, DV Connect contacted Ms Bradford following a referral from police regarding accommodation support. Ms Bradford declined assistance for emergency refuge accommodation support, stating she was feeling quite good, was focused on her future plans which involved moving into a place of her own, and was not requiring refuge assistance from DV Connect at this point.

Two days later, on 28 January 2017, Ms Bradford was transported to the GCUH via QAS with presenting issues of chest pains. She reported significant weight loss in the past eight weeks, which she attributed to stress following the assault, and voiced her concerns about returning to the family home in the context of Mr Bradford being out on bail. Ms Bradford was admitted to hospital overnight and received social worker support[8] while admitted. On discharge, Ms Bradford reported she felt well supported in the community and was happy to be discharged in to the care of her new partner who she stated she would stay with overnight until she could contact DV Connect in the morning to arrange alternate accommodation. Based on the DV Connect notes, there is no indication that crisis accommodation support was sought by Ms Bradford following her discharge.

Mr Bradford attended a consultation with his GP on 30 January 2017, one day prior to the deaths, stating that he had self-ceased all medications, including his anti-depressant medication, due to his dissatisfaction with how they made his feel (tired, drowsy and emotional). While the treating doctor made attempts to deter Mr Bradford from ceasing his medication by explaining the increased risk of seizures, mood change and pain if Mr Bradford were to remain non-compliant with his medication regime, Mr Bradford stated he felt better, more energetic, less emotional and had increased motivation and improved moods following cessation of his medication.

It is noted that a similar pattern of non-compliance with medication had preceded the prior assault on the 28 November 2016 in which Mr Bradford ceased anti-depressants 10 days earlier.

This was the last known contact Mr Bradford had with formal service providers prior to murdering Ms Bradford and taking his own life the following morning.

67. The DFVDRU concluded that in relation to the contacts that Ms Bradford and Mr Bradford had with service support systems there were elements of good

[8] Ms Bradford was provided with crisis event counselling and education regarding domestic violence, trauma responses and symptoms and was provided options regarding ongoing support via victim services and specialist domestic violence supports. Safety planning was discussed and Ms Bradford consented to receiving further support from the DVPC via a referral. Ongoing support from QPS and Intensive Family Support Program was also noted, including Ms Bradford's house being flagged for urgent response by police.

practice and also practices and responses that caused concern.

Primary health care providers

68. Elements of good practice by primary health care providers included:

- Formal mental health risk assessments and appropriate referral and follow up of specialist services eg the GP referred Mr Bradford to a psychologist for further exploration of his presenting concerns of depression and adjustment issues in the context of his physical impairment and escalating family conflict. The GP actively encouraged Mr Bradford to engage with the service on two follow up occasions when it became apparent that Mr Bradford was yet to make contact;

- There was evidence of appropriate referral to specialist services for community support when stressors were identified post-separation, including where the GP made concerted attempts to link Mr Bradford with community-based social support options to assist with financial and accommodation concerns.

69. Concerns included:

- A lack of consistency in terms of follow up after-care about progress or potential need for ongoing support eg the GP, who had knowledge of Mr Bradford's release from custody at the time and the history of violence in the relationship, saw Ms Bradford for back pain in the week before her death. The focus of the consultation was solely centred on the immediate presentation and the GP did not explore the topic of domestic violence or vulnerabilities of the victim (particularly with respect to safety planning) now that Mr Bradford was living in the community.
- The degree to which direct or indicative disclosures of abusive behaviour were challenged or explored by the GP.
- Both Ms Bradford and Mr Bradford were seen by the same GP over the period of time in which there was an escalation of violence and relevant disclosures made by both parties about domestic violence in the relationship and this extended to both parties being referred to the same psychology service at the same time for psychological input and counselling support in relation to intimate partner violence, post-separation. While the GP referred them separately for individual counselling under their respective Mental Health Care Plans, this was to the same psychologist. This inadvertently afforded opportunities to Mr Bradford to gain access to Ms Bradford at a time of significant risk to her in an environment where safety and support should be paramount; demonstrating limited consideration of safety risk or planning.

