QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Elsie May Robertson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
FILE NO(s):	2013/839
DELIVERED ON:	23 October 2015
DELIVERED AT:	Cairns
HEARING DATE(s):	15 September 2015; 21-22 October 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: inquest, violent death, domestic violence, Policelink call, police response.

REPRESENTATION:

Counsel Assisting:	Miss E. Cooper
Queensland Police Service:	Mr C. Capper (Public Safety Business Agency)
Ms Robertson's family:	Mr S. Burgess (Aboriginal & Torres Strait Islander Legal Service) (ATSILS)
Constable Orr and Senior Constable Batticciotto:	Mr T. Schmidt
Mr Grannigan:	Mr P. Richardson (Richardson and Associates)

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Introduction

1. Elsie Robertson was a 39 year old woman of Aboriginal descent who was found deceased at a residence in Cairns on 6 March 2013. She was found by police at about 10:20pm in one of the bedrooms of the residence, naked and face down on a mattress on the floor.

2. Ms Robertson's partner, James Grannigan, had been alone with her in the room before police arrived and for most of the afternoon. Earlier that day, she and Mr Grannigan were heard by other occupants of the house to be arguing in the bedroom. They had also consumed alcohol and cannabis. The other occupants of the house were Anne Conway (Ms Robertson's aunt) and Ms Conway's partner, Alan Donovan.

3. It appears that the sounds of fighting had stopped at about 8:00pm, and the police were called shortly after 9:00pm, after Ms Conway became worried when Ms Robertson did not respond to her expressions of concern about her welfare.

4. When Constables Jason Orr and Celeste Batticciotto attended at the residence at about 10:20pm, Ms Robertson's body showed signs of trauma. There was dried blood on her face and on the bedding. Extensive efforts at resuscitation were attempted, but were not successful.

5. The death was subsequently investigated by police from the Ethical Standards Command as a death in the course of, or as a result of, police operations. This investigation was conducted by Inspector Christopher Hobbs, who concluded that there was an unreasonable delay between the time of the first call to Policelink by Ms Conway (9:04pm) to when police actually attended at the residence (10:20pm). The officers involved in the initial response have been disciplined. I thank Inspector Hobbs for his comprehensive report.

6. Mr Grannigan was charged with Ms Robertson's murder, and the matter proceeded through committal and was listed for trial. On the morning of the trial, the Crown accepted Mr Grannigan's offer to plead to manslaughter. The factual basis of the plea was a not matter of contention at the sentence proceedings. The ultimate Crown submission was that Ms Robertson died from blunt force trauma, the nature of which could not be determined.

7. On 8 October 2014, Mr Grannigan was sentenced by Justice Henry in the Supreme Court at Cairns to eight years imprisonment. He is currently in custody at the Lotus Glen Correctional Centre. In his sentencing remarks, Justice Henry said:

> "*As to what happened, you advance through your counsel no discrete account of your own, nor is it suggested that you gave any account to anyone, other than having told those in the aftermath, the police and/or ambulance who*

attended, a comment to the effect, "She was drunk and fell down." It is plain enough there is more to what happened than that. It may well be, of course, that your own memory of what transpired may be poor by reason of your consumption of alcohol, and with all due respect, given your criminal history and the probability of you having abused alcohol for a lengthy period of your life, it may well be that your memory is perhaps not as good as the average citizen's, in any event."

Personal circumstances

8. Ms Robertson was born on Palm Island and went to school there. Her mother, Ms Margaret Parker, attended the inquest and informed me that Elsie was a talented sportswoman who had played representative netball. The last time she saw Elsie alive was at Christmas 2012.

9. Ms Parker also said that Ms Robertson had three children (now aged 24, 22 and 20 years) and four grandchildren. Ms Robertson is survived by her mother, children, grandchildren and four brothers, who live on Palm Island and at Kowanyama. I extend my condolences to her family.

10. Ms Parker said that Elsie was a good mother and a loving person who was always willing to help. They shared a special relationship because Elsie was Ms Parker's only daughter. She had cared for her father when he was ill.

Issues for Inquest

11. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, I am required to find:-

    a. whether a death in fact happened;
    b. the identity of the deceased;
    c. when, where and how the death occurred; and
    d. what caused the person to die.

12. As Ms Robertson was killed by her partner, the inquest also considered issues associated with domestic violence related deaths, and whether there are ways to prevent such deaths from happening in the future.

The scope of the Coroner's inquiry and findings

13. Prior to the sentencing hearing in the Supreme Court there were a number of other proceedings within the criminal justice system. This included committal proceedings in the Magistrates Court at Cairns where the forensic pathologist was cross-examined. This court has the benefit of the whole of the investigation material consisting of numerous exhibits, photographs, medical evidence, recorded interviews, statements of witnesses and court transcripts from both the committal hearing and in the Supreme Court.

14. While it would be futile not to acknowledge that Ms Robertson's death has already been dealt with by the criminal justice system, it is important to recognise the important distinction between coronial inquests and criminal trials. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."*

15. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred. To clarify the distinction in roles, the *Coroners Act 2003* specifically states that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.

The Admissibility of Evidence and the Standard of Proof

16. Proceedings in a coroner's court are not bound by the rules of evidence and the *Coroners Act* provides that the court "*may inform itself in any way it considers appropriate."* That does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining the weight that should be given to the information.

17. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial. If a witness refuses to give oral evidence at an inquest because the evidence would tend to incriminate the person, the coroner may require the witness to give evidence that would tend to incriminate the witness if satisfied it is in the public interest to do so. The evidence, when given, and any derivative evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury.

18. A coroner applies the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needs to be for the trier of fact to be satisfied that it has been proven to the civil standard.

19. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially. This means that no findings adverse to the

interest of any party may be made without that party first being given a right to be heard in opposition to that finding.

20. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed an indictable offence, the coroner must give the information to the Director of Public Prosecutions.

Police investigation

21. The Queensland Police Service (QPS) investigation essentially proceeded as a murder investigation. The Ethical Standards Command (ESC) also conducted a parallel investigation into the initial response by police to the call made by Ms Conway, reporting what she had seen and heard happening between Ms Robertson and Mr Grannigan at her house.

22. The ESC investigation confirmed that Ms Conway first called the Policelink number '131 444' from a pay phone just after 9:00pm. The call was transferred to the Cairns Communication Centre at 9:04pm. The call taker, Penny Topp, spoke with Ms Conway and took details of the incident while entering them into 'QCAD' (QPS Computer Aided Dispatch). The call was terminated at 9:07pm and Ms Topp continued to check and validate the details provided. This process involved checking relevant persons for any flags for violence or outstanding warrants. The address was also checked to see if it was known to police.

23. The data entry was finalised by Ms Topp at 9:20pm. This then allowed the job to be visible to the Communications Coordinator (COMCO) on the QCAD system. At 9:28pm, COMCO Sergeant David Cooper viewed the incident and assessed the known facts. While he left the incident as a priority code 3, he would try to allocate a resource to it as soon as a suitable crew became available.

24. Sergeant Cooper then tried to locate a suitable crew to attend. He said that he attended the general duties dayroom, in addition to contacting the Criminal Investigation Branch and Child Protection Investigation Unit. He was unable to find a suitable crew. At 9:31pm, he left an entry against the incident in QCAD stating "*VERY BUSY SHIFT WITH (6) CODE 2 JOBS ON THE GO AT THE SAME TIME.*"

25. At 9:46pm, Sergeant Cooper spoke with the incoming COMCO, Sergeant Stephen Polzin. He briefed Sergeant Polzin and advised him that the incident required immediate attention, but he had no staff to allocate.

