QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND
FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr M**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
DATE:	26 May 2020
FILE NO(s):	2015/1301
FINDINGS OF:	Don MacKenzie, Brisbane Coroner
CATCHWORDS:	CORONERS: Domestic Violence, intimate partner, new partner, response by Queensland Police Service to violence, recommendations, 'Not Now, Not Ever'.

Contents

Executive Summary

1. Mr M ("the deceased") aged 50 died on 6 April 2015 as a result of stab wounds inflicted by Mr F, the former partner of Mr M's new partner Ms C.

2. The deceased had only been in an intimate partner relationship with Ms C for approximately three months. Mr F was convicted of the offence of Murder and is currently serving a sentence of life imprisonment and will be eligible for release on 5 April 2035, after serving 20 years in jail.

3. These findings will concentrate on what went wrong and what has been done to minimise the potential of a recurrence of this dreadful crime and shortcomings in protecting the deceased.

History of domestic and family violence: Mr F and Ms C

4. Prior to the commencement of her relationship with the deceased, Ms C was previously in an intimate partner relationship with Mr F for approximately 17 years. It was characterised by periods of separation and subsequent reconciliation. Ms C had an infant child, Child 1, from a previous relationship (17 years old). Their union produced a child, Child 2, (14 years old) and Child 3, (9 years old). Ms C reported that Mr F perpetrated domestic and family violence against her from the outset of their union. She was told by police in Brisbane that Mr F had been the subject of similar complaints from an earlier relationship.

5. On 30 May, 2001, police were called to attend their home when Mr F had consumed a six pack of beer, threatened to "bash [Ms C's] head in", pushed her against a wall, and smashed a telephone so that she could not call police. Ms C was able to flee with one of the children (Child 1). However, when she saw Mr F holding the four-month old Child 2 over a veranda railing, she returned to the house. In attempting to flee again, Mr F pushed her to the floor and threw beer bottles at her. Ultimately, she fled out the back door and over the fence with the children and sought the assistance of a neighbour, who called the police.

6. A police application for a temporary Domestic and Family Violence protection order was made the following day and permanently ordered on 5 July 2001. It was not contested. The order required Mr F to be of good behaviour and not perpetrate domestic and family violence against Ms C; not to have possession of a weapon; and not to reside with, nor contact, nor approach Ms C, her children and her mother. There were exceptions for contact with the children. In her affidavit supporting this application, Ms C deposed to several previous instances of violence said to have been perpetrated by Mr F on Christmas Eve of 1999 (head butting) and on at least five other previous occasions (choking). This Domestic and Family Violence protection order was in place until 4 July 2003.
7. On 11 May 2002 Mr F was convicted of contravening this protection order in a Magistrates Court. A monetary penalty was imposed. Ms C had informed Mr F

that she wanted to end the relationship, and in response, Mr F broke into Ms C's home and assaulted her with violence.

8. At some stage, the family resumed cohabitation and then in late 2005 moved to a suburb north of Brisbane. On 18 December 2005, Mr F threatened to drown Ms C in the family pool and demanded that she leave with the children. At this time Ms C was seven months pregnant with their second child, Child 3. The following morning, Ms C stated that she was intending to leave. Mr F then yelled that she was not leaving, kicked her, and grabbed her by the throat and restricted her breathing, an apparent act of non-lethal strangulation. Ms C left with the assistance of neighbours and Mr F returned to the house and hid her car keys. When police attended, Mr F was aggressive towards police and refused to provide them with Ms C's car keys. He was arrested and remanded in custody temporarily, and a Magistrates Court granted a second protection order for two years duration to 21 December 2007. However, only the usual mandatory conditions, that Mr F be of good behaviour and commit no further domestic violence, were sought, and granted.

9. On 7 July 2006, during the currency of this protection order, there was an ugly incident where Mr F effectively committed a "home invasion" type offence upon friends of Ms C's, who were protecting her from his violence. Police were called. On agreement that the family friends would not pursue the "home invasion' offences, Mr F pleaded guilty to committing public nuisance and obstruct police charges. He was ordered to perform community service.

10. On 14 March 2007 Mr F was convicted of breaching the December 2005, Domestic and Family Violence protection order. He had verbally abused Ms C in February 2007, when drunk and then kicked her and pushed her into a fence. He was placed on probation for 12 months and was required to attend a program for perpetrators of domestic and family violence. Interestingly, he described the program as "a waste of time" to his probation officer.

11. On 20 March 2008, Ms C made a private application for a Domestic and Family Violence protection order. In her application, Ms C cited a number of incidents: verbal abuse, an argument about mowing the lawn resulting in Mr F throwing her to the ground, hitting and kicking her, throwing "stubbies" at her. Mr F had apparently also threatened to kill her in the presence of their son, Child 3 (aged 2) telling him: *"This is how you treat women and dogs".* The following extract from her complaint as the aggrieved, unfortunately reflects the terrifying ordeal of many victims of domestic and family violence:

> '*I have left [Mr F] before, but the violence and threats continued, with him breaking into my house etc… I have tried continuously over the years to rectify the domestic violence situation in my house, but to no [avail]. [Mr F] drinks alcohol daily and has lost perspective over his behaviour. No matter how I behave, or what I do; violence whether*

physical or verbal is inevitable in the near future. I am living in constant fear of violent outbreak in my life.'

12. A permanent Domestic and Family Violence protection order was granted on 10 April 2008, Mr F breached the order again by contacting Ms C. Mr F was convicted of this offence and a monetary penalty was imposed on 4 July 2008. Ms C and Mr F did not live together again but remained in contact for Mr F's child visitations.

13. On 4 January 2011, Ms C approached the courts for protection and applied for a private Domestic and Family Violence protection order against Mr F for the fourth time. Ms C was living with the children and Mr F was residing at another residence, while the house they owned was being rented. Ms C made the application after Mr F made threats to kill her and the dogs and horses, arson, throwing a bicycle at Ms C, choking, and striking to the head. Again, some of Ms C's own words reflect the heightened state of fear she was living with at the time:

> "The *violence always escalates at Christmas time. I want to sell the house that we both own and am buying a place of my own. This is making him angry he feels that I don't deserve anything and would rather burn the house down and neither of us get any money. I have known Mr F for 12 years, he has been violent for at least 10 of these."*

14. On 10 February 2011, an order was granted including extensive non-contact provisions only until 9 February 2012. Mr F's non-compliance with this order was not formally sanctioned as there were no further prosecutions of Mr F for breaches of such orders. However, Ms C later indicated to police that after the expiry of this order, there were continued "violent episodes and threats". Nevertheless, no Domestic and Family Violence orders were sought until 24 February 2015.

Immediate background and Circumstances of the Death

15. Ms C commenced a relationship with the deceased, Mr M, in early February 2015. Mr M had a son, (Mr M's son), a student who was aged 17 living with him at the home he owned at a suburb north of Brisbane. Mr M was 173 cm tall and weighed 67 kilograms. Ms C lived at another address with her daughter Child 2 (14 years old) and her son Child 3 (9 years old). Mr F is the natural father of both Child 2 and Child 3. Ms C informed Mr F of the new relationship in an effort to control the manner in which Mr F learned of it. She quite correctly anticipated that he would be angry, as he had never really considered their relationship to have ended despite her making it clear that it had.

16. Unfortunately, issues regarding their children necessitated regular contact. Most communication surrounded Child 3's visits to Mr F who also lived locally. On 17

January 2015, Ms C contacted police following an argument with Mr F, primarily expressing her concern for her children, who were currently in his care. No application to court was made by, or on behalf of, Ms C. However, on 23 February 2015, Ms C received a telephone call from Mr F who was angry about her new relationship. He threatened to kill Mr M's son and "stab everyone else" if she pursued the relationship. He added that he 'didn't care if he went to jail". On 26 February 2015, a temporary protection order based on the above allegations, was issued in relation to Mr F and Ms C. The Temporary Protection Order (TPO) was made by a Magistrate on 26 February 2015 and that order named Ms C as the aggrieved and Child 1, Child 2, Child 3, Mr M and Mr M's son as persons in need of protection. The order prohibited Mr F from having contact with Ms C aside from as required in relation to their son Child 3. It was served on Mr F, and hence, in force, from 27 February 2015. It was adjourned for hearing on 24 March 2015.