70. The DFVDRU noted:

> *In the inquest into the death of Noelene Marie Beutel, with respect to relationships characterised by intimate partner violence, Coroner Hutton noted the issue of whether a GP should treat one, both or neither party as important, but considered it to be largely unresolved at the time of inquest by current policy or practice guidelines. Accordingly, Coroner Hutton recommended that the medical profession itself, along with the Queensland Government, should explore the issue further with a view to establishing guidelines to assist GPs, extending upon the existing 'Abuse and violence: working with our patients in general practice, 4th edition' guidelines otherwise known as the 'White Book'[9] which were most recently updated in 2014; and constitute the primary resource to guide GPs in their response to victims and perpetrators of domestic and family violence.*
>
> *Subsequent to this inquest, the Special Taskforce supported the recommendation that the Royal Australian College of General Practitioners (RACGP) refines the RACGP 'White Book' to be more prescriptive and provide more definitive advice and decision making pathways for general practitioners (Recommendation 50). The Queensland Government supported the recommendation in its response to the Special Taskforce report and it was noted that the Health Minister would write to the RACGP in support of this recommendation.*

71. At the time of publishing these findings, the White Book remains unedited or revised since 2014 and there are no identifiable alternative actions to improve primary health care responses to domestic and family violence currently underway across the state.

Health system responses

72. Elements of good practice included evidence of mental health risk assessment and appropriate referral. Mr Bradford was referred for urgent mental health review after a neurological specialist recognised he was experiencing suicidal ideation after self-ceasing his medication in the context of the relationship breakdown.

73. The following issues were identified:

- A reliance on Ms Bradford (the victim) to provide ancillary care and support to Mr Bradford (her abuser) in relation to underlying health issues, including (largely) mental health concerns.

[9] Chapter 5 of the 'White Book' provides practice guidelines on working with perpetrators in clinical practice. Refer: https://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-5-dealing-with-perpetrators-in-clinical-practice/

- Limited respite or in-home care support was provided to the family despite Ms Bradford consistently disclosing an inability to cope with the increasing demands of having to assume the role of sole provider and caregiver to Mr Bradford and the children in the context of managing Mr Bradford's complex needs.

- Limited evidence of formal assessment of the risk of harm posed to Ms Bradford and the children with the primary focus of risk assessment on identifying a risk of suicide or self-harm as it related to the perpetrator. Where such screening was used the tools demonstrated limited reliability or validity as they were reliant mainly on self-reports, with limited evidence of collateral information checking. This meant that the assessment screened Mr Bradford (who was the primary perpetrator in the relationship) as being at risk of domestic and family violence victimisation from his wife, (financial abuse) and his son (physical abuse).

- The degree to which risk assessment and victim safety was factored into treatment and discharge planning, where, despite photographic evidence of injuries to Ms Bradford (black eye) and Mr Bradford being assessed as 'violent' and a risk to his wife and children during mental health review, the treating team:

    - (post-near fatal assault) requested Ms Bradford attend a face-to-face family meeting with Mr Bradford to '*clear the air'* as Mr Bradford had denied the allegations;
    - planned to discharge Mr Bradford in to the care of his son within hours of the initial near-fatal assault and only changed the plan when his son refused to take him after voicing concerns about the active risk he posed and the need for mental health treatment; and
    - released Mr Bradford, unsupervised, on day leave to attend court without advising police or the victim so that this information may inform safety planning.

- The health response to Mr Bradford's mental health concerns were prioritised over treating Ms Bradford's physical injuries. Ms Bradford reported that she was required to self-present to the Emergency Department for treatment of her injuries post-strangulation after responding paramedics prioritised Mr Bradford's need for mental health assessment on attendance at the scene. It may have been the case that they also failed to understand her need for treatment, although she reported experiencing memory loss, disorientation and confusion as a result of being a victim of non-lethal strangulation at the scene.

- The lack of integration, communication and apparent lack of understanding of risk from treating clinicians in the mental health setting when managing complex needs and risk including:

    - An over-reliance on self-reporting and limited evidence of seeking collateral information resulting in risk assessments based on partial or incomplete information across most of the cases;
    - Limited attention given to assessing and/or managing potential risk posed to family members even where there was knowledge of historical or recent violence in the home and/or the presence of protection orders and the potential risk to partners and children was not formally assessed by health practitioners.