26. At 9:54pm, Sergeant Polzin logged into QCAD. He was aware that the shift was about to change over, and as such spoke to the incoming duty Sergeant Simon Laverty. Sergeant Polzin requested that a crew be allocated to the incident immediately. Sergeant Laverty then allocated

the incident to Constables Celeste Batticciotto and Jason Orr who were preparing to commence a shift at 10:00pm. They logged on at 10:09pm and proceeded to Ms Conway's address, arriving at 10:18pm.

27. While I heard from both Officers Batticciotto and Orr at the inquest, their oral evidence did not significantly add to the evidence already contained in their written statements, and transcripts of interview, which had already been tendered.

28. Upon arriving at the address, Officers Batticciotto and Orr knocked on the door, which was answered by Ms Conway. She asked to speak with the police outside the house. Ms Conway told police that her niece, Elsie, and Elsie's boyfriend were inside and were visiting from Palm Island. There had been a disturbance earlier, during which Ms Conway heard banging against a brick wall and she was concerned for her niece. She had been trying to check if Elsie was still alive but she had not heard anything from her and she was worried.

29. She directed police to the room where Mr Grannigan was located. Police pushed open the door slightly, knocked on it, and announced themselves. The light was off, so Officer Batticciotto put her hand inside the room to turn it on. She saw Mr Grannigan lying on the ground with his legs towards the entrance of the door, and his head towards the back wall. She saw a female, with no clothes on, laying in the opposite direction with her head more towards the door, and her feet to the wall.

30. Constable Orr pushed the door open some more, at which point Mr Grannigan stood up. Constable Orr could see a lot of dry blood on the pillow and on Mr Grannigan's feet. He took hold of him, and he was placed under arrest on an outstanding warrant. He was walked to the couch in the living room and handcuffed.

31. Constable Batticciotto returned to where Ms Robertson was, conducted a sternum rub, and received no response. She noticed that Ms Robertson had blood around the nose and mouth area. She was unconscious and not breathing.

32. At 10:29pm, Constable Orr called the QAS, and began conducting chest compressions. Constable Batticciotto cautioned Mr Grannigan under the *Police Powers and Responsibilities Act 2000*, and he responded by nodding that he understood.

33. Resuscitation efforts continued from the police officers until three paramedics from the QAS attended at 10:36pm. Other officers from the QPS also started arriving after this time. Paramedic Byron Tubb declared Ms Robertson deceased at 11:09pm.

Evidence from Anne Conway and Alan Donovan

34. Ms Conway and Mr Donovan both gave evidence at the inquest. Their statements previously provided to police for the murder investigation were also tendered. At the time of Ms Robertson's death, they had been in a relationship for some 2.5 years, and are still in a relationship. Ms Conway had resided at the incident address with Mr Donovan for almost a year.

35. It was made clear at the outset of the evidence from both witnesses, that their best recollection of the events was what was contained in their written statements. Given the time that has passed since Ms Robertson's death, being some 2.5 years, it is understandable that their distinct memory of the events was somewhat blurred.

36. Mr Donovan did not have a lot of prior knowledge of Ms Robertson or Mr Grannigan. Ms Conway gave evidence confirming that Ms Robertson grew up on Palm Island, had known Mr Grannigan since kindergarten, and they had an 'on-off' relationship. Ms Robertson and Mr Grannigan had also lived in Townsville in previous years, sleeping rough, as had Ms Conway.

37. Ms Conway described the relationship as unhealthy. She gave evidence that she knew Mr Grannigan to be violent and aggressive. He would give Ms Robertson black eyes and bruises. In her statement she said Mr Grannigan would become jealous and obsessive towards Ms Robertson and other women. He had a bad temper, was a big drinker, and addicted to marijuana.

38. Ms Robertson and Mr Grannigan had only been in Cairns for about a month, having moved up from Townsville. Ms Conway confirmed in her evidence that Wednesday, 6 March 2013, the day of Ms Robertson's death, was the first time she had seen her niece and Mr Grannigan in about two years.

39. Between 9:30am – 10:00am, Ms Robertson and Mr Grannigan showed up at Ms Conway's residence asking for a place to stay. Ms Conway told them they could stay until Monday, at which time they would need to find somewhere else to live. Ms Robertson and Mr Grannigan had a mattress and some shopping bags with them. They put the food in the fridge and the mattress in the spare room, and went to the bathroom to 'smoke a bong'.

40. Mr Grannigan then gave Ms Conway a sum of money to buy some alcohol. Ms Conway went and bought two 4L white wine casks and four 'XXXX Gold' 'tallies'. She returned to the unit where she, Mr Donovan, Ms Robertson and Mr Grannigan were present. Ms Conway initially recalled that she returned to the unit at about midday, however, upon further reflection she said it was about 10:45am.

41. Mr Grannigan was initially drinking the beer and Ms Robertson was drinking the wine. Ms Conway gave evidence that Mr Grannigan started to get into 'one of his mood swings'. He started to get angry because Ms Robertson just wanted to sit and drink. He told her that he did not want her drinking because she would throw a tantrum.

42. Ms Conway initially said that at about 1:00pm, Mr Grannigan carried Ms Robertson to the bedroom so she would sleep. Mr Donovan thought that it was between 2:00-3:00pm. Whatever the exact time, I accept it was in the early afternoon. Ms Robertson was kicking her legs, and Mr Grannigan became more aggressive with her and was arguing with her. He went into the room with Ms Robertson and shut the door. The door had a locking mechanism where it could be locked by a button on the inside of the door. Ms Conway gave evidence that both Mr Grannigan and Ms Robertson were drunk and stoned at this time. Mr Donovan heard Mr Grannigan say to Ms Robertson that he did not want her to drink anymore because she was getting too drunk.

43. Ms Conway's evidence to the inquest was that, on this particular afternoon, she had consumed almost an entire 4L cask of wine. Despite this, she confirmed that she was confident that she was coherent and was still aware of what was going on around her. She could hear Ms Robertson and Mr Grannigan arguing inside the room. Ms Conway heard Mr Grannigan say "*can't you just leave me go – I want to go my own way*." Ms Robertson kept saying "*no, I love you*." Mr Donovan confirmed to the inquest that he did not drink much alcohol anymore, and was drinking cordial and one tallie on this particular afternoon.

44. Ms Conway could hear Mr Grannigan slapping Ms Robertson and punching her with a closed fist. She did not see it, but could tell what was happening by the distinct sounds being made. She heard Ms Robertson say "*what are you hitting me for. Oh you are hitting me*." Ms Conway called out a couple of times and knocked on the bedroom door. She said to Mr Grannigan words to the effect of "*stop it, behave, this is not your place. Behave and have some respect*."

45. Ms Conway gave evidence that this behaviour lasted until about 7:00pm that night. She initially said that Ms Robertson did not come out of the bedroom for that entire time. However, she then recalled Ms Robertson had been led in and out of the bedroom by Mr Grannigan, 4 or 5 times, to go to the toilet. At the inquest Ms Conway said that she could see blood on Ms Robertson's mouth. While they were in the bedroom Ms Conway could hear Mr Grannigan punching her and banging her head up against the wall. It would stop for a time, and then start again. She described the sound of Ms Robertson's head against the wall as being similar to when "*someone falls and hits their head on the concrete*." Ms Conway recalled Ms Robertson crying out "*oh leave me alone…I am sore…sister help me*."

46. Ms Conway recalled in her addendum statement to police that at about 4:00pm she and Mr Donovan left the unit to go to the Edge Hill Tavern; and Mr Donovan corroborated this. Mr Grannigan had asked them to get another cask of wine. Ms Robertson was still in the bedroom at this time. When they returned to the unit, Ms Conway asked if Ms Robertson was okay. Mr Grannigan invited her to the doorway of the bedroom, and Ms Conway looked inside. She could see Ms Robertson lying down, she was naked and lying slightly to her side. Her head and top of her body were lying on the mattress and her legs were hanging off the mattress.