17. On 27 February 2015, Mr F sent at text message to Ms C stating: *"I know you are sick of hearing from me but I can't stop trying!! Please don't be with another man please Ms C! I could NEVER be with another woman. I love you too much!!"*

18. Approximately three weeks prior to the offences, Mr F asked Child 3 who was in his care on an agreed parental visit, to direct him to the deceased's house at a suburb north of Brisbane. Mr F rode his motorbike in the company of Child 3 to the deceased's house and asked Child 3 '*is that where he lives?'.*

19. On 14 March 2015 Mr F approached Ms C and the deceased at local showgrounds during Mr F's son's football match. Mr F called Ms C a "*tacky bitch"* and stated the *"whole town was talking about her".* He shouted that the deceased was a *"paedophile"* and that he had a criminal record.

20. At 15:18 hours on 23 March 2015, Mr F sent at text message to Ms C asking her to amend the conditions sought to just the mandatory "be of good behaviour and not commit domestic violence "conditions. It was stated that "*he just wanted to be able to have contact with the kids".* The following day at about the same time, Mr F sent a text message: "*… I went to see the police and they don't have the paperwork … can see Child 3 this weekend."* Ms C immediately replied: "*the order is still the same …Child 3 can stay at your place this weekend."* In a later text at 18:03 hours, Mr F asked: "… *Is Child 3 able to come over the Easter long weekend?"* to which Ms C replied: "*Yes."*

21. There were a number of conversations with police officers by Ms C and the deceased between 17 January 2015 and 6 April 2015. Ms C has complained to various agencies including this Court that no appropriate action was taken by the Queensland Police Service. These issues are dealt with below.

The Event of 6 April 2015

22. The 6 April 2015 was Easter Monday. Child 3 was visiting with his father, Mr F. That afternoon, Ms C sent a text message to Mr F asking where she could meet him to pick up her son. Mr F asked Ms C to come to his house. Ms C insisted Mr F meet him outside the local Police station. She was scared. Mr F was angry about meeting at the police station but ultimately agreed.

23. At approximately 5:30 pm, Ms C, in the company of the deceased Mr M, drove to the street in front of the police station, met Mr F and collected her son. As Ms C got back in the car, Mr F grabbed the passenger door, leaned into the car and an argument commenced with the deceased. The deceased started the car and drove away. Mr F, when interviewed by the police after the death, stated that he was angry that the handover was done using Mr M's car. He felt that he did not get to say goodbye properly to Child 3. He felt upset and humiliated and felt that both Mr M and Ms C had been smirking at him as though he was an "insignificant joke".

24. At 6:45pm on 6 April 2015, Constable C from the police station, attended Mr F's house and served him with the Domestic Violence Protection Order issued by the local Magistrates Court on 24 March 2015. This order was identical to the temporary protection order taken out on 26 February 2015 and served the next day. He also advised Mr F that the police wished to speak to him regarding the alleged breaches of the temporary protection order issued on 26 February 2015. These breaches related to Mr F text messaging Ms C without authority and approaching Ms C on 14 March 2015 at the football match. Mr F told police he was annoyed about the way the handover of his son had gone that afternoon. Mr F believed that Ms C and the deceased had not shown him any "dignity" during the handover. Upon being served with the Order Mr F said to police: *"Mate I'm just going to end up going to prison over this. This is going to end badly.*

25. On the evening of 6 April 2015,[1] the deceased and Ms C were at the deceased's home at a suburb north of Brisbane. Also, at the house were Child 3, Mr M's son and also present was an elderly tenant, Ms D.

26. At approximately 7:20pm, Mr F, at his home, changed clothes into his motorcycle jacket and work boots, grabbed a knife from his kitchen, got into his 4WD Utility then drove to the deceased's house. The distance from Mr F's house to the deceased's house is 8.5 km or an approximate 9-minute drive.

27. At 7:30pm the deceased, Ms C, Ms D, Mr M's son, and Child 3 were sitting at the dining table after dinner. Ms C heard a car outside, and the deceased got up from the table and yelled, "It's Mr F, he's heading straight towards the house!"

[1] These factual findings follow the agreed schedule of facts tendered at sentence hearing of Mr F in the Supreme Court at Brisbane.

The deceased locked the front sliding door and began moving to lock the other doors at which time Mr F drove his Ford F250 utility through the front door of the house into the living room (Dangerous Operation of a Motor Vehicle).

28. The crash caused a wall to fall on the dining table where Ms C was sitting which caused cuts to her legs. Mr F got out of the driver's seat holding a knife. The blade was 13 cm long and 2 cm wide at the base with a black plastic handle. Mr F was yelling about police going to his house earlier that day. Mr F then ran towards the deceased, pushing him backwards onto the couch and stabbed him approximately 2 times, once to the upper left chest area/shoulder area and once to the upper left arm. The deceased yelled out, *"Why are you stabbing me!"* Ms C began screaming out for help and yelled at Child 3 and Mr M's son to get out of the house.

29. Ms D grabbed Mr F from behind while he was still on top of the deceased. She grabbed his right hand, which was holding the knife, and pulled him off the couch onto the ground, wrapping her legs around him to restrain him. Ms C grabbed the blade of the knife and informed Mr F that he was hurting her. Mr F *"stopped for a bit"* and Ms C ended up with the knife. The deceased, who was covered in blood, managed to get off the lounge and walk towards the bathroom. Ms C yelled to Mr M's son to call the police and ambulance and get a towel and to try to take the deceased outside. Ms C stood holding the knife and said to Mr F *"stop or I'll stab you".*

30. While Mr M's son was walking out the back door of the house with Child 3, he found the deceased sitting on the ground with his back against the toilet door. He had a stab wound to his left upper chest and left upper arm. Mr M's son got a towel to bind his father's wounds. Ms D held Mr F on the ground for ten minutes. While on the ground Mr F continued to rant and behave aggressively. Mr F repeatedly yelled at Ms D to let him go and attempted to break her grip. Ms C was standing at Mr F's feet holding the knife. Mr F repeatedly kicked out with his legs, trying to get free. Ms C threw the knife into the hallway to get it away from Mr F. Mr M's son picked it up and held on to it.

31. Ms D yelled to Ms C, *"Get out",* as she was losing her grip on Mr F. Mr F broke free of Ms D's grip. Ms C jumped out of the window to get away from Mr F and broke her foot as a result of the fall. Mr F jumped over the kitchen bench and picked up a different knife from the floor of the kitchen. The knife was a large kitchen knife with a blade approximately 15 cm long with a black handle. He followed a trail of blood from the bathroom door. The deceased managed to get into the bathroom and lock the door.

32. Mr M's son ran out of the back door and stood ten metres from the back door of the house near the bathroom. Mr F yelled, *"Where's Child 3"* (Mr F's 9-year-old son to Ms C) to which Mr M's son replied, *"He's safe".* Mr F stood in the back doorway and yelled, *"Where is he! Take me to him! Show me where he is!"* Mr

F noticed the light in the bathroom was on and said, *"Is he in there? Who's in there?"*

33. Mr F grabbed a gas bottle from the laundry. He turned the gas on and used his lighter to light the gas and burn the bathroom door to attempt to get into the bathroom. The fire caused extensive damage to the bathroom door. Mr F then moved out the back door towards Mr M's son, yelling at him while holding the knife. While Mr F's back was to the house, the deceased removed the fly screen on the bathroom window and got outside and ran into the garden at the front of the property. Mr F noticed that the deceased had left through the bathroom window and followed the deceased into the garden. Mr M's son turned the gas bottle off and yelled to Mr F, *"The police are coming, they're on their way!"* Mr F said, *"Yeah that's what I'm still here for mate."*

34. Mr F started moving back towards Mr M's son and the deceased yelled out to Mr F: *"No!"* Mr F then approached the deceased in the front yard. He grabbed the deceased and stabbed him. The deceased yelled out and they both fell to the ground. Mr F stabbed the deceased in the right side of his chest when he was on the ground. The deceased yelled out, *"You've killed me!"* Mr M's son screamed, *"Leave him alone, you're going to kill him!"* Mr F replied, *"I hope so mate".* Mr F got up and kicked the deceased several times on the side of his torso.

35. Ms C ran to a neighbour's house with Child 3 and told her to call the police as Mr F was trying to kill the deceased. She then ran back to the house. As Ms C approached the house, she could still hear the deceased yelling in pain. As she got closer to the house, she saw Mr F in the front yard waving his hands above his head while standing over the deceased. The deceased was lying motionless on the grass.

36. Police and Ambulance Officers arrived approximately 30 seconds later. Mr F surrendered himself to police and was arrested. While being restrained on the ground, Mr F yelled out, *"Suck em in big Mr M!"* While being placed into the police car, Mr F told police he deliberately changed into his motorcycle jacket for body armour and had put on his work boots so he could *"Kick the shit out of him (*the deceased)."