74. The DFVDRU commented on the response to dual diagnosis and complexity of need with regard to the circumstances of this case:

    Dual-diagnosis is a term used to describe co-occurring diagnoses of two or more types of mental illness/es and drug related disorder/s. Dual diagnosis is often associated with poorer treatment outcomes, severe illness and high service use; and it is recognised that people with dual diagnosis may have a higher level of risk for suicide, self-harm, aggression and violence[10].

    Research clearly indicates this cohort is the norm and not the exception, with research suggesting that the prevalence of dual diagnosis ranges from 50 to 70 per cent in mental health settings, and 40 to 80 per cent in alcohol and other drug treatment settings[11]. It is therefore incumbent upon clinicians to respond in an integrated manner and avoid treating one issue in isolation of the other/s.

    A focus on integrated care, from a clinical perspective, recognises not only the individual issues arising from mental illness and drug disorders but seeks to contextualise responses within the broader psychosocial circumstances and needs of the individual; leading to improved clinical outcomes and a reduction in risk of harm (to self or others).

    Mr Bradford was given a provisional diagnosis of possible adjustment disorder and depression six days prior to assaulting Ms Bradford and was referred back to his primary healthcare service for monitoring without the hospital having addressed, or referred Mr Bradford to specialist services who could address, his intervention needs. Given that Mr Bradford was released on day leave to go

[10] Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.
[11] Queensland Health 2003, Strategic plan for people with a dual diagnosis (mental health and alcohol and other drug problems), Queensland Health, Brisbane.

to court, and subsequently never returned as he was detained in custody, no discharge planning ever took place by the hospital on this occasion.

It is also salient to note that research suggests depression is the most common diagnosis in murder-suicides[12], and around three in ten homicide-suicide perpetrators had contact with mental health services prior to the deaths.[13]

While noting that homicide suicides are relatively rare, this research highlights a potential opportunity for intervention. As such efforts to enhance gatekeeper training to include more focus on educating clinicians about the possibility of violence towards others as well as to the self so they can better provide support to their clients, and their families may be of benefit.[14]

Criminal justice system responses

75. Elements of good practice included:

- Whilst the initial investigation was lacking, upon the receipt of an additional statement by Ms Bradford, police acted quickly to pursue criminal charges, tripled the requested conditions on the police application to enhance protection for Ms Bradford and the children, and utilised appropriate referral pathways to link Ms Bradford with specialist support;
- the investigating officer contacted Ms Bradford while she was in attendance at court and coordinated a response to intercept Mr Bradford upon hearing he was no longer in the care of mental health services;
- the officers made an objection to bail outlining Mr Bradford's unreasonable risk of harm to himself and others as a result of his 'fragile mental state' and the likelihood he would commit further offences; and
- flags were placed on Ms Bradford's residence for immediate response if calls for assistance were made and Policelink actively referred Ms Bradford to

[12] Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.
[13] McPhedran, S., Erikkson, L., and Mazerolle, P. (2014) To prevent murder suicide we need to better understand offenders. The Conversation, online at: http://theconversation.com/to-prevent-murder-suicide-we-need-to-better-understand-offenders-31561
[14] The Mental Health Sentinel Events Review made recommendations that support this finding, namely: Recommendation 22 – Implement a three level violence risk assessment framework; Recommendation 46 – Consistent with the recommended phased model of risk assessment and management, all clinicians require training in principles of risk assessment of people with mental illnesses. This knowledge is necessary to complete the risk assessment screening required for all consumers. Senior clinicians require training in risk assessment and management necessary to enable them to undertake the level two risk assessments using and interpreting validated risk assessment measures; Recommendation 47 – Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumer's needs rather than being passively identified in documents; Recommendation 48 – provide training and supervision specific to identification of risk factors of violence to ensure appropriate escalation processes are included where indicated; Recommendation 49 – Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors; and, Recommendation 50 – Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and family/carers allows for open discourse on risk and discovery of important factors to be considered in care planning.

services for financial, accommodation and legal support in response to her disclosures of concern.