47. Ms Conway noted that Ms Robertson was "*out to it*", but she could only see the side of her face. She was in the bedroom for about one minute and had a quick glance. She thought that Ms Robertson was drunk and stoned, and while she told police she did not notice any blood in the room, at the inquest she said that she could see that Ms Robertson was still bleeding from the mouth. Ms Conway also said that she was shaking her but could not get a response, but Ms Robertson was still breathing.

48. Ms Conway saw Mr Grannigan exit the bedroom approximately four times throughout the course of the afternoon. Each time was only short in duration, and he would fill up his cup with more wine. Ms Conway recalled that, just after 'Home and Away' finished, Mr Grannigan came out of the bedroom and asked her to "*put the wine away, or Elsie will take it out and drink it all hours of the night*." Ms Conway said to Mr Grannigan "*no fighting now. Just sleep it off till the morning*." She again asked Mr Grannigan if Ms Robertson was okay, to which he replied that she was asleep.

49. Mr Donovan's recollection was different to Ms Conway's in terms of the sequence of events. He said that the arguing began around the same time as 'Deal or No Deal' was on the TV (5:30pm – 6:00pm) however, he heard screaming coming from the bedroom. He also heard Ms Robertson yelling out for Ms Conway to come into the room and that she needed help. It was at about 8:30pm that Mr Donovan was in his bedroom and could hear the walls vibrating and he could hear a thudding noise. He heard the thudding noise about four times, and he said it made him "*feel funny and sick in the guts*." He said it then went quiet.

50. Ms Conway could not get into the room to see if Ms Robertson was okay as the door was shut and Mr Grannigan was laying against it. She had a feeling that Ms Robertson was badly hurt. She could not hear any more cries. Ms Conway called out to Ms Robertson "*are you ok*" to which she received no response.

51. Ms Conway said to Mr Donovan that she wanted to walk up to the local phone box to ring the police. She had a bad feeling that Ms Robertson was badly hurt and was concerned that she was not replying to her or making any sounds from within the bedroom. Her landline phone was not working at the time.

52. Mr Donovan recalled that they left for the phone box at about 8:50pm, and Ms Conway recalled that it took about 5 or 10 minutes to walk there. She gave evidence that she did not leave to call police earlier as she was worried about her children and what would happen if she was evicted from the unit. She was also afraid of Mr Grannigan. Mr Donovan did not want to become involved. The call to police was logged as being made at 9:00pm. I was provided with that recording during the course of the inquest.

53. After the call, Ms Conway and Mr Donovan walked back to the unit and waited for police. She could not hear any noises coming from the bedroom apart from Mr Grannigan's snoring. She tried to push open the door to the bedroom, but could not get in as Mr Grannigan was still lying against the door. The police arrived after what Ms Conway thought was about 45 minutes, and Mr Donovan estimated was about an hour.

54. At the inquest, Ms Conway said that she had made two additional calls to 000 on the night of Ms Robertson's death. I asked for further enquiries to be conducted in relation to this matter and I am satisfied that only one call to Policelink was made by Ms Conway on 6 March 2013, at 9:00pm.

Police response to the incident

55. As the time it took for police to arrive at the unit may have contributed to Ms Robertson's death, the former State Coroner, Mr Barnes, requested that the death be investigated as having occurred in the course of, or as a result of, police operations. This investigation was led by Inspector Christopher Hobbs. The police report with respect to that investigation was tendered to me at the inquest and I also heard oral evidence from Inspector Hobbs.

56. Inspector Hobbs gave evidence that it was ultimately determined that there was an unreasonable delay from when the first Policelink phone call was made by Ms Conway (9:00pm) to when police actually attended at the residence (10:20pm). Inspector Hobbs helpfully provided the following table of relevant events in his report, which I extract below:

9:00pm Conway call to Policelink
9:03pm Policelink switch call to Cairns Comms
9:04pm Call taken by Topp
9:07pm Call ended
9:20pm Topp finalises validating and linking data in QCAD
9:28pm Cooper views job 001810-06032013
9:31pm Cooper makes entry on QCAD after unsuccessfully trying to locate an available crew
9:46pm Cooper states he briefed Polzin during Comco Handover and logs out of QCAD
9:49pm QCAD timestamp of Cooper logged out
9:52pm QCAD Timestamp of Polzin Logged in
9:54pm QCAD Status shows Polzin views job 001810-06032013
10:00pm QCAD entry by Polzin "Passed to Sgt Laverty"
10:09pm CA209 Orr/Batticciotto book on as proceeding from Cairns Station
10:18pm CA209 Book off at job address

10:28pm CA209 requests QAS and job entry "REQUEST QAS TO INC LOC RE FEMALE, UNCONSC AND UNKNOWN IF BREATHING, FEMALE IS
NAKED AND HAS BRUISING OVER HER BODY"
10:28PM CA209 advise "FEMALE NOT BREATHING, NO PULSE"
10:30pm Polzin makes entry on QCAD "QAS ADV ON WAY"
10:31pm CA209 request "REQUIRE ANOTHER UNIT .. CREW ARE TRYING TO COMMENCE CPR BUT REQUIRE ANOTHER OFFICER TO HOLD OFFENDER BACK"
10:40pm Hutchison makes notebook entry QAS arrive at scene at same time he and Greenwood arrive
l 1:09pm Life Extinct pronounced

Figure 2: Table depicting timings and occurrences.

57. QPS administrative officer Penny Topp took the COMCO call which took place at 9:04pm. Ms Topp recalled that Ms Conway was pretty calm and did not seem overly panicked. The information provided by Ms Conway is captured in the recording and transcript of the call. I have extracted that as follows:

> *"Policelink: This is Stephen from police link got a case ID for you.*
> *Topp: OK go ahead.*
> *Policelink: 17 48838.*
> *Policelink: I've got Anne Conway she is calling from unit 3 91 Boden Street, BODEN that's at Edge Hill There's a domestic disturbance at her unit.*
> *Topp: OK.*
> *Policelink: OK I'm just putting you through, she is living in that unit and she feels that her niece is in danger from another male person there. No phone number. she is calling from a public telephone box.*
> *Topp: Yeah go ahead.*
> *Conway: Hello um I'm living in a unit look um I have my niece up there she just got back from a residential place somewhere over in Davis street . She been living in a relationship with a bloke and this is been going on nearly all day at my unit.*
> *Topp: Yep.*
> *Conway: He been violent against her.*
> *Topp: What's her name?*
> *Conway: Well to be honest look uh she's scared and that and look this fella just finished banging her head up against the wall, I 'm singing out at my door at my unit door, the second room and she not answering and that's why I'm crying and all that and I was upset and I don't know if she's awake or what or unconscious*
> *Topp: What's his name?*
> *Conway: Well he told me that if I tell youse he gonna get angry with me and smash my unit uh hold on I ask my partner (distant) what's his name? Jamesie Brannagan yeah Brannagan.*
> *Topp: What's your nieces' name?*
> *Conway: Elsie May Robertson.*
> *Topp: Elsie Robertson.*

Conway: *Yeah Elsie May Robertson I a bit concerned about her and I'm feeling a bit feverish and I don't know just things are not sitting right.*
Topp: *Alright we will get someone to go round.*
Conway: *Yes please I be at home waiting for them to attend my address please.*
Topp: *Elsie's surname is that ROBERTSON*
Conway: *Yeah please.*
Topp: *How old is she.*
Conway: *I would not know but she just been screaming out stop hitting me all day she had pain and what he doing its annoying me he won't let she come out of the room out of my unit she goes for the toilet and he carry her back in the room and then belts her all day long and just gets away with the crap. And now I just heard a couple big bangs on my back room wall and then no answer.*
Topp: *OK.*
Conway: *Then I standing at my unit door saying you there Elsie you right this is Mum Annie there's no answer.*
Topp: *OK we will get someone to go and have a look.*
Conway: *Alright thank you bye how long that be?*
Topp: *I'm not sure sorry.*
Conway: *Alright bye."*

58. Ms Topp said to ESC investigators that, in hindsight, she could have advised the QAS of the situation, but she did not. This decision was deemed to be reasonable by the ESC, as there was no information provided by Ms Conway which confirmed an actual injury had occurred.