37. Ambulance Officers attempted to resuscitate the deceased at the scene but were unsuccessful. He was pronounced dead at the scene.

38. Ms C was transported to the local hospital for treatment for her injuries. She sustained fractures to the bone immediately behind her big toe (requiring a cast), a 7cm cut to the back-right calf, which was closed with stitches, a 2mm puncture wound to the left calf and other cuts and bruising. The physical injuries suffered by the others were not serious but psychologically all have been severely affected.

39. Mr F participated in a record of interview with police at the scene at 8:53pm. He participated in a further recorded interview with police at the station later that night at 11:47pm. He made full admissions to the offences. He stated his anger had been building for some time about the way the deceased and Ms C were *"rubbing their relationship in his face'* and not giving him any "*dignity"*. He stated that after police attended his house on the afternoon and served him with the Domestic Violence Order, he *"snapped".* He got changed into his Motorcycle jacket and heavy work boots, grabbed a knife from his kitchen and drive to the deceased's house with the intention of killing him. He stated that he *"just lost the plot"* and *"had just had enough*". He felt upset and humiliated. He stated that whenever he had interactions with the deceased and Ms C, he had been *"left like feeling a dirty piece of shit at the end of it. Where they can see that I 'm upset and they laugh, they have a bit of a chuckle".* He stated he went to the house to stab the deceased as he felt he had stolen his family from him.

40. Mr F stated he drove through the front of the house so the deceased would not have a chance to reach a phone before carrying out the homicide. Mr F admitted to searching for the deceased outside and stabbing him multiple times.

Autopsy

41. External and full internal examinations were ordered and performed on 8 April 2015 by forensic pathologist, Dr Beng Ong. CT scans, toxicology testing, and examination of the knife recovered by police at the crime scene were performed. Critically, Dr Ong noted three stab wounds to the front of the chest and a single stab wound to the back. There were also three stab wounds to the upper left arm and a number of less serious incised wounds to the hands, torso, and head of the deceased's body. No natural disease that might have caused death was found.

42. Of the three stab wounds to the chest, an incision to the right front chest was the deepest. The length of the stab wound was approximately 10cm from the skin surface. The right lung had been cut and had partially collapsed. There were two track wounds within this wound indicating that the knife was partially withdrawn before being thrust inward again. The first stab track almost completely incised the right main pulmonary artery and completely incised the right main bronchus (airway into lung). It had cut vital structures, caused profuse haemorrhaging and air to enter the lung cavities. This wound was consistent with several thrusts by the knife supplied by police. The second stab track entered through the same wound on the lung before exiting the rear of the right lung and causing an incision on the prevertebral fascia (muscle near vertebra). Then length of the stab wound was approximately 13 cm from the skin surface.

43. It was neither possible to determine the temporal order of the infliction of these wounds nor establish which primary wound caused death. All were inflicted with

severe force and delivered with sufficient force to incise bone tissue in the opinion of Dr Ong. All, in contribution, caused such a massive blood loss that death was inevitable. Toxicology testing detected small constituent of cannabis. No alcohol or other drugs were detected in the deceased's body. The formal cause of death was determined to be as a result of the 1(a) stab wounds to the chest and upper arm.

The Prosecution of Mr F for Murder

44. Mr F was charged with murder on 7 April 2015. He was committed for trial to the Supreme Court of Queensland on that charge but eventually entered a plea of guilty to murder, dangerous operation of a motor vehicle, two breaches of a domestic violence order and disqualified driving. On 23 May 2017 he was sentenced to life imprisonment with 778 days of pre-sentence custody declared as imprisonment already served. He will be eligible for release on 5 April 2035 after serving 20 years imprisonment.

45. Justice Douglas described this crime as "horrific". He noted that Mr F engaged in a premeditated, persistent, and protracted attack, overcoming those who tried to assist the deceased. He further observed "… *and acting in breach of the Court orders. It seems that, historically, you have had a real problem with violence and with the abuse of alcohol… Your behaviour as is completely unsurprising, has very seriously affected those people who were present at the scene, including Mr M's son, father, daughter, Ms C of course, and Ms D. The trail of destruction you have caused will continue to have very serious consequences for them and, I suspect, for your own children, probably for the rest of their lives. And that is something you will have to live with."*

Shortcomings of the Queensland Police Service response prior to the murder

46. Unsurprisingly, a number of preliminary investigations, audits and reports have been undertaken over the last five years by the Queensland Police Service and the Domestic and Family Violence Death Review Unit (DFVDRU) (attached to the Coroners Court of Queensland), especially since the criminal proceedings were completed in 2017. Of particular concern to Ms C was the police inaction to her complaints that she and her new partner (the deceased) were not given the priority they deserved.

47. On 17 January 2015, within ten days of commencing her relationship with the deceased, Ms C attended the local police station to report that she had had an argument with Mr F and that she was concerned for the safety of her children, who were currently in his care. Constable H and Sgt H attended and spoke to Mr F, and sighted the children, who appeared calm and happy. Constable H recorded the incident as '*NO DV*' and stated that Ms C and Mr F had an

argument over Mr F's perception of '*infidelity'* by the aggrieved. Sgt H, who responded to the incident with Constable H, verified the report as '*NO DV'.*

48. On 23 February 2015 at 9:10pm, the deceased called Policelink and spoke with a Client Service Officer (CSO) L to report threats made to his partner, himself, and their families. He indicated at the time that Ms C was corresponding with a domestic violence support line and was too afraid to contact police herself. CSO L instructed the deceased that Ms C would be required to call in order to warrant any police intervention. I cannot see that this instruction is supported by the policies and procedures of police that were in place at the time.

49. Consequently, at 9:48pm, Ms C called Policelink and reported a call she had received from Mr F asking to resume their relationship. Ms C expressed concerns that Mr F had made threats, specifically to kill the deceased and his son, after she advised him of her new relationship with the deceased. Ms C also told the CSO that she did not believe Mr F knew where the deceased lived. The deceased contacted Policelink again at 9:56pm to reiterate his concerns for Ms C and his desire for a police presence. At 10:21pm a supervisor from Policelink contacted Ms C clarifying that the incident was more complex than originally thought. Ms C reportedly told police officers that she felt safe and was happy for them to attend her residence to collect a statement in the morning before she left for work at 7:30am.

50. The following morning (24 February 2015) at 8:21am, Ms C contacted Policelink to ascertain when police would be attending to speak with her. Senior Constable G returned her call and then revised the incident log as a 'Community Assist'. The entry stated Ms C '*only wanted advice on how DV orders work and the processes.* Later that day Ms C attended the local Magistrates Court and applied for an urgent private protection order. The application stated Mr F had threatened to kill the deceased and his son. It stated that Mr F had said that he would find out where the deceased lived and would kill his son first and that he did not care if he went to jail.

51. On 26 February 2015, a temporary protection order was issued by the Magistrates Court imposing no contact conditions restricting Mr F's contact with Ms C, the deceased and the children who resided with them. On 27 February 2015 Mr F was served with a copy of the temporary protection order. Later that day the deceased called Policelink and spoke with CSO H. The deceased reported Mr F's breach of the temporary protection order by sending harassing texts and threatening to harm him. He further stated that he had called the local police station but there was no answer. The deceased articulated his, and Ms C's feelings, of distress, as he reported that they were petrified and felt '*they were being brushed off by the police'.* CSO H asked if he wanted to speak with another police station, to which he declined.

52. On 14 March 2015, the deceased and Ms C were at the local showgrounds watching her son play football. Mr F was also present and began shouting obscenities, calling the deceased a paedophile. These were reported to police as breaches of the protection order and later that day Mr F was charged by Constable C with the breaches. On this occasion Mr F was offered and accepted a SupportLink referral. At 9:58pm the deceased contacted Policelink and stated that he was concerned for the welfare of Ms C's son, who was currently on the phone to Ms C and extremely distressed. The deceased clarified that their trepidation and concern arose as a consequence of Mr F's propensity to be a violent man.

53. At 10:22pm a Sergeant from the Police Communications Centre (PCC) called Ms C to seek further explanation of the circumstances surrounding the concern she held for her son. The Sergeant determined that the information Ms C had relayed to him did not give him cause to have concern for her son's welfare. Subsequently, the deceased spoke with the Sergeant after Ms C became frustrated with the progress of the conversation, whereby he explained there was a protection order in place and Mr F had threatened to kill him and his son.