76. The DFVDRU identified the following issues with criminal justice system responses:

- A degree of victim shaming when police responded to reports of domestic violence and reportedly told Ms Bradford to take a shower after observing her to be covered in faeces and urine (indicating an evident failure to recognise this as a sign of loss of consciousness during an act of non-lethal strangulation);
- Victim blaming during court proceedings where court remarks by Mr Bradford's legal defence questioned the validity of the victim's account with respect to the nature and seriousness of the offence by suggesting Ms Bradford "embellished" the assault; ultimately discrediting the victim's narrative in favour of the perpetrator and inadvertently sending a message to the perpetrator that his behaviour was condoned or justifiable.
- Insufficient safety planning, including a failure by corrective services staff to inform Ms Bradford, as the victim, of the decision to grant bail to Mr Bradford in relation to violent offences he had committed against her;
- The degree to which Mr Bradford was able to manipulate police perception or may have been engaging in acts of system abuse, for example, in the initial service response to the prior near fatal assault, Mr Bradford was able to 'downplay' the episode of violence to emergency services despite evidence of non-lethal strangulation, reprioritising the focus of services on to himself as the person in distress and needing support.

77. The DFVDRU noted that, following the death of Ms Bradford, the Queensland Parliament passed reforms to the *Bail (Domestic Violence) and Another Act Amendment Bill 2017* in March 2017, including:

- The introduction of a new system to alert a victim of a relevant domestic violence offence when the defendant applies for bail, is released on bail, or receives a variation to a bail condition;
- The introduction of a mandatory reporting provision to the parole system for when a prisoner applies for and receives parole so that a victim of domestic violence can receive information about a prisoner, even if the offence that the prisoner was convicted for is not a domestic violence offence;
- The reversal of the presumption of bail for an alleged offender charged with a relevant domestic violence offence;
- The establishment of a bail condition for a tracking device to be imposed against a person charged with a relevant domestic violence offence; and
- The introduction of a provision to allow for an urgent review of a bail decision in a higher court, where the original bail decision would be stayed for up to three

business days ensuring that the alleged offender would not be released during that period.

Specialist services, and integrated responses

78. The DFVDRU stated:

Integrated service responses to domestic and family violence are increasingly recognised as the most effective response to addressing the complex needs experienced by victims and perpetrators; and have flourished in the past decade throughout Australia and internationally.

A focus on integration is also a core principle across a range of sectors and underpins policy, program and practice approaches in areas such as health and criminal justice. This arises in recognition of the often complex and co-occurring issues experienced by, for example, people living with a mental illness or problematic substance misuse issues and the associated need to comprehensively address a person's needs across a range of domains, (such as housing, employment, child safety or education).

As such, there has long been an onus across sectors to embed integrated practices and pathways to reduce a siloed approach to service delivery and improve a client's outcomes, however implementation continues to be an issue at an operational level.

The Gold Coast has had an integrated service response operating for a long period of time. The Gold Coast Domestic Violence Integrated Response is a community based multi-agency response to domestic violence which was established in 1996 to enhance responses following high rates of violence, and domestic homicides within this region.

Under this response model, agencies are meant to work together to provide co-ordinated appropriate and consistent responses to women and their children affected by domestic and family violence, and men who perpetrate violence. It operates within a justice reform model, which has drawn on international expertise in its development; and continues to evolve over time.

Ms Bradford was supported by the Domestic Violence Prevention Centre (DVPC) (Gold Coast) who provided case management via risk assessment, safety planning, court support, and counselling services.

79. The DFVDRU identified the following elements of good practice in terms of specialist service system responses:

- Collaborative development of safety planning for Ms Bradford who was well supported by DVPC, in particular, in terms of developing safety plans and the provision of other supports, including assisting Ms Bradford to navigate the court process.
- Implementation of safety planning where there was an identified escalation of risk, which occurred when DVPC workers implemented an immediate action plan to ensure the relocation of Ms Bradford's children when it became apparent that Mr Bradford's whereabouts was unknown. Pathways to information sharing through the Gold Coast Domestic Violence Taskforce were employed by DVPC to confirm Mr Bradford's apprehension and Ms Bradford was informed accordingly.
- Liaison between relevant agencies to support the delivery of services for Ms Bradford;
- Recognition of the urgent need for medical intervention and appropriate referral following acts of non-lethal strangulation where DV Connect urged Ms Bradford to seek medical treatment after she reported experiencing blackouts and dizziness in the hours after the assault.