59. Ms Topp did not raise the matter verbally with the COMCO, as she did not consider it to be that urgent, and she was aware that the matter would have immediately become visible on the COMCO's list for him to assess. Ms Topp explained why she deemed the matter not to be that urgent. While Ms Robertson may have been unconscious, on the information available this had not been confirmed, and it was not known what was making the sounds on the wall.

60. Ms Topp also gave consideration to the fact that the incident had reportedly been going on all day and, if it was that serious, there would have been a call to police sooner. It was explained by Ms Topp during her ESC interview that despite her having entered the words on QCAD "*INF IS CONCERNED HER NIECE IS UNCONC OR DEAD*", this information was not actually given by Ms Conway during the call. It seems this may have been information which was inferred by Ms Topp.

61. Ms Topp coded the job as a priority 3, which is non-urgent. Ms Topp assessed that the request was in the nature of a welfare check and reiterated that this was because:
    - it was a fairly busy shift;
    - Ms Conway did not seem overly distressed or alarmed; and
    - The incident had been going on all day.

62. Sergeant Cooper was working a 2:00pm to 10:00pm shift on 6 March 2013 as the COMCO. He told ESC investigators that when he first became aware of Ms Conway's call he had no crews available to attend. He assessed the information available on QCAD, and said that though there were some concerning aspects in the information, there were also factors which mitigated that concern.

63. Sergeant Cooper noted that the incident had been prioritised as a Code 3 and, after assessing the full circumstances, he did not consider it warranted elevation to Code 2. At the change of shift Sergeant Cooper advised Sergeant Polzin of the job, but acknowledged that this advice might not have been very detailed.

64. Sergeant Cooper said to ESC investigators that, by 9:30pm, there were six Code 2 jobs still active. Cairns resources were fully engaged in response to those jobs. To his best knowledge and belief, there were no available crews to attend to Ms Conway's report. At 9:31pm, Sergeant Cooper made the following notation in QCAD "*NCA. VERY BUSY SHIFT WITH (6) CODE 2 JOBS ON THE GO AT THE SAME TIME."* From the time of this entry, until 9:46pm when he handed over to Sergeant Polzin, Sergeant Cooper kept scanning the electronic "bingo card" in an attempt to locate a crew to assign the incident to.

65. Sergeant Stephen Polzin took over as the COMCO at 10:00pm. There was a handover prior to his starting shift, where Sergeant Cooper informed him that it had been a very busy shift, and he was given a 'run down' of the jobs on hand. Sergeant Polzin saw that Ms Conway's call was at the top of the list due to the severity of the code, and there was also another assault matter which was important. There were no other important jobs awaiting the attendance of crews.

66. Sergeant Polzin printed out a job log for each incident and spoke to Sergeant Simon Laverty who was in the dayroom. He asked Sergeant Laverty to get a crew to attend to Ms Conway's report straight away. He then made a note on QCAD that he had passed the job on to Sergeant Laverty. The time stamp of this being done is 10:00pm. At 10:09pm Sergeant Polzin became aware that a crew was booked on to go to the job, Constables Orr and Batticciotto.

67. Sergeant Simon Laverty was also interviewed by ESC investigators. His version largely corroborated that provided by Sergeant Polzin. His view of the job was that it related to a domestic incident with information that a person's head had been banged on a wall and that it came in at 9:20pm, so he directed a crew to head straight out to the job.

Operational Procedures Manual

68. Inspector Hobbs gave evidence at the inquest surrounding the relevant sections of the QPS Operational Procedures Manual ('OPM'). When members of the public make contact with the QPS seeking a physical

response, the priority of that response is to be assessed based on the information provided.

69. The assessment process commences with contact with the call taker, who enters the information onto QCAD and conducts verification and officer safety related checks. Once this is completed, the QCAD entry appears on the work list of the designated COMCO for further assessment and tasking. From that assessment, the COMCO is required to give the incident a priority code and determine an appropriate level of response. The application of the Priority Policing Process assists in this response.

70. The COMCO should refer to the policy contained in section 14.24 of the OPM for guidance, I have re-produced the relevant section below:

"*OPM 14.24 Priority Codes*

POLICY

The Service recognises the inherently unpredictable nature of policing and the need to be able to identify a flexible response to calls for service. Where personal safety is threatened, the community expects a timely and effective response. To maximise the Service's ability to effectively respond, there is a need to employ appropriate demand management strategies which may include the allocation of tasks to officers who do not usually operate in a first response capacity.

This policy acknowledges and reaffirms that the safety of people and the security of property are the priority of all officers. This policy embodies a flexible operational resource allocation model which ensures that internal organisational and administrative structures do not impede the efficient and effective delivery of policing services.

The priority policing process establishes a method for determining whether to initiate an immediate response to a call for service or to implement an alternative expectation strategy based on the nature of the call for service and the availability of operational resources.

Receiving calls for service

POLICY

Members receiving calls for policing services are to ensure that:
(i) the relevant information is recorded in accordance with s.1.6.1: 'Recording initial demand' of this Manual; and
(ii) the particulars of the call are referred to an officer for tasking (a tasking officer).

Tasking officers

POLICY

Assistant Commissioners of regions and commands are to ensure:

(i) suitable tasking officers are identified for all areas under their control. Local standing operating procedures are to nominate specific officers or holders of particular positions to fill the role of tasking officer. Tasking officers may be nominated to have responsibility for tasking within a geographical area or within an organisational unit depending on the requirements of the relevant region or command.

Generally, a tasking officer will be an officer with responsibility for assigning priority codes in accordance with s.14.24 'Priority codes' of this chapter. The responsibility for tasking, and authority to issue associated directions in any particular case should be clearly defined to avoid the potential for confusion as to an officer's responsibility and authority as a tasking officer;

(ii) appropriate arrangements are made with the officers in charge of neighbouring regions to establish processes by which operational resources may be assigned to calls for service in
neighbouring regions; and

(iii) procedures are established within their area of responsibility to resolve issues arising as a result of tasking decisions (e.g. the tasking of units previously allocated to a particular activity to other calls to service). In all circumstances, however, priority is to be given to responses to calls for service involving a threat to personal safety

The role of a tasking officer is to:
(i) allocate priority codes to calls for service in accordance with s.14.24 'Priority codes' of this chapter; and
(ii) direct officers to attend calls for service in accordance with the priority policing process

A tasking officer need not be a senior officer and for the purposes of directing officers to attend to calls for service has the authority to direct all officers subject to any limitations established in Service or regional policy.

Tasking decisions of a tasking officer are not to be disputed by members receiving the tasking. Members who wish to query a tasking decision are to attend the tasking as directed and may raise the issue in accordance with regional arrangements.

In cases where an officer or officers are tasked to attend a call for service in circumstances that would place the officer at unreasonable risk (e.g. officers who are not qualified in OST being directed to attend a violent incident), the officer should immediately advise the tasking officer of that fact. Tasking officers should act upon such advice to ensure, as far as practicable, that additional or alternative resources are tasked to mitigate such risk.