54. The deceased reported that approximately one-hour prior, Mr F had turned up at his house with Ms C's on the back of a motorbike. He explained that they could hear them talking and heard Mr F say, *'Where is it? Is that where he lives?'.* The Sergeant said he would arrange for police to attend and check on Ms C's son and requested that the deceased and Ms C wait for the police to contact them. At 11:28pm police officers Constable M and Constable H, attended Mr F's premises to check on the welfare of Ms C's son. The police classified the incident on QPRIME as a 'Community Assist'. It does not appear that Constables H or M contacted either the deceased or Ms C to interview them with respect to their complaint or advise them of the action they took on this occasion.

55. On 18 March 2015, the deceased called Policelink questioning the availability of officers at local station, and the deceased was advised the station did not open until 8:30am. The deceased stated that he was upset with the lack of assistance from the local police. The deceased relayed the breaches of the temporary protection order committed by Mr F. He further outlined previous threats and incidents to the CSO, including on 14 March, when he and Ms C attended the local police station and were told by an unidentified officer, they were too busy to respond to their concerns.

56. On 19 March 2015, Ms C and the deceased attended the local police station and reported that between 14 and 19 March 2015, Ms C received a number of text messages from Mr F, breaching the no contact provision of the temporary protection order. The deceased also made a complaint regarding the events on 14 March in which Mr F has reportedly asked his son to show him where the deceased resided. Constable C, who charged Mr F with the breach on 14 March, was tasked with investigating these additional allegations. Police observed Ms

C's phone and confirmed the text messages and a digital recording was taken of her version of events, and Scenes of Crime were requested to photograph these messages.

57. On 6 April 2015 Constable C attended Mr F's premises and served him with a copy of the full protection order. In addition to the standard conditions, the order had seven additional conditions prohibiting Mr F from contacting or approaching Ms C or any other named person in the order. The protection order also included the following named persons: Child 1, Child 2, and Chiild 3 (children of the aggrieved) as well as the deceased's son. Formally, that meant that Mr F could no longer have contact with his son or daughter until 23 March 2017.

58. Whilst serving the order on Mr F, Constable C informed him he was investigating further allegations of breaches of the temporary protection order and asked him whether Mr F would like to attend the police station during the following week to discuss them, as he didn't want him to come up to the station at night. Approximately an hour after being served with the protection order, Mr F went to the deceased's home and (inter alia) stabbed Mr M to death.

Issues for Review

59. The apparent inaction and tardiness in responding to the complaints made about Mr F's conduct, which eventually culminated in Mr M's death and other terrifying events of 6 April 2015 is demonstrated by the following:

    i) Mr F had a thirty year criminal history which included convictions for Assault occasioning bodily harm (3 court appearances), Assault (4 court appearances), Wilful damage (5 court appearances), Dangerous operation of a motor vehicle (1 court appearance), Assault/obstruct police (3 court appearances) and Breaches of Community Service or Probation orders (3 court appearances).

    ii) Mr F had three previous convictions for Breaches of Domestic and Family Violence Act orders involving the deceased's new partner, Ms C.

    iii) Between 17 January 2015 and 6 April 2015 Ms C and the deceased reported that they attended or contacted the Queensland Police Service "two or three times per week with concerns about the behaviour of Mr F, including threats to kill. Section 100 of the *Domestic and Family Violence Protection Act 2012* requires police officers to investigate if there is a reasonable suspicion domestic violence has occurred.

    iv) On 27 February 2015 Mr F had been served with, and was subject henceforth to, a temporary Domestic and Family Violence Protection Order from the Magistrates Court the previous day.

v) On 15 March 2015, Mr F had been served with a Notice to Appear in the Magistrates Court on 14 April 2015 in relation to a Breach of Domestic Violence Order the previous day.

vi) On the night of 14 March 2015, the deceased and Ms C contacted police to report that Mr F had ridden his motorcycle to the deceased's home shown the way by his son Child 3 who had visited that address on several occasions.

vii) On 24 March 2015, the temporary protection order was made permanent but was not served on Mr F by police until 6 April 2015.

viii) On 24 March 2015, Mr F it seems was incorrectly informed by the police that the temporary order allowed continued contact with his son and daughter.[2]

ix) Ms C and the deceased and their families were not informed that the service of that permanent 24 March 2015 order was to take place on 6 April 2015. Within one hour of that service on 6 April 2015, the murder occurred; and

x) According to the police Operational Procedures Manual, police officers should take a respondent into custody if they reasonably suspect that the person has committed domestic violence and they believe there is a danger of personal injury or property damage.

60. In the recordings and written notes of conversations between the deceased and Ms C and various police officers, Ms C, in particular, comes across as a terrified victim of domestic abuse. On other occasions she is alleged by police to be erratic, angry, and demanding. That cannot be a valid criticism as she was the subject of intense ongoing domestic violence. Of course, it is also no excuse for incompetence, maladministration, and bias but it might explain perceptions by both Ms C and police of suspicion and mistrust. In the recordings of conversations between police and Ms C and Mr M, the police are clearly professional.

61. Disappointingly, many of the above issues raised by Ms C were also identified in the report by the Crime and Misconduct Commission (CMC) *Policing Domestic Violence in Queensland: Meeting the challenges (2005).* Whilst recognising the challenges faced by police in responding to domestic and family violence, including the resourcing required to manage these types of offences compared to other areas, the CMC identified significant cultural barriers to the provision of effective support by police.

62. This leads to an important consideration in this investigation. Many of Ms C's allegations against the local police have been contested, explained, and contradicted by police. Coronial investigations are not directed towards

[2] See text message 15:18 hours 23 March 2015, Mr F to Ms C page 9 supra

ascertaining whether or not there is criminal, civil, or disciplinary liability. Error and failure must be regarded as "not abnormal" and attention must concentrate on identifying factors that cause errors or mistakes that create catastrophic effects. The coronial jurisdiction is about the prevention of death not necessarily blame.[3]

63. Accordingly, devolving this investigation into the minutia of a *"he said' no 'she said'"* evidentiary contest about events in 2015 involving police and Ms C and the deceased will hardly assist in diagnosing errors and mistakes. It seems apparent that there are a number of systemic failures by police, prior to the tragic outcome for the deceased and his loved ones. However, the role of Mr F's truly *malam mens rea* cannot be ignored. Moreover, poor police responses to domestic violence related deaths around 2015 have already been the subject of coronial review.[4] The focus of this investigation must be on systemic errors and important reforms that have subsequently been put in place by the Queensland Police Service.

Review by the Coronial Domestic and Family Violence Death Review Unit

64. The Domestic and Family Violence Death Review Unit ("the DFVDRU") was established within the Coroners Court of Queensland in 2011 to provide specialist advice and assistance to Coroners in their investigations into domestic and family violence related deaths. The purpose of the unit is to assist Coroners in understanding the broader context and circumstances of the death, consider any relevant service system contact, and identify whether there were any missed opportunities for intervention or prevention.

65. The DFVDRU identified several issues in the police service response to the domestic and family violence concerns in this case. Importantly, in 2019 the Queensland Police Service provided a detailed update on reforms within the police aimed at addressing many of the systemic failures that were identified in the DFVDRU review.

66. Given the extent of the contact is was not possible to outline each response in specific detail, however a number of recurring issues were identified, Helpfully, I also had access to a preliminary internal audit completed by Sergeant R (2015), a review by the DFVDRU (2016) and other later Queensland Police Service responses. These reviews readily and effectively identified four key failures in the systems and procedures of the police in this matter:

[3] See Section 3 Objectives of this Act Coroners Act (Qld); Freckleton & Ranson Death Investigation and the Coroner's Inquest Oxford University Press Melbourne 2006 724; The Australian Coroners Manual The Federation Press Sydney 2005
[4] Inquest Findings into Death: Death of Nolene Beutel 2011/2288 (Coroner Hutton); Non-Inquest Findings into Death of DM 2011/140 9 February 2016 (Deputy State Coroner Lock); Death of Elsie May Robertson 2013/839 22 October 2015 (State Coroner Ryan); Death of Rinabel Tigalo Blackmore 2015/594 4 April 2019 (Coroner Wilson)

i) Failure to correctly identify, respond and investigate domestic violence incidents;

ii) Failure to accurately assess and triage calls for assistance;

iii) Inadequate resourcing and priority of police responses to domestic and family violence; and

iv) Insufficient understanding and recognition of the dynamics of domestic and family violence by police.