80. The DFVDRU identified the following issues:

- There were issues in the integrated response, with services continuing to work in siloes to some extent. There were up to six services engaging with Ms Bradford at any given time and, yet, Ms Bradford disclosed feeling 'in the dark', unsafe and frustrated with the system due to the lack of communication and help. Notably the integrated service response has been longstanding within the Gold Coast region, and it is not clear why this response does not appear to have been operating for Ms Bradford. Some of this may have been because some agencies were working with her in relation to the presenting episode of domestic violence, while others she was in contact with as Mr Bradford's carer which highlights the importance of ensuring services are cognisant of a victim or perpetrator's broader support needs. Conversely, Mr Bradford was linked into the GCIC[15] which is an integrated service response for people with complex health care needs, and it appears that there was limited consideration given to the impact of his behaviours on the familial network as part of this response.

[15] The Gold Coast Integrated Care program is a program led by general practitioners and health specialists in the Gold Coast region, supported by the Gold Coast Hospital and Health Service, aimed at ensuring patients and practitioners work in partnership to create the best possible outcomes for patient care. The program aims to reduce unplanned hospitalisations by sharing knowledge and linking services for people with chronic and complex health issues. A single shared care health plan for each identified patient is developed and monitored by the patient's treating GP with the support of the local health system (including input from specialists, allied health providers and community health services). The patient consents to, and actively participates in, the development of the healthcare plan. Refer to link: http://gcintegratedcare.com.au/

- Opportunities for perpetrator engagement and intervention were not intensively nurtured by service providers as preventative strategies to increase safety and improve accountability. Although he was only released two and a half weeks prior to the homicide, this is particularly apparent when considering the evident need for additional support, and the lack thereof provided to Mr Bradford, during and after his remand in custody to address the increased risk and vulnerabilities associated with his physical and cognitive impairments. An effective integrated service response aims to reduce the chances of these types of service issues occurring through ensuring services are working together collaboratively, with the intention of building on each agencies collective efforts to improve victim safety and perpetrator accountability.

81. The DFVDRU commented:

Service integration is promoted as an overarching mechanism for providing cohesive and comprehensive responses to victims, and their children, of domestic and family violence. There are identified benefits to clients and service providers to utilising integrated service response models.

To be effective however, integrated responses to domestic and family violence need to involve both crisis and long-term counselling / support, safety planning, health and mental health services, criminal justice services, and where applicable other relevant agencies such as housing and employment services. As such, service integration is promoted as an overarching mechanism for providing cohesive and comprehensive responses to victims, and their children, of domestic and family violence. There are identified benefits to clients[16] and service providers[17] to utilising integrated service response models.[18]

The Special Taskforce on Domestic and Family Violence Final Report made several recommendations with respect to the development and implementation of integrated service response trials informed by Coroner Hutton's inquest findings into the death of Noelene Beutel.[19] Trial sites were originally implemented in Logan/Beenleigh, Mount Isa, and Cherbourg, with additional sites[20] commencing in 2017-18.

[16] For example, simplified coordinated response to multiple client needs particularly when they are one-stop shops; multiple entry points for intervention; and, minimisation of secondary victimisation

[17] For example, cost effectiveness achieved through minimising duplication of services; formalised information sharing between services; potential up-skilling of workers across different issues; and, enhanced transparency and accountability between services and workers.

[18] Breckenridge, J., Rees, S., Valentine, K., & Murray, S. (2015). *Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence Against Women: State of knowledge paper*. Sydney: Australian National Research Organisation for Women's Safety.

[19] Recommendations 9, 74, 75, 76, 77, 78, 79, 80, 82 and 83 of the Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Author.

[20] Brisbane, Ipswich and Cairns

As part of the implementation of these reforms, ANROWS was commissioned to develop a suite of tools to support the integrated service response, including a common risk assessment framework, supporting documentation and information sharing guidelines which are currently being trialled, but are not publically available.

The Queensland Centre for Domestic and Family Violence Research were commissioned to evaluate the trial sites. In July 2016, an 18 month evaluation of the three trial sites commenced.