Priority Policing Process

POLICY

Tasking officers receiving details of calls for policing services are to·
(i) determine whether the call relates to a threat to personal safety or property security;

(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 to the call for service or initiate an alternative expectation strategy based on the application of the priority policing process. See the priority policing process flowcharts contained in Appendixes 14.5: 'Threats to Personal Safety', 14.6: 'Threats to Property Security' and 14.7: 'Other Calls for Service' of this chapter; and
(iv) ensure that 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 relevant regional arrangements, to direct officers from that area to attend the call tor 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.

14.24.1 Priority codes

POLICY

Job tasking is assigned one of four priority codes by members under the supervision of:
(i) the Duty Officer, Police Communications Centre, Brisbane;
(ii) the officer in charge of a police communications centre in areas not controlled by the Police Communications Centre, Brisbane; or
(iii) in places where no police communications centre exists, the officer in charge of the station where the information requiring the attendance of police is received; or
(iv) the inspector, Special Emergency Response Team, where due to the type, or methodologies of the duties being performed it is not practical to obtain a priority code as outlined in paragraphs (i) to (iii) above.

To ensure that officers are aware of the degree of urgency required in attending an incident, complaint, request for assistance or other matter, the following priority codes are allocated:
(i) Code 1 - for very urgent matters when danger to human life is imminent;
(ii) Code 2 - for urgent matters involving injury or present threat of injury to person or property;
(iii) Code 3 - for routine matters; or
(iv) Code 4 – negotiated response.

14.24.2 Criteria for assigning a priority code

POLICY

A member assigning a priority code to a task should use the following guidelines:

Code 1 – 'Very Urgent' – may be assigned in the following circumstances:

(i) when an officer or member of the public is in need of help in circumstances where life is actually and directly threatened and is in immediate danger of

death. This includes the need for assistance in similar circumstances when an officer is having problems escorting
prisoners, is trying to effect crowd control or is endeavouring to keep law and order at civil disturbances, etc;
(ii) when shots are being fired for an explosion or bombing has occurred and danger to human life is imminent;
(iii) at the time of a major incident or serious fire, or in the case of a robbery or any crime in progress where there is danger to human life;
(iv) in instances of asphyxiation or electrocution where life may be saved or where a person is attempting suicide or other forms of self harm likely to cause death or serious injury; or
(v) in any ether instance where it is known that danger to human life is imminent.

Code 2 - 'Urgent' – may be assigned in the following circumstances:

(i) incidents similar to those above and any other urgent situations without the element of imminent danger to human life being apparent;
(ii) in any other urgent situation where it is known that danger to human life is not imminent; or
(iii) incidents involving injury to a person or present threat of injury to a person or property,

Code 3 - 'Routine' - may be assigned to all other matters which are considered to be routine and not requiring classification of Code 1 or 2.
(See also s.14.6: 'Use of police sirens and flashing or revolving warning lights and activating the light bar' of the Traffic Manual)

Code 4 - 'Negotiated Response' - is only to be assigned to calls for service in accordance with approved Regional/Command/District negotiated response policies.

ORDER

The member responsible for assigning a priority code to a task is to:
(i) assign a code to the task having regard to Service policy and the information available;
(ii) change the code as circumstances and information warrant; and
(iii) advise the member responsible for transmitting the task of the assigned code for that task and any change to that code.

The member responsible for transmitting the task and code is to notify the member assigned the task of the priority code for the task and any change to that code.

Officers are not to alter or upgrade allocated priority codes unless directed by a member responsible for assigning priority codes."

71. Inspector Hobbs confirmed at the inquest that Ms Topp and Sergeant Cooper had been disciplined in relation to their involvement in responding to Ms Conway's phone call.

72. During his evidence at the inquest, Inspector Hobbs confirmed that Ms Topp had explained why she had categorised Ms Conway's call as a priority 3, and why she did not raise it personally with Sergeant Cooper.

She was unable to explain why she made the reference to "unconscious or dead" if that was not actually said by Ms Conway.

73. It was Ms Topp's decision not to verbally escalate the urgency of the job with Sergeant Cooper, having regard to the 'threat to personal safety' outlined by Ms Conway, which underpinned Inspector Hobbs' recommendation for Ms Topp to be disciplined.

74. Sergeant Cooper provided Inspector Hobbs with his rationale for leaving the job at priority 3 and not fully complying with the requirements of the priority policing process. He also did not request the radio operator to make an 'any unit' call to try and respond to the matter.

75. Inspector Hobbs' recommendation for Sergeant Cooper to be disciplined was underpinned by Sergeant Cooper's decision not to note the 'threat to personal safety' clearly articulated in the job details and subsequently invoke the priority policing process.

76. By 9:49pm, the job was still outstanding, and Sergeant Polzin logged on to QCAD and accordingly became the responsible officer. He took immediate action to have the matter actioned by police by personally directing Sergeant Laverty to get a crew to attend as soon as possible.

77. I have had regard to each of the discipline outcome notices tendered to the inquest and have no further comments with respect to the notices or with respect to further disciplinary action against any of the officers involved.

Evidence of James Grannigan given to police

78. The only information Mr Grannigan gave to the police about what occurred is taken from the evidence of Constable Jason Orr, one of the first response police officers. In his police statement which was tendered to the inquest, Constable Orr recalled a conversation he had with Mr Grannigan shortly after arriving at the house. That conversation is extracted from his tendered statement below:

> "*I have then stated words to the effect of to the defendant 'what has happened? We need to know what has happened to her so we can help her.'*
>
> *The defendant stated 'she was drunk and fell down*."

79. This is the only information Mr Grannigan provided during the course of the police investigation with respect to what happened. He subsequently invoked his right to silence.

Evidence of James Grannigan at the inquest

80. I acknowledge the assistance provided by Mr Richardson in appearing for Mr Grannigan as friend of the court.

81. Mr Grannigan took an oath and gave evidence at the inquest. It was acknowledged that Mr Grannigan understood that while he could object to answering questions on the grounds of self-incrimination he could be compelled to do so under the *Coroners Act*.

82. This was the first occasion that Mr Grannigan had given evidence about the events that took place in 2013.

83. Mr Grannigan said that he and Ms Robertson were both drunk and had consumed cannabis before he took her into the bedroom on 6 March 2013. He said that they continued to drink in the bedroom. He then tried to stop Ms Robertson from drinking. His evidence was that he became angry with her when she would not stop drinking. She started to hit herself in the head with her cup, and the wall became covered with alcohol.

84. Mr Grannigan agreed that he had caused the injuries to Ms Robertson's head by punching her with his fist. He had punched her to stop her from drinking.

85. He said that he had asked Ms Conway to call for an ambulance but she delayed making a call and it was several hours before help arrived. Mr Grannigan stated at the inquest that this delay contributed to Ms Robertson's death. While this appears to demonstrate that he does not accept that his actions were associated with the death, I accept that he was genuinely sorry for what had happened.

Medical Evidence

Dr Paull Botterill

86. Dr Paull Botterill is a very experienced forensic pathologist. He conducted a full internal autopsy on 7 March 2013. His findings at autopsy were peer-reviewed by his colleague Dr Rebecca Williams. His autopsy report was tendered at the inquest, as was the evidence he gave at the committal proceedings. I also heard oral evidence from him.

87. External examination showed a variety of injuries which can be listed as follows:
    - Tear of the skin of the right side of the face;
    - Bruising under the skin surfaces of both sides of the face, the lower jaw, both temple regions and the left ear;
    - A graze over the nose.

88. Internal examination revealed bruising to under the surface of the front of the brain and some bruising between the left and right sides of the brain. There was an excess of fluid in the lungs and equivocal enlargement of the heart.