(i) Failure to correctly identify, respond and investigate domestic violence incidents

67. A good example of this concern occurred on 17 January 2015 when Ms C first reported to the police that she was concerned for the safety of her children following an argument with Mr F about Mr F's perception of her "*infidelity".* Constable H recorded the incident as a *'NO DV'.* Both he, Sergeant H (Officer in Charge of the police station) and Sergeant R, the Domestic and Family Violence Coordinator for [redacted] District failed to recognise that an accusation of infidelity by a former partner post-separation was potentially indicative of an underlying pattern of domestic violence.

68. There was no reference to checks on the criminal history or domestic violence history of Mr F. In accordance with s. 100(1) of the *Domestic and Family Violence Protection Act 2012* police must investigate, or cause to be investigated, a report of domestic violence, or a circumstance in which it is reasonably suspected that domestic violence has occurred.

69. The police responses to reported or suspected episodes of domestic and family violence are governed by Chapter 9 of the Queensland Police Service Operational Procedural Manual (OPM) which describes the responsibilities of police officers responding to, and investigating, domestic and family violence. Additionally, it provides guidance to officers to ascertain the level of risk within a relevant relationship and to identify opportunities for intervention and referral. An occurrence can only be recorded as 'No DV' when police attend a location where domestic violence was alleged to have occurred and investigations reveal (inter alia) that no do domestic violence has occurred, or is alleged to have occurred as defined under s. 8 of the *Domestic and Family Violence Protection Act 2012.*

70. Further concern arises from Constable H's assessment of the incident, as expressed in his statement taken after the death that he *'did not have any fears for the safety of the children from the way (Mr F) presented and also the way the kids were smiling and laughing. The way it was attempted to be explained to Police by (Ms C) was extremely erratic and appeared to be overdramatised on this occasion.'* Sergeant's statement refers to having had a conversation with Mr

F, then forming the opinion that this was not an incident that required police action because of his perception that the version provided by Mr F and the actions of the children were inconsistent with how Ms C was '*yelling'* at them at the police station.

71. It appears that both Constable H and Sergeant H may have failed to recognise the genuine fear Ms C had of Mr F, labelling her instead as aggressive and overdramatic, and possibly limiting the credibility they attached to her reported concerns. It seems that this lack of awareness and understanding of behaviour which may constitute domestic and family violence, as well as the associated impact this may have on the victim, has meant that no further action was taken by the responding officers.

(ii) Failure to accurately assess and triage calls for assistance

72. Disappointingly again, this issue was identified in a report by the Crime and Misconduct Commission (CMC) *Policing Domestic Violence in Queensland: Meeting the challenges (2005)* ten years earlier. This report noted that an incident by incident response that does not adequately triage repeat calls for service and means that a response may be deficient in that it does not reflect the actual nature, extend and context of these events.

73. As detailed above, there were a number of occasions in the months leading up to Mr M's death where he and Ms C reported to police incidents involving Mr F that constituted contraventions of a temporary protection order in place at the time. Whilst some of these reports were dealt with appropriately, several were not.

74. For example, the deceased called Policelink on 27 February 2015 regarding Mr F sending texts, threatening him, and asking about the service of the temporary protection order. The deceased stated they were "*petrified*" at being sent threatening texts by the respondent. He stated that he felt they were being brushed off by the police. This is particularly salient as this harassment occurred shortly after Mr F had been served with the temporary protection order, and in part because he had just been served with the order. It is indicative of retaliatory action taken against the couple in response to the order.

75. On this occasion the deceased spoke with CSO H. Policelink is intended only for non-urgent matters or general inquiries. Calls for service requiring a policing response are meant to be transferred to the Police Communications Centre (PCC). In this instance CSO H should have referred the deceased's concerns for police response (via PCC) or provided him with alternative options to obtain a police response, particularly with consideration that the deceased said to the CSO that they were petrified of Mr F.

76. When members of the public contact police seeking a response to an alleged offence, the priority of that response is to be assessed based on the information

provided. The Queensland Police Service Operational Procedure Manual at 14.24 Priority Policing Process policy stated at the time:

> *"Tasking officers receiving calls for policing services are to:*
>
> *i) Determine whether the call **relates to a threat to personal safety** or property;*
>
> *ii) In the case of **threats to personal safety** or property security, establish whether the call **indicates a known threat, a potential threat or a perceived threat;***
>
> *iii) Direct officers to attend the call for service or initiate an alternative expectation strategy based on the application of the priority policing process; and*
>
> *iv) **Ensure that the organisational boundaries do not impede an appropriate and timely response to calls for service.** Where no officers are available within a tasking officer's area of responsibility and an immediate response is required, the tasking officer should request a tasking officer in a neighbouring area, in accordance with the relevant regional arrangements, to direct officers from that area to attend the call for service. Tasking officers receiving requests for assistance from tasking officers in other areas are to ensure that officers are directed to attend the call for service in accordance with the priority policing process and regional arrangements."*

77. It is apparent that this protocol was not followed.

(iii) Resourcing and priority of police to domestic and family violence

78. Between 17 March 2015 and 19 March 2015, Ms C received a series of text messages from Mr F in breach of the temporary protection order dated 26 February 2015 and served upon him the next day. There is no evidence of any substantial investigation into these breaches being made by the police between 19 March 2015 and the deceased's murder on 6 April 2015 (11 days later). There is no sensible explanation as to why the breaches had not been actioned in that time. Indeed, the full protection order was granted in the interim on 25 March 2015 but was not served on Mr F until 6 April 2015, some 13 days later.

79. Ms C complains that when Constable C served the final order on Mr F, he effectively warned him that Ms C and the deceased had made further allegations of breaches but did not take action to hold Mr F to account for his ongoing abuse of the couple. At the time, Mr F said to Constable C, *"Mate I 'm just going to end up in prison over this. This is going to end very badly!'*

80. Constable C had only recently, on 14 March 2015, issued a Notice to Appear upon Mr F for contravention the temporary protection order by verbally abusing Ms C at their son' football match. Further, Constable C documented on QPRIME on this occasion that there were previous breaches and although they were *'minor'* the frequency of them was *'increasing'.* Police responses to reported or suspected breaches of domestic violence orders is documented under s.9.6.6 of the OPM's (Contravention of domestic violence order, release conditions or police prosecution notice). It states that to ensure domestic violence strategies are effective, respondents should be held accountable for an action in contravention of:

    i) a domestic violence order;

    ii) a temporary protection order;

    iii) release conditions;

    iv) a police protection notice; or

    v) any other order made under the *Domestic and Family Violence Protection Act 2012.*

81. The OPM outlines that a respondent who contravenes a condition of a domestic violence order other than failing to appear before a court commits a criminal offence. It further states that '*officers should approach a contravention of a domestic violence order in the same manner as investigating any other criminal offence'.* Constable C could have reasonably charged Mr F with the fresh alleged breaches of the temporary protection order when he served him with the final domestic violence order on 6 April 2015. There is a possibility officers could have detained him, removing the imminent danger to Ms C and the deceased. This s particularly salient as Mr F had clearly stated to Constable C that things were going to go badly, there had been multiple and escalating breaches, there was a prior history of domestic and family violence between the couple and Mr F had previously retaliated when served with the temporary protection order.

82. There is a further inference to be drawn from the evidence. It is clear that Mr F was allowed to continue contact visits with his son on advice from the police and the acquiescence of Ms C. It is also clear that the temporary order and the permanent order did not allow Mr F such contact: "8*. The respondent is prohibited from following or remaining or approaching to within 50 metres of the named person (viz CHILD OF THE AGGRIEVED: Child 3 and CHILD OF THE AGGRIEVED: Child 2) when the named person is at any place'.* Mr F was contemptuous of the protection regime provided for by the *Domestic and Family Violence Protection Act 2012* by not ever attending court and regularly not complying with any such court orders.

(iv) The need for greater understanding and recognition of the dynamics of domestic and family violence by police

83. Whilst physically separating and leaving a relationship characterised by domestic violence may seem the obvious solution to prevent further abuse, in many cases the risk of being hurt or killed is greatly increased when women or men make a decision to leave or commence a new relationship.[5] [6] When perpetrators sense they may be losing control over their partner, for example by entering into a new relationship, an escalation in abuse may occur in an attempt to regain or maintain this control, or to punish their partner for leaving. [7] Post separation violence tends to be more serious, more obsessive, more likely to involve stalking, and most importantly, more likely to lead to a homicide than violence which occurs within an intact relationship.[8]

84. The recognition of multiple risk factors within a relationship allows for a comprehensive assessment of risk, safety planning and, potentially the prevention of future deaths related to domestic and family violence can assist services to identify and quantify the level of risk or danger; allocate resources; and assist victims to understand that they may be at a high risk of violence against them. In respect of the death of Mr M, all the following lethality risk factors can be identified:

    a. History of violence outside the family by perpetrator.
    b. History of domestic violence (current partner);
    c. History of domestic violence (previous partners);
    d. Prior threats to kill victim;
    e. Prior attempts to isolate the victim;
    f. Prior destruction or deprivation of victim's property;
    g. Choked /strangled victim in the past;
    h. Victim and perpetrator living in common-law; and
    i. Actual or pending separation (or new partner).