Prior to the completion of the evaluation the trial sites were expanded to include eight total locations that all use the Common Risk and Safety Framework. Those locations were:

- *Cairns*
- *Cherbourg (initial trial site)*
- *Ipswich*
- *Logan/Beenleigh (initial trial site)*
- *Mackay*
- *Moreton Bay (Brisbane)*
- *Moreton Bay (Caboolture)*
- *Mount Isa/Gulf (initial trial site)*

The evaluation was completed in 2019, though only a summary of the evaluation has been released to date. While Central Queensland University's Centre for Domestic and Family Violence Research was originally contracted to do this work, the final evaluation was completed by Griffith University. Somewhat confusingly, the integrated service response is often interchangeably referred to as 'High Risk Teams' in this document though in reality the high risk teams are only one component of the integrated service response.

The summary document states that numerous benefits were identified by the evaluation including strengthening a focus on victims of domestic and family violence, increased awareness of DFV among government agencies, and some increased focus on perpetrators. The following 'challenges' were also identified:

- *the common approach to assessing risk has developed differently than was intended, meaning that participating agencies are assessing risk differently — this has broadened the scope of work for high risk teams*
- *confusion about the separation of roles and responsibilities of the high risk teams and the broader integrated service system response*
- *confusion around information sharing outside of the role/functions of high risk teams, and a perception among many stakeholders that the high risk team was the only mechanism for information sharing*
- *the need for more culturally appropriate processes and services for Aboriginal and Torres Strait Islander participants and those from culturally and linguistically diverse backgrounds*
- *while there is a significant focus on improving victim safety, this could be strengthened by more focus on perpetrators and holding them to account.*

The evaluation summary identifies 'key suggestions for further strengthening the model' and these include:

1. *Clarifying the different purposes and roles of the integrated service response and the high risk teams.*
2. *Clarifying the different purposes of assessing risk at different points in the service delivery response.*
3. *Supporting an increased focus on perpetrators within the integrated service response model.*
4. *Clarifying and unifying approaches to information sharing between agencies.*
5. *In the context of other key suggestions for strengthening the model, continuing to support sustainable models and processes.*
6. *Embedding a culture of continuous improvement and best practice in integrated responses to domestic and family violence.*

The summary reflects that the high risk team model is in a state of 'emerging practice' and that more needs to be done to 'consolidate and embed these reforms'.

Accessing crisis or alternative accommodation

82. The DFVDRU identified issues with Ms Bradford's ability to obtain safe, secure and affordable accommodation. Ms Bradford was killed in her home. She had been forced to continue to reside with Mr Bradford post-separation due to financial restrictions and a lack of alternative arrangements. This continued up until the previous near fatal assault in November 2016. This gave Mr Bradford access to Ms Bradford during a period of heightened safety risk as well as causing further trauma to her and her children.

83. The DFVDRU commented:

The combined efforts of service providers to assist Ms Bradford with accommodation support following the episode of violence in November 2016 was commendable and represents an example of good practice risk management to address the needs of the victim. DV Connect provided intermittent support to Ms Bradford around safety planning and emergency relocation with the provision that this accommodation would be suitable for Ms Bradford and her four children. A two bedroom unit was confirmed to be available within the week and, in the meantime, DV Connect discussed safe accommodation options, including motel accommodation, which Ms Bradford was initially agreeable to. Pets in Crisis support was also offered to Ms Bradford to accommodate her cats. The matter was closed to DV Connect when Ms Bradford declined assistance as she felt supported to remain at a friend's house, wanted to source her own affordable accommodation and did not want to go into a refuge.

She subsequently returned to her home at some stage during the period where Mr Bradford was remanded in custody, and it is unclear why this occurred, although, this may be because she felt safe to do so while Mr Bradford was no longer living in the community.

Ms Bradford disclosed prior to her death that she felt unsafe at the family home upon Mr Bradford's return to the community, and was intending to move to a new rental and relocate her children to an alternate school in the coming weeks (although, she was struggling to find affordable accommodation at the time). During this period she was support by the DVPC who submitted a high risk referral to Rent Connect for immediate accommodation relocation assistance and was re-referred by police to DV Connect, as well as Victims Assist and Legal Aid, for accommodation, financial and legal support.