89. Dr Botterill's evidence at the inquest was that the injuries that caused Ms Robertson's death were recent, occurring close to the time of death or within 24 hours of it. He said that there were at least six blunt force contacts leading to bruising within the brain.

90. At the time of autopsy, the cause of death was not clear to Dr Botterill. The consequences of the blunt force trauma to the head, with or without concurrent alcohol or other drug toxicity, appeared to be the most likely explanation. Dr Botterill commenced further testing by way of microscopic examinations.

91. This further examination revealed lung congestion, mild liver fatty changes, some heart and lung muscle changes consistent with resuscitation efforts, and fresh bleeding over the surface of, and focally within the brain.

92. Toxicology testing revealed the presence of alcohol at a level of 0.12, or two times the legal limit. Dr Botterill provided opinion that such a level would usually result in a degree of impairment of rapid and extremely complex motor skills, and may also lead to behavioural changes. The level was not sufficiently high to result in death by itself. There was also the presence of cannabis metabolites indicating recent use.

93. Dr Botterill said in his report that although unequivocal ante-mortem brain injury was confirmed, consistent with blunt force contact, the extent of brain surface and deeper bleeding was less than that usually seen in fatal head injuries. However, death can result from head injury with even less overt injury than that seen in Ms Robertson.

94. The cause of death was most likely blunt force head injury, on a background of alcohol and cannabis intoxication. However, Dr Botterill indicated that some pathologists would consider a number of other possibilities, such as smothering causing asphyxia, blunt force head injury, intoxication, or a combination of these, may be consistent with the autopsy findings and potentially explain the death.

95. Accordingly, Dr Botterill's peer-reviewed autopsy report confirmed the cause of death as being undetermined.

96. On 11 December 2013, Dr Botterill was called to give evidence at the committal proceedings for the murder charge. He was the only witness called. In his evidence at the committal, Dr Botterill was cross examined as to the contents of his autopsy report. He accepted that the majority of external injuries he observed were to Ms Robertson's head area. He could not exclude that the injuries to the chest and forearm were sustained during the extensive resuscitation efforts.

97. Dr Botterill was asked about the petechial haemorrhages, and clarified that they are generally non-specific. They can be caused due to multiple circumstances, namely:

- Pressure to the neck causing an impairment of blood flow from the head back to the rest of the body;
- Compression of the chest in an action consistent with resuscitation;
- Obstruction of the airway that may or may not have a relationship with the head injury.

98. He accepted that the petechial haemorrhages could be related to some form of asphyxiation, in the sense of an obstruction to the airway. He accepted that this could possibly be from strangulation, however, also gave evidence that he did not observe any changes to the skin surface of the neck or in the deeper tissues which sometimes would be seen in a case of strangulation. Further, there were injuries to both sides of the head, but not to the back of the head.

99. In terms of the force required to inflict the injuries to the head, Dr Botterill said that it would be mild to moderate force. This degree of force would be enough to cause the bruising as well as the skin tears.

100. When asked about the potential mechanism with which the force might have been applied, Dr Botterill suggested a fist or a foot, but it could be any part of the body, or a piece of furniture, or even contact with the ground or a wall. The injuries could be the result of multiple falls. Dr Botterill was unable to say with any degree of certainty the mechanism of how the injuries were sustained. He did say, however, that the fact most of the injuries were concentrated around the head was unusual for multiple falls.

101. Dr Botterill clarified in his evidence that the confounding issues in this case were the results of the toxicology and the petechial haemorrhages. The petechial haemorrhages raised the possibility of another mechanism such as the obstruction of the airway as a potential cause of death. The elevated blood alcohol level, in addition to cannabis, could have worked together to impair consciousness and make the risks associated with obstructed airway and minor blunt force head injury even greater.

102. In his autopsy report, Dr Botterill accepted that smothering causing asphyxia, blunt force head injury, intoxication or a combination of each were all live possibilities. He accepted that his opinion was that it was a combination of them because the circumstances of the death were unknown.

103. The level of alcohol was not sufficient to cause death on its own. However, placed in the right context, such as where someone is incapacitated so that their airway was obstructed, it could be postulated that the death could occur from a lower level of alcohol intoxication. The level of cannabis would add to that level of intoxication. Dr Botterill was able to say that the level of intoxication would have had a significant impact on Ms Robertson's motor skills and balance, and leave her more

likely to fall. In that context, the level of intoxication may have contributed to her death.

104. Dr Botterill was asked additional questions by police investigators in the lead up to the criminal trial with respect to the timing of the death. He was also asked about this issue at the inquest. He was unable to assist with an exact time of death, but was able to narrow it down to a window of six hours, with a one in twenty chance that it occurred outside that period.

105. At the inquest, Dr Botterill said that the fact that Ms Robertson's body was still warm to touch when QAS officers arrived did not assist in establishing the time of death as the body's core temperature can remain stable for 2-3 hours after death.

106. Dr Botterill ultimately agreed at the inquest that, while it was not without doubt, in his opinion it was more likely than not that the cause of death was blunt force trauma on a background of alcohol and cannabis intoxication.

History of domestic violence

107. During the course of my investigation, evidence from a variety of sources was provided which confirmed an extensive history of domestic violence between Mr Grannigan and Ms Robertson. This history involved violence inflicted on Ms Robertson by Mr Grannigan and vice versa. Their relationship was characterised by a pattern of coercive controlling violence, with the records indicating that Mr Grannigan displayed threatening and jealous behaviours, and was both verbally and physically abusive towards Ms Robertson.

108. The history included numerous Domestic Violence Protection Orders (DVPO) and various breaches of those orders. In some instances Ms Robertson required the attendance of the QAS or admission to hospital for the treatment of injuries attributed to Mr Grannigan.

109. The documented history of violence between Ms Robertson and Mr Grannigan began in May 2003, and spanned right up until the night of Ms Robertson's death. It is clear that by late 2004, both Ms Robertson and Mr Grannigan had commenced relationships with other people. There are records confirming various domestic violence orders in place with respect to those relationships as well. Throughout 2005 until mid-2006, there are no records indicating any domestic violence orders in place between them.

110. For most of June 2006, a temporary protection order was in place, naming Ms Robertson as the aggrieved. However, from 26 September 2006 the situation had changed, and a two year protection order was put in place naming Mr Grannigan as the aggrieved. This order expired on 24 September 2008. From the records available to me, it is clear that for

the duration of this order, and up until early 2011, there are no records of domestic violence occurring between Ms Robertson and Mr Grannigan. Of note, from 24 September 2008, there was a period of about 2 ½ years where there are no protection orders in place between them.

111. By early 2011, Ms Robertson and Mr Grannigan were back together and there are more records confirming a violent relationship. In January 2011, Ms Robertson was admitted to hospital with a head injury, allegedly caused by Mr Grannigan. She had no memory of the event. In mid-July 2011, a domestic violence application was made by police in relation to an allegation by Ms Robertson that Mr Grannigan had caused her bodily harm. On 28 July 2011, Ms Robertson presented to the Townsville Police Station where she was taken to hospital due to the extent of her facial injuries.

112. In August 2011, a temporary protection order was granted on application by the police. On 9 September 2011, a protection order was made for a period of two years, with a mandatory condition that Mr Grannigan (respondent) must be of good behaviour towards Ms Robertson (aggrieved) and must not commit domestic violence. The order was served on Mr Grannigan on 6 October 2011.

113. By early 2012, Ms Robertson had commenced a relationship with another male. This relationship was also the subject of a protection order, granted upon application by the police. The situation throughout the remainder of 2012 is unclear, but by early 2013 Mr Grannigan had a further domestic violence application brought against him by another partner.

114. In February 2013, Mr Grannigan and Ms Robertson were back together and reportedly living with family. There were no documented reports of domestic violence from this time, at least up until Ms Robertson's death on 6 March 2013. The protection order made on 9 September 2011 was still in effect at the time of Ms Robertson's death.