85. All of these Protective Assessment Factors (PAF) were known to responding officers at the time that multiple episodes of domestic violence were reported to them. They were readily accessible through police PRIME reports and would have informed the officer's response to the multiple reported concerns by the deceased and Ms C. Indeed, there was direct evidence of:

    1. previous history of domestic and family violence;
    2. respondent in non-compliant with a protection order (failure to comply with authority;

---

[5] Hotton, T. (2001). Spousal Violence after Marital Separation. *Canadian Centre for Justice Statistics. 21(7)*. Cat. No.85-2002.
[6] Anderson, D.K. & Saunders, D.G. (2003). Leaving an Abusive Partner: an empirical review of predators, the process of leaving and psychological well-being. *Trauma, Violence and Abuse 4(2), 163-191.*
[7] Fleury, R.E., Sullivan, C.M. & Bybee, D.J. (2000). When Ending the Relationship does not End the Violence: Women's Experiences of Violence by Former Partners. *Violence against Women, 12, 1363-83.*
[8] Mr Fransisson, H. & Hotton, T. (2003). Losing Control: Homicide Risk in Estranged and Intact Intimate Relationships. *Homicide Studies, 7, 58-84.*

3. actual or pending relationship separation;
4. prior threats to kill;
5. prior strangulation;
6. prior attempts to isolate the victim;
7. child custody and access disputes;
8. prior attempts to isolate the victim;
9. prior threats against the victim's pets;
10. prior assault while pregnant;
11. a new partner in the victim's life;
12. sexual jealousy;
13. the victim is fearful of the perpetrator;
14. the perpetrator threatened harm to the children; and
15. there was a noted escalation of violent threats.

86. Whilst Constable C did complete a Protective Assessment on 14 and 19 March with respect to the reported breaches of the protection order, the score of medium should have been high with consideration of the death threats and constant harassment. The relevant factors present in this case at any time these occurrences were reported to the police included:

> *Category 1 Factors:* increased frequency of DV incidents, previous incidents of DV/contraventions, separation, a significant change in circumstances, past strangulation, threats to kill either the aggrieved or family members.
>
> *Category 2 Factors:* respondent history of violence, ongoing conflict, controlling behaviour, stalking, violent threats and threats of animal cruelty.
>
> *Fear Level:* very fearful (aggrieved appears very fearful of domestic violence occurring in the future).

87. Some criticism of this categorisation can be legitimately made. For example, jealousy or sexual possessiveness are currently not included in risk factors on the PAF, which means there is no prompt for responding officers to consider the significance of allegations of infidelity. Sexual jealousy or obsessive possessiveness is a factor that has been consistently linked to domestic homicides internationally.[9] If officers had an awareness of the presence and significance of all of these indicators at the time of responding to the reported incidents, it is likely that officers would have been able to assess the level of risk as 'high' which recommends a proactive police response.

88. However, since Mr M's death new protocols for such assessments are now in place and an extensive review of the Protective Assessment tools has been undertaken. Further, such a risk assessment is limited by the accuracy and

[9] Websdale, N (2000) Lethality Assessment Tools: A Critical Analysis. National Online Resource Centre on Violence Against Women

reliability of the data that is assessed. It seems apparent that Constable C did not have all of the data available to him at the time the assessment was made.

Legislative and Organisational Changes since the Death of Mr M (6 April 2015)

89. Since April 2016 there has been an increased recognition of the devastating impact of domestic and family violence on individuals, families and communities in Queensland and dynamic reforms in a number of government agencies.

90. Most notably, the Special Taskforce on Domestic and Family Violence, chaired by Dame Quentin Bryce, identified issues with health, justice, and other service responses to victims of domestic and family violence. In their report, *'Not now, Not ever*: *Putting an End to Domestic and Family Violence in Queensland'* (2015)', the taskforce made recommendations to:

    a. Improve training and practice;
    b. Improve cross-agency information sharing, collaboration and integration; and
    c. Strengthen legislative provisions such as the introduction of a stand-alone offence for non-lethal strangulation.

91. Of particular relevance to the issues identified above the DFVDRU, the Taskforce report included recommendations to the Queensland Police Service that are intended to:

    a. Improve the criminal investigation and prosecution of perpetrators of domestic and family violence;
    b. Achieve a more pro-active investigation and protection policy;
    c. Ensure that arrest is prioritised where a risk assessment indicates the action is appropriate; and
    d. Improve governance, supervision, and training of police officers in relation to domestic and family violence.

92. The recommendations aimed at enhancing interagency responses more broadly, has resulted in the establishment of 'high risk teams' in trial sites across the state that include police as core members. Further, dedicated Domestic Violence Review teams operate in each police region to coordinate reviews and audits and responses to investigations such as this. The appointment and training of Domestic and Family Violence Co-ordinators ("DFVC") to each police district were fundamental to this escalation in awareness of domestic violence. These Coordinators complement the existing DFVC network by providing additional state-wide support to frontline officers on legislation, policy and practice; providing appropriate police response to non-lethal strangulation reports; and identification of appropriate support and referral pathways for victims and offenders.

93. In late 2015 a Deputy Commissioner of Police was appointed to oversee their Domestic and Family Violence Cultural Change Program. The role of the State Domestic and Family Violence Coordinator role was also reinstated, although it was not clear when that role had been removed. Also, a specific Domestic, Family Violence and Vulnerable Persons Unit (DFVVP Unit) was established whose primary function is to deliver reforms related to vulnerable persons, particularly those affected by domestic and family violence and impaired mental capacity. In 2016 two other units were amalgamated with the DFVVP Unit such that it now has responsibility for other pertinent social issues such as elder abuse, disability and suicide prevention.

94. Significantly, there have been a raft of legislative changes since 2015 to domestic violence laws. Amendments to the *Domestic and Family Violence Protection Act 2012* in 2015 onwards provided a platform for the Queensland Police Service to shape the future directions of the service in the way it approaches, investigates and resolves Domestic and Family Violence matters. These amendments enabled police to issue a Police Protection Notice (PPN) to provide immediate protection for victims and named persons until such time as the court could determine the necessity for a Domestic Violence Court Order; and share relevant information across prescribed government and non-government entities for the purpose of ensuring victim safety and perpetrator accountability. Amendments to the *Criminal Code 1899* with the introduction of s.315A Strangulation, Choking, Suffocation in a Domestic Setting has also enhanced the ability of police and the justice system to hold perpetrators accountable. Amendments were also made to s. 16 of the *Bail Act 1980* in 2017 widening the circumstances in which a police officer authorised to grant bail shall refuse bail, to include where an offender has been charged with a relevant domestic violence offence. Further provisions were also created (19CA and 19D (2)) to provide a defendant, complainant, prosecutor or person appearing on behalf of the Crown to apply to the 'reviewing court' for a review of a decision about the release of a defendant.

Queensland Police Service Responses to Coroners Directives

95. In August, last year, the Queensland Police Service were directed to comment on any changes and improvements (by way of policies, procedures, standards and training) implemented and relevant to front line attendances at, and management of, incidents of domestic violence since the death of Mr M. A comprehensive and considered response was received from the Queensland Police Service on 1 November 2019 under the hand of Steve Gollschewski APM, Deputy Commissioner, Strategy, Policy and Performance. There were some further materials delivered on 13 November 2019. This material is too voluminous to form part of these findings. A summary is as follows.