Ms Bradford ultimately did not take up support options with respect to refuge accommodation as she advised she was focused on her future plans which involved moving into a place of her own, and did not wish to go ahead with refuge assistance from DV Connect. In this respect her desire for stable accommodation over time was a priority for her, particularly as she had four children and provided the option of a two bedroom unit; which while providing her with immediate safety, was unlikely to be practical for a large family.

These cases illustrate the practical and financial barriers many women who escape violent relationships face in obtaining safe and sustainable accommodation for them and their children. Although support is often more intensive and accessible in the immediate period after a victim flees a violent relationship, it may take many years of sustained support for victims to fully recover. For Ms Bradford, it is clear she was trying to obtain an education so that she could support a career in nursing, after many years of supporting Mr Bradford to run the family business; which was a source of frustration for Mr Bradford as he criticised her new found independence.

In a recent perpetrator suicide case that went to coronial inquest,[21] the aggrieved partner in the case confirmed that she and the respondent (deceased) had remained living together despite the no contact conditions of the protection order, as they both had 'nowhere else to go.' This theme has also been seen in a number of domestic and family violence related deaths reviewed by the Domestic and Family Violence Death Review Unit in recent years.

The Australian Government has invested funds into the 'Keeping Women Safe in their Home' project, to improve frontline support and services, leverage innovative

[21] Inquest into the death of Robert Turpin: http://www.courts.qld.gov.au/__data/assets/pdf_file/0007/519298/cif-turpin-rn-20170504.pdf

technologies to keep women safe and provide education resources to help change community attitudes.

The Australian National Research Organisation for Women's Safety (ANROWS) also recently undertook a national mapping and meta-evaluation project outlining key features of effective 'safe at home' programs that enhance safety and prevent homelessness for women and their children who have experienced domestic and family violence.

This research identified that 'safe at home' strategies are not intended to supplant refuges of specialist homelessness services, but to complement these, and to provide a safe option for women who refuse to uproot their lives by fleeing the family home. The four pillars of effective safe at home responses identified were:

- *maximising women's safety – using a combination of criminal justice responses including proactive policing, safety alarms, home security upgrades, and legal provisions to keep the perpetrator from the home;*
- *preventing homelessness – includes ensuring women are informed about their housing options before crisis, and providing support for women to maintain their housing afterwards;*
- *an integrated response involving partnerships between local services; and*
- *enhancing women's economic security.*

Specialist services should ensure they follow these principles when developing safety plans for victims who remain within a shared residence, or where the perpetrators knows they are residing. There is no evidence of any safety upgrades being undertaken by specialist services as part of their planning processes in any of the cases or reviewed by the DFVDRU to date.

The Queensland Government has also enacted a range of reforms following the Special Taskforce on Domestic and Family Violence to improve housing outcomes for victims of domestic and family violence. This reform, led by the Department of Housing and Public Works (DHPW) and Department of Communities, Child Safety and Disability Services (DCCSDS), aims to improve accessibility and affordability of housing for female victims and their children who experience domestic and family violence in recognition that this is a key contributor to homelessness.

Common Risk and Safety Framework

84. The Common Risk and Safety Framework was released in 2020. It was accompanied by an announcement that *'a revision of the Framework is currently underway, in response to an independent evaluation completed in 2019 which made recommendations for further strengthening the Framework.*

Validation of the Framework is expected to occur as part of this revision. Agencies and services should take this into consideration when deciding how they use Version 1 of the Framework to support their responses to DFV'.

85. The framework consists of three tiers of risk assessment:

    Level 1: Routine asking about domestic and family violence
    Level 2: Risk assessment and referral to a high risk team
    Level 3: Multiagency risk assessment and safety plan completed by a high risk team

86. While acknowledging the framework is being revised, the DFVDRU identified some general preliminary concerns with the document:

    - *proposed tools lack scientific rigour to be able to predict future episodes of violence or homicide. While most of the risk factors listed in the risk assessment tool are evidence-based and have been shown to be associated with future harm and lethality, the interconnectedness between factors has not been considered.*
    - *The level 2 risk assessment tool is long and lacks usability for generalist and specialist support workers. The tool consists of some 51-items, plus open-ended questions about the victim's perception and professional judgement. Given that this tool is intended to be utilised in frontline situations (for example with emergency department social workers or police), when staff are responding to crises, the ability to complete the assessment in a timely and robust manner is compromised, and likely unrealistic in certain settings. A Victorian review of their equivalent framework identified that the length of the assessment was a limitation to the usability of the tool. The Queensland tool is twice as long as the Victorian tool (51 questions vs. 26 questions).*
    - *The level 2 tool is titled 'domestic violence risk assessment and safety planning'; yet protective factors are absent within this tool. This information would be particularly important with respect to safety planning for a victim, to ascertain what strengths and supports they have available to them to help mitigate future risk of harm (i.e. social supports, access to finances).*
    - *While recognising the presence of vulnerable populations, the tools have not been developed to consider the risks and needs of priority populations, which by definition, have greater vulnerability to domestic violence (including lethal acts of violence). Of particular concern is the lack of consideration of the factors which are prevalent for Aboriginal and Torres Strait Islander women who are victims of violence. There is no consideration of how Aboriginal and Torres Strait Islander women use violence to a greater extent than non-Indigenous women as a means to protect themselves, and what the implication may be for their presentation at services. The presence of these factors has the potential to impact on the ability of services to adequately assess for risk and provide a culturally appropriate response for Aboriginal and Torres Strait Islander victims, and perpetrators, of family violence.*

- *Furthermore, the tools do not consider family violence, perpetuating the misconception that intimate partner violence is the prevailing form of violence in domestic settings. There is a view that the service system struggles to address needs of victims, or perpetrators, of family violence. The Common Risk and Safety Framework and Integrated Service Response as designed does nothing to explicitly address this.*

87. Other relevant actions undertaken to alleviate housing stress and homelessness for women and their children escaping violence identified by the DFVDRU include:

- *Automated bond loan approvals for clients experiencing domestic and family violence who have verified their circumstances.*
- *Improvements to the Housing Needs Assessment tool to help the government more easily identify women and children affected by domestic and family violence.*
- *Clarification with Domestic and Family Violence Specialist Homelessness Services that clients experiencing domestic and family violence can expect to receive a range of support from Housing Service Centres in relation to bond loans and rental grants; Rent Connect services; social housing assistance; and, tenants and management of social housing tenancies.*
- *Development and distribution of information to Housing Service Centre staff that details and clarifies housing assistance available for clients impacted by domestic and family violence.*
- *Engaging with Housing Service Centre staff to strengthen knowledge and understanding of the assistance and available support services to ensure that appropriate and timely referrals can be made when needed.*

Bystander interventions

88. A positive element of this case was the action taken by staff from the children's school who actively intervened and referred Ms Bradford to a specialist domestic violence service when it became apparent that she was experiencing domestic violence on observation of her injuries following the assault.

Conclusions

89. I find that Ms Bradford died from head injuries inflicted on her by Mr Bradford with an axe in the context of intimate partner domestic abuse.

90. I find that Mr Bradford died from self-inflicted neck wounds. His death was due to suicide.

91. I agree with the conclusions of the DFVDRU. Overall, there were numerous

examples where support services, health systems and the Queensland Police Service provided a high level of assistance and support to Ms Bradford. Unfortunately, there were also examples of poor responses to Ms Bradford when she sought assistance. The support provided by services was insufficient to protect her from Mr Bradford as was the Domestic Violence Protection Order which was in force. A more integrated approach may have made a difference to the tragic outcome, however, it is unlikely to have done so. Reforms to domestic abuse support services and laws continue to be identified and implemented and, in Queensland, are currently the subject of a taskforce chaired by The Honourable Margaret McMurdo AC.

Findings required by s.45

Identity of the deceased –	Teresa Bradford and David Bradford
How they died –	Ms Bradford died from head injuries inflicted on her by Mr Bradford with an axe in the context of intimate partner domestic abuse. Mr Bradford died from self-inflicted neck wounds. His death was due to suicide.
Place of death –	45 Matas Drive PIMPAMA QLD 4209 AUSTRALIA
Date of death –	31/01/2017
Cause of death –	Teresa Bradford - Head injuries David Bradford - Incised neck injury

I close the investigations.

Jane Bentley
Deputy State Coroner
CORONERS COURT OF QUEENSLAND – SOUTHERN REGION

15 June 2021