115. The orders made throughout the relationship were as follows:

- 9 September 2011 – 8 September 2013 - Protection Order in place – Ms Robertson aggrieved
- 12 August 2011 – 9 September 2011 – Temporary Protection Order in place – Ms Robertson aggrieved
- 26 September 2006 – 24 September 2008 – Temporary Protection Order in place – Mr Grannigan aggrieved
- 8 June 2006 – 20 June 2006 - Temporary Protection Order in place – Ms Robertson aggrieved
- 13 April 2004 – 2 June 2005 – Further Protection Order made which amended the previous existing order – extra condition that Mr Grannigan not enter or remain in the premises where Ms

Robertson (or any of her associates/relatives/children) were staying/living/working – Ms Robertson aggrieved

- 3 June 2003 – 2 June 2005: Protection Order made – on 11 February 2004 Ms Robertson applied to vary the order so as to remove the no contact clause – application withdrawn – Ms Robertson aggrieved
- 19 May 2003 – 3 June 2003: Protection Order made – Ms Robertson aggrieved

Review by the Domestic and Family Violence Death Review Unit

116. In the lead up to the inquest, I was helpfully provided with a review of Ms Robertson's domestic violence history by Ms Susan Beattie of the Domestic and Family Violence Death Review Unit, which sits within the Office of the State Coroner. That review was informed by the brief of evidence, additional police records, as well as various health service records. It was tendered to me as part of the inquest brief.

117. It is clear from the review that Ms Robertson and Mr Grannigan were in an 'on and off' de-facto relationship for about ten years. They had known each since they were children on Palm Island. The records relating to their contact with the courts, police, and health services are sporadic. This is largely due to the couple separating for periods of time, during which both engaged in relationships with other people which were also characterised by violence.

118. Ms Beattie provided a detailed table capturing the history of violence between Ms Robertson and Mr Grannigan. She also provided a synopsis of that history, which I have reproduced below:

"*16 May 2003:*
Police made an application for a protection order after the couple attended the police beat where Elsie told police that James had punched her in the mouth a few days earlier on the 12 May 2003. The couple had been in an argument and he had been calling her a lesbian. The police officer sought extra conditions on the order, however the Magistrate was reluctant to make an ouster order as he was unsure where the couple were residing.

08 August 2003:
Police charged James with a breach of this order as they were called to a disturbance at a Hotel. James had grabbed Elsie around the shoulder and neck, attempting to drag her out of the door of the hotel. She has tried to break free and he has ripped her shirt off. She has then gone to the ground and started crawling under a pool table when he has grabbed her by the legs and tried to pull her out. Elsie has then crawled to the bar area and yelled for help and he was shuffled from the premises by others and left the scene.

14 October 2003:
Elsie was treated by paramedics for head injuries. She told them she had been punched and kicked by a male ex-partner, and they had a long history of similar abuse. She had injuries to her face and forearm, and said that she was unable to see out of one eye.

20 November 2003:
Police charged James with another breach of this order when they were called to respond to a fight where James had assaulted Elsie in the mall, he had punched her under the left eye causing bruising. He had left prior to police attendance and she refused to be taken to a place of safety, saying her sister would be unable to find her if she was taken anywhere. She was very intoxicated and uncooperative so police were unable to take a statement.

22 November 2003:
Police charged James with another breach of this order after Elsie told police that James had approached her when she was sitting with her sister, calling her a lesbian and threatening to kill her by hanging her. She was noted as being afraid for her safety and ran to get away from him. Elsie had numerous injuries including a black eye, a stab wound to the leg and finger marks on her throat.

21 December 2003:
Police charged James with a breach of the protection order, after they attended the residence and Elsie told them James had threatened her with a knife. This was confirmed by several residents from this address. Elsie told police that James had breached the order by forcing him to return to his residence with him a few weeks ago where he threatened her with a knife.

22 March 2004:
Police charged James with a breach of the protection order after she presented at the police station telling him he had hit her a few days before on the 18 March 2004 when they were walking home. She told police that James had kicked her and punched her with both hands to the face, with bruising and swelling to both eyes noted by police. She was noted as extremely intoxicated at the time of reporting, James had originally been with her when she went to the station, but he left before police had a chance to talk to him.

29 March 2004:
When police located James to talk about the previous incident, he denied any knowledge of the incident and didn't admit to the assault. He admitted to previously assaulting Elsie as 'they constantly fight and she swears and calls him names in front of friends and family'. He said that the relationship was over and maybe this is why she had made a complaint against him.

30 March 2004:
Elsie arrived at her uncle's house when James was there. He has approached her and attempted to punch her, she has used her uncle as a shield and stood behind him though James still managed to hit her. He has then grabbed her by the shirt around the neck whilst she was behind her uncle and tried to force Elsie to leave with him. Elsie has held on to her uncle to remain, her Aunty has then come down the stairs demanding James leave which he then did. Police noted injuries to both her eyes, forehead, rear of neck and head, right knee and left upper thigh, some of these were from previous incidents.

15 April 2004:
James was convicted and sentenced to six months for the aforementioned breaches of the protection order in place between James and Elsie and two counts of assault occasioning bodily harm.

<u>26 September 2006:</u>
James is listed as an aggrieved as Elsie as the respondent on a private application for a protection order. No further information is available from current records about this incident.

<u>29 January 2011</u>:
Elsie was admitted to hospital through the emergency department after being found collapsed by the roadside with a severe head injury. She later absconded from hospital on the 9 February 2011 and was treated by ambulance officers later that day. In July 2011 Elsie told police in early 2011 that James had bashed her so severely that she had been in intensive care but she couldn't make a complaint because she had no recollection of the incident due to her head injury.

<u>21-22 July 2011</u>:
James and Elsie were at her niece's house drinking together in the bedroom when he became angry and verbally abusive towards Elsie over her speaking to another man. He has then punched her in the face using both closed fists. She has attempted to cry out for help but James has held his hand over her mouth so that she could not be heard. She has then tried to cover her face with her arms, whilst he continued to punch her. This continued over two days with some respite in between assaults. He has remained in the house with her for two days prior to leaving.

<u>28 July 2011:</u>
Elsie attended the police station to make an assault complaint against James after the previous incident. Police called the ambulance officers to attend the station to treat her injuries. Police made an application for a protection order listing James as the respondent and Elsie as the aggrieved.

<u>24 August 2012:</u>
Elsie withdrew her assault complaint from 2011 saying that she no longer wished to support any action against James."

119. In addition to the history of domestic violence with James Grannigan, Elsie Robertson had a history of being named as both a respondent and an aggrieved in applications for protection orders with other men and women, specifically:

- 2004 – as an aggrieved with Shaun L (spousal relationship)
- 2005 – as a respondent with Shaun L (spousal relationship)
- 2005 – as a respondent with her father Lindsay R (family relationship)
- 2008 – as an aggrieved with Derek A (spousal relationship)
- 2009 – as an aggrieved with Sandra W (family relationship)
- 2012 – as an aggrieved with Daniel M (spousal relationship)

120. Mr Grannigan and Ms Robertson also had criminal histories for offences involving violence. In that context, the review noted that the experience

of Aboriginal and Torres Strait Islander peoples with family violence is qualitatively very different to that of other Australians. One simply has to peruse the histories of Ms Robertson and Mr Grannigan to appreciate the pervasive history of violence that occurred within both of their intimate partner relationships, and among both immediate and extended family networks. The review noted that the use of the term 'family violence' recognises that this type of violence occurs across a broader range of family relationships within Aboriginal and Torres Strait Islander communities.