96. As stated earlier, the [redacted] District Domestic and Family Violence Coordinator, [redacted] Patrol Group, Sergeant R conducted a homicide audit and made

a number of recommendations which were progressed to me. The Queensland Police Service response under the hand of Steve Gollschewski APM, Deputy Commissioner adopted Sergeant R observations that the primary concern was the lack of dedicated domestic violence training in the service. At paragraph 36 of his report, Sergeant R articulated [10]:

> *36. It would be my recommendation that a state-wide training to all relevant Staff especially at the academies would progress improvement in a number of*
> *areas;*
>
> *a) Investigation of domestic violence incidents.*
> *b) Create awareness for all police of high-risk markers associated with domestic violence and domestic violence related homicides.*
> *c) Provide an instrument that standardises the protection of aggrieved through an interagency case management approach to domestic violence for example PRADO.*
> *d) Establish a standard base line of knowledge regarding domestic violence*
> *methodologies and policies, throughout the QPS and other stakeholders.*
> *e) Improve responses to domestic violence incidents particularly in the management of recidivist behaviour.*
> *f) Incorporate established practices from other agencies who have used risk*
> *assessment instruments for several years both within the police service and in other government and non-government agencies.*
> *g) Assist in identifying recidivist offenders, their modus operandi and record*
> *them appropriately on QPS data bases such as QPRIME.*
> *h) Specialised domestic violence training for civilian Client Service staff, especially Policelink staff. They are the first point of contact for a large percent of aggrieved attending Police stations. Further training in domestic*
> *violence can only have a positive effect on the way persons, especially aggrieved are dealt with at a Police station and it is a way of making sure they receive the correct advice and support. Which has not happened at times in the past, this causes further upset and stress to the aggrieved parties. This can have a detrimental effect on the attitude of the aggrieved parties wishing to report domestic violence to QPS.*
> *i) Engage a dedicated station DFVC for [redacted] rural stations, who would be the first contact for all domestic violence related matters in the rural areas of the district.*

[10] Sgt R, 2015, Audit of Domestic Violence Related Homicide Aggrieved: Mr M, Reported 21 May 2015.

97. These recommendations were referred to the Domestic and Family Violence and Vulnerable Person Unit, Community Contact Command who responded to me in a strategic context providing information relevant to training programs, case management, integrated service support and policy to address Domestic and Family Violence. Eight of the recommendations (a-h) have been responded to by the Domestic and Family Violence and Vulnerable Persons Unit. Recommendation (i) above was specifically referred to in the [redacted] District Queensland Police Service District Command for a response.

98. Based on the 140 recommendations from the *"Not Now, Not Ever: Putting an End to Domestic Violence in Queensland Report"* the Queensland Police Service engaged the Queensland Centre for Domestic and Family Violence (QCDFVR) Central Queensland University to conduct an audit and review of domestic violence training. Their final report *"An Evidence-based review of Queensland Police Service's DFV training"* was delivered in 2017. Primarily, its recommendations were:

    1. development of a state-wide DFV education and training framework recognising foundational, promotional and ongoing professional development needs of all Queensland Police Service employees;

    2. annual DFV refresher training, continual educational opportunities for the DFVC network and development of an evaluation strategy to enable ongoing review of programs;

    3. review of delivery models and methods of current training programs to ensure they can achieve optimum learning outcomes; and

    4. address identified training gaps through inclusion of specific communication and interpersonal skills, cultural awareness and understanding of the complexities of domestic violence within specified communities, enhanced understanding of the role and benefits of police referrals.

99. In 2017, the Queensland Police Service Domestic, Family Violence and Vulnerable Persons (DFV&VP) Unit developed a Vulnerable Persons Training Package in response to recommendations made in the *Queensland Police Service Violent Confrontations Review* (Queensland Police Service , 2014), the "*Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland"* report (2015) and Central Queensland University's **"***An Evidence based review of Queensland Police Service's DFV training".* This comprehensive training package, delivered to all police officers up to the rank of Inspector and selected non-sworn employees, was delivered in two parts consisting of: an online learning product providing officers with the knowledge needed to ensure the Service is complaint with legislative and associated police and procedural requirements; and face-to-face workshops.

100. In response to other recommendations made in the *"Not Now, Not Ever: Putting an End to Domestic Violence in Queensland Report"*[11], the DFVVP Unit developed a specialist course modelled on the South Australia Police training package. This five-day, face-to-face course was first piloted in February 2019. A second course was held in July 2019 with a third course in October 2019. The course is designed for specialists working in the area of Domestic and Family Violence such as: Domestic Violence Liaison Officers, Police Prosecutors, Detectives, Child Protection Investigation Unit members, Intelligence Officers and domestic violence High Risk Teams (HRT). The training specifically covered the following areas in line with the recommendations made by Sergeant R, namely to create awareness of Domestic and Family Violence including homicides and risk markers such as the significance of separation, new relationships, domestic violence homicide prevention, victim support and police referrals and the importance of investigation and prosecution of Domestic and Family Violence incidents. Since 2015, the Queensland Police Service has hosted annual workshops for its specialists including the DFVC network, Mental Health Intervention Coordinators, HRT members and Police Referrals Coordinators.

101. In 2016, *Queensland Police Service recruit training was identified as a critical early awareness program.* Enhancements made to the recruit training program included: additional training on communication; the nature and dynamics of DFV; internal culture and attitudes; referral and integration services; cultural awareness and sensitivity to diversity; legislation and policy provisions; strangulation prevention and delivery mode. Enhancements were also made to the first-year constable program in relation to communication, strangulation and legislative provisions. Training was also modified to include face to face training for some components. Further, to raise the profile of DFVCs to the 'practitioner level', the Queensland Police Service now offers access to professional development opportunities, such as the Queensland University of Technology (QUT) Graduate Certificate in Domestic and Family Violence. Between 2016 and 2017 six DFVCs completed this course. In 2018 the DFV&VP Unit funded five DFVCs to undertake post graduate studies in DFV. In 2019, a further four have been funded and are currently undertaking this study. This training was specifically designed to cover the recommendations made by Sergeant R.

102. Enhanced information sharing was a second concern to Sergeant R and the *"Not Now, Not Ever: Putting an End to Domestic Violence in Queensland Report".* To support the High-Risk Teams, the Department of Child Safety, Youth and Women developed an ICT platform to enable the timely sharing of relevant information related to high risk domestic violence. Specific guidelines were established in 2017 outlining the information sharing provisions and the responsibility of government and non-government agencies in supporting a multi-agency response to DFV.[12] In addition to these guidelines, the *Domestic and Family*

[11] 134,135,136 and 138
[12]These guidelines are publicly available on the Department of Child Safety, Youth and Women website https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/our progress/strengthening-justice-system-responses/domestic -family-violence-information-sharing-guidelines

Violence Protection Act 2012 was amended to include Part 5A Information Sharing provisions to enable the timely sharing of relevant information across agencies.

103. In response to recommendations 10 and 11 of the Domestic and Family Violence Death Review and Advisory Board Annual Report 2016/2017 (Domestic and Family Violence Death Review and Advisory Board, 2017) and Recommendations 135, 136 and 137 of the of the "*Not Now, Not Ever: Putting an End to Domestic Violence in Queensland Report"* (2015), the DFV&VP Unit commenced a trial to embed two DFVCs in the central Police Communications Centre (PCC). The trial commenced in September 2018 for an initial six-month period, however due to its success, the trial was been extended to October 2019. The DFV&VP Unit is preparing a submission for the Service's Demand and Resource Committee to seek approval to establish the permanency of the DFVC-PCC project. It seems to have been a success.

104. As of 23 May 2019, the DFVC-PCC had provided advice in relation to 848 domestic violence calls for service. Frontline officers were not the only area to utilise the service with requests for advice received from communications centre staff, officers in charge of stations, supervisors and District Duty Officers, Child Protection and Investigation Unit officers, Tactical Crime Squad and Criminal Investigations Branch. In addition, when calls for service are referred to HRT clients, the DFVC-PCC notified the relevant HRT to ensure safety management strategies could be addressed.

105. The Queensland Police Service Domestic Violence – Protective Assessment Framework (DV-PAF) was developed in 2013. It was based on an Ontario Domestic Violence Death Review Committee's lethality risk assessment coding system from 2003 to 2012 data. Its potential shortcomings have discussed earlier. [13] However, the key ingredient to a risk assessment system is the available data. In 2017, the DFV&VP Unit contacted Professor Mark Kebbell, and expert in the field of risk assessment and investigative psychology to re-evaluate the DV-PAF and determine whether it was still fit for purpose and how it could be better integrated into information sharing systems. Preliminary results suggested the DV-PAF, whilst understood by frontline officers assessing risk, would benefit from a mixed framework incorporating static, dynamic risk factors on and professional judgement. This review is ongoing but there have been upgrades and training improvements.