121. From the evidence I heard at the inquest from Ms Conway, and also information I received from Ms Robertson's mother, it is clear that families, friends and witnesses tried to intervene on numerous occasions to stop the violence being perpetrated against Ms Robertson, and to stop Mr Grannigan from perpetrating further violence on both Ms Robertson and his other partners.

122. Ms Beattie's analysis of the records informed her opinion that, apart from the particular issues relating to the delayed response on the night Ms Robertson was killed, Queensland Police Service officers responded appropriately to the violence between the couple over time (as well as in their other relationships) having regard to the policies, procedures and legislation in place at the time. I do not underestimate the challenges associated with policing domestic and violence, particularly in circumstances where one or both parties are intoxicated.

Conclusions

Timing of the death

123. There is limited evidence to support the conclusion that the death may have occurred in the window between when the QPS was called and when they arrived, 9:00pm and 10:20pm. While Ms Robertson's body was warm to touch when she was found by ambulance officers, Dr Botterill's evidence was that this was not helpful in determining a precise time of death. There is more evidence to suggest that death happened at an earlier time, including:

    - The presence of dried blood on Ms Robertson's face and head;
    - Ms Conway had not heard anything from Ms Robertson for some hours before the QPS arrived;
    - Noises suggesting hitting/violence had been occurring all afternoon (from around 1:00pm – 7:00pm); and
    - Mr Grannigan's evidence that he punched Ms Robertson after they went into the bedroom to prevent her from drinking.

124. With respect to the issue of whether, in fact, the death occurred during the course of, or as a result of, police operations, I cannot be satisfied that Ms Robertson did not die sometime before the police were first called at 9:00pm.

How the death occurred

125. Elsie Robertson was in a relationship with James Grannigan. Mr Grannigan had a history of relationships with women characterised by domestic violence. His relationship with Ms Robertson was no different. There is sufficient evidence that here were arguments between the two and of subsequent violence towards Ms Robertson.

126. Ms Robertson died on the evening of 6 March 2013 at her aunt's unit in Cairns. This followed an afternoon of loud verbal conflict between Ms Robertson and Mr Grannigan, where he was heard to inflict blunt force trauma upon Ms Robertson.

127. There may have been more minor assaults throughout the course of the afternoon where the injuries caused would not have resulted in her death. After hearing from Mr Grannigan, I can conclude that she was struck on the head by his fists on more than one occasion. The force with which he struck her was sufficient to cause her death.

128. I am satisfied Ms Robertson died as a result of the direct actions of Mr Grannigan following his repeated assaults upon her.

Findings required by s45

Identity of the deceased – Elsie May Robertson

How she died – Ms Robertson died as a result of violence inflicted on her by her partner. There was a long history of domestic violence between Ms Robertson and her partner. This culminated in an afternoon of violence towards her in which she suffered repeated blows to the head, which ultimately resulted in her death.

Place of death – Boden Street, Edge Hill, Cairns in the State of Queensland

Date of death– 6 March 2013

Cause of death – Blunt force trauma to the head, on a background of alcohol and cannabis toxicity.

Comments and recommendations

129. Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

130. Ms Robertson was killed by her partner, Mr Grannigan. During the course of the inquest I heard evidence confirming the volatile nature of their longstanding relationship. Sadly, it is possible to conclude that domestic violence was a normal part of everyday life for Ms Robertson.

131. Domestic violence is currently an issue of considerable prominence. On 28 February 2015, the Honourable Dame Quentin Bryce AD CVO released the Domestic and Family Violence Taskforce Report (the Report): "Not Now, Not Ever: Putting an End to *Domestic and Family Violence in Queensland*". In that Report, it was aptly stated that "*fatalities are rarely without warning and are generally preceded by violent or abusive incidents indicating a heightened risk of future harm. It is because of these indicators that these types of deaths are considered some of the most preventable*." It is without a doubt that Ms Robertson's death occurred in this context, and was entirely preventable.

132. I acknowledge that the discussion of the context of Ms Robertson's death in these findings, and relevance of recommendations in the Report, has been largely informed by the comprehensive review prepared by Ms Beattie.

133. The Report's 140 recommendations for reducing domestic and family violence are extensive and cut across universal, primary and secondary systems; government, community and business sectors; and policy, funding and legislation. Of particular relevance to the coronial jurisdiction are:
    - Recommendations for strengthening the Domestic and Family Violence Death Review Unit within the Office of the State Coroner, and for establishing an independent multi-disciplinary Domestic and Family Violence Death Review Board; and
    - References to the inquest into the death of Noelene Beutel, and the adoption of a number of Coroner Hutton's recommendations.

134. Significantly, the Queensland Government has committed to the implementation of all 140 recommendations in the Report.

Family Violence in Aboriginal and Torres Strait Islander Communities

135. The Report makes it clear that family violence in ATSI communities is disproportionately high in comparison to the rates of the same types of violence in the Australian population as a whole.

136. Aboriginal and Torres Strait Islander women experience violent victimisation at an estimated rate 2 – 3 times higher than non-Indigenous women. The physical abuse they experience is also more severe, more frequent and leads to significantly higher rates of hospitalisations for assault related injuries. For Aboriginal and Torres Strait Islander females, rates for non-fatal family violence related assaults were 34.2 times that of other non-Indigenous females in 2012-13.[1]

137. As the Report highlighted, the violence and abuse experienced by Aboriginal and Torres Strait Islander people In Queensland is so disproportionally high and prevalent in some communities that it has become normalised, seen as inevitable and minimised to avoid confrontation or aggravating the situation.

138. ATSI male perpetrated violence can be understood as both an expression of patriarchal power and control but also as compensation for a lack of status, esteem and value associated with the disruption in the ATSI way of life that has taken place since colonisation.[2] It is also a reflection of the intergenerational trauma experienced by those who live in Indigenous communities.

139. Indigenous homicide is strongly correlated with high rates of alcohol consumption and high incidences of spousal or family violence. Alcohol misuse is not a causal factor for violence but it is a primary risk factor for violence perpetrated within Indigenous communities, increasing both the severity and incidence of abuse. Within ATSI communities, the risk of an Indigenous person becoming a victim of family violence has been shown to increase with the level of alcohol consumption.

140. There have been numerous inquiries that have found that the violence experienced by ATSI families and communities can be so disproportionally prevalent that it has become normalised, seen as inevitable and minimised to avoid confrontation or aggravating the situation. Families and kinship networks can play a positive role in supporting a victim of family violence and reporting the violence. However, family and kin may also play a negative role in pressuring a victim not to report domestic and family violence, particularly as there may be cultural pressures for the couple to remain together.

141. When violence occurs, witnesses may be traumatised but also ambivalent, with a propensity to look the other way, sympathy may be offered by female relatives but this falls short of encouraging victims to invite *a 'new set of problems'* by seeking support from police or courts.[3] There is an associated fear of having their children taken away, which is

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[1] *Overcoming Indigenous Disadvantage Indicators 2014 Report*

[2] C Cunneen, Alternative and Improved Response to Domestic and Family Violence in Queensland Indigenous Communities, Queensland Government, Department of Communities, 2010, page 32.

[3] Whilst this research is based in Canada, the circumstances of Aboriginal family violence have significant similarities to other first national peoples Dickson-Gilmore, J. (2014) Whither Restorativeness? Restorative Justice and the Challenge of Intimate Violence in Aboriginal Communities.

a barrier to seeking assistance from government agencies or other mainstream services.

142. It is clear that, in Ms Robertson's case, Ms Conway and Mr Donovan were reluctant to intervene, and in fact did not intervene until Ms Conway had a feeling or appreciation that Ms Robertson was badly hurt. It has been accepted that a lack of involvement by bystanders in domestic and family violence incidents has been attributed to a range of variables including fear of