106. Further, the DFV&VP Unit is progressing the potential development of the DV-PAF/ODARA tool. A state-wide review has been conducted of finalised domestic violence matters in QPRIME, the Queensland Police Service primary crime information module. In 2017, Policelink implemented changes to require an

[13] These guidelines are publicly available on the Department of Child Safety, Youth and Women websitehttps://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/our progress/strengthening-justice-system-responses/domestic -family-violence-information-sharing-guidelines

Officer in Charge to approve status definitions and implemented changes to require an Officer in Charge to approve finalisation of specific offences/occurrences to ensure consistency, accuracy and legitimacy of records. Crime managers within each district conduct regular reviews of all crime (including domestic violence related) reported on QPRIME and are responsible for assigning appropriate investigative tasking to officers in relation to these occurrences. District DFVCs or relevant officers now conduct audits on Domestic Violence Occurrences in Queensland. Where necessary or as issues are identified, DFVCs will task the investigating officer to follow up with specific actions. DFVCs and Domestic Violence Liaison Officers will report on identified exceptions and compliance issued to the Officers in Charge of Divisions within their District for further action as required. This QPRIME upgrade will significantly improve and expand the immediate availability of data to police investigating domestic and family violence matters through DV-PAF/ODARA tool. The Sergeant R Audit recommended at (i) that a dedicated station-level Domestic and Family Violence Co-ordinator ("DDFVC") be appointed across the operational districts in the [redacted] Queensland Police Service District.

107. DDFVC positions co-ordinate and monitor policing responses to domestic violence within the district in accordance with Queensland Police Service strategic directions, policy, legislation and procedures. These positions have responsibilities for providing direction, guidance and advice to police. They build relationships with the community, government and non-government agencies and develop networks and preventative strategies for dealing with domestic violence. DDFVCs assist with District Education and Training to educate policing of domestic violence. Additionally, DDFVCs participate in multi-disciplinary teams managing domestic violence issues in the District.

108. DDFVC positions are currently are currently mandated for police districts throughout Queensland but not at station level[14]. The [redacted] District has two permanent Sergeant DDFVCs, one for [redacted] Patrol Group ([redacted] and [redacted] Police Divisions) and one for [redacted] Patrol Group ([redacted], [redacted], [redacted], [redacted] and [redacted] Police Divisions). Clarification was sought from Sergeant R as to the expectations of this recommendation. He said that the intention was not to create additional DDFVC positions, but to ensure the rural divisions were supported by a position focused on domestic and family violence, support and involved persons in their divisions.

109. Queensland Police Service policy prescribes that the 'Officer in Charge' of a station is, by virtue of their position, the domestic and family violence liaison officer for their station'[15]. The Officer in Charge (OIC) may delegate the responsibility of domestic and family violence liaison to another officer within the station (a Station Domestic and Family Violence Liaison officer (DVLO).

[14] Queensland Police Service, 2019, Operational Procedures Manual, section 9.15.3. *https://Queensland Police Servicenet.qldpol/spp/occ/cd/opi/Documents/Service%20Manuals/OPM%20Current.pdf*
[15] Queensland Police Service, 2019, Operational Procedures Manual, section 9.15.3.

However, the officer in charge remains responsible for the performance and supervision of the officer and should allow adequate time and resources for the performance of these duties[16]. Divisions within [redacted] Police District have appointed Station DVLOs to assist the OIC with domestic and family violence responsibilities. The Police Division has appointed a dedicated DVLO.

110. Further, specific initiatives and reforms have taken place in the [redacted] police district since April 2015:

- There was a review of the [redacted] area Policelink interaction and capability to refer potential complaints to referral services to seek assistance directly without further arrangements with police where required.

- The staff at the police station now have QLites which are iPhone or iPad which speedily integrate searches, relevantly here, under categories such as "Domestic Violence Index". This enables immediate review of the court history, bail status, complaint history and police interest in persons and events to be better informed in decision making when considering issues such as bail.

- These devices also enable members to offer referrals while at the premises which increases the possibility of complainants and respondents accepting such referrals.

- Queensland Police Service Officers-in-Charge, Supervisors and Staff are now required to audit all actions (including "attendance at" and 'no person's home") undertaken in relation to the investigation of Domestic Violence within the Police Occurrence Enquiry Log are entered. This clearly demonstrates what actions police have taken in each circumstance to outline the '*investigation'* which has been conducted in these matters.

- [redacted] District has initiated an on-call Senior Sergeant to provide advice and approval for various conditions within the Domestic Violence Legislation. And

- [redacted] District now has a Domestic Family Violence High Risk Team (HRT). This is a collaboration of several Government Department who review and deliberate on High Risk DV occurrences and provide specific case management solutions to these vulnerable persons and matters.

111. Had any of these additional initiatives been operating in the weeks before, and on 6 April 2015 the tragic events on that day may not have occurred.

[16] Queensland Police Service, 2019, Operational Procedures Manual, section 9.15.3.

Conclusion and Findings

112. Ms C suffered many years of domestic violence at the hand of her former partner, Mr F. Numerous Domestic and Family Violence protection orders were issued in the courts over a seventeen-year period. Police were involved in some but not all of the incidents. Mr M came into Ms C's life only weeks before his death as her new partner. During those weeks, Mr F through jealousy and a fear of loss of control of Ms C harassed them both in what were clearly acts of domestic violence.

113. Is difficult to perceive a more egregious or horrific domestic violence matter. There had been numerous domestic violence interactions with police and the courts in relation to abuse from Mr F over that three-month period. This murder represents a tragic failure of a court-based scheme designed to protect victims of domestic violence from harm. More than anything, it highlights the paramount need, particularly by police, to understand that the *Domestic and Family Violence Protection Act 2012 (Qld)* creates a regime designed to protect.

114. In retrospect, the response of the Queensland Police Service was inadequate. Had one dedicated police authority had all of the information and resources to expose the danger that Mr F posed; proper steps may have been taken to mitigate the risk of such a tragedy occurring. That being the case Mr F is ultimately responsible for his actions on 6 April 2015.

115. Since the murder of Mr M on 6 April 2015, the Queensland Police Service had undertaken a considerable review, investigation and changes which instil some confidence that lessons have been learned from this tragedy. The last of this material arrived in early December 2019, creating a significant effluxion of time. Bearing that in mind, there is no public interest in conducting an Inquest where few, if any, factual disputes arise and any recommendations that could be made, have already been by and large implemented.

116. Moreover, the 140 recommendations of the final report of the Special Taskforce on Domestic and Family Violence in Queensland, *"Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland (2015)",* have been adopted by the Queensland Government. Queensland Police Service implemented the policing response to domestic and family violence. Dedicated Domestic and Family Violence Co-ordinators, amendments to the Operations Manual, specific Domestic and Family Violence training packages for all Queensland Police Service officers, improved case management and integrated information sharing within the police service and other government agencies, more elaborate risk assessment criteria and quality assurance have otherwise changed the landscape of investigations and responses to domestic and family violence over the last five years.

117. Coronial investigations are not directed towards whether there is criminal, civil or disciplinary liability and are primarily about the prevention of death rather than blame. To that end, reform surrounding domestic and family violence is a prevalent issue of high importance.

118. In deciding whether to hold an inquest into Mr M's death, I have considered all of the considerable bodies of evidence gathered for this investigation. In particular, the extensive and responsible reforms undertaken by the Queensland Police Service generally and the [redacted] Police District specifically. They clearly demonstrate a changing police infrastructure, culture and prioritisation of domestic violence concerns. Indeed, a number of recent coronial investigations have confirmed these police reforms.[17]

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

Condolences

120. I offer my sincerest condolences to Mr M's son and wider family and Ms C and her wider family and thank them for providing their consideration to these non-inquest findings.

Acknowledgements

121. I acknowledge the considered and comprehensive response provide to me by the Queensland Police Service. The Service is committed to finding new and better ways to deal with domestic violence.

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

Identity of the deceased - Mr M

How he died - Mr M (aged 50) died at his home at a suburb north of Brisbane, on 6 April 2015 as a result of stab wounds inflicted by Mr F, the former partner of Mr M's new partner Ms C.

[17] Refer to the death of DM 2011/2140, 9 February 2016 (Deputy State Coroner Lock); *Death of Elsie May Robertson* 2013/839, 22 October 2015 (State Coroner Ryan); and *Death of Rinabel Tigalo Blackmore 2015/59,* 4 April 2019 (Coroner Wilson)

Date of death -	6 April 2015
Place of death -	Deceased's residence
Cause of death -	1(a) Stab wound to chest and upper left limb

122. I close the investigation.

Donald MacKenzie

Brisbane Coroner

26 May 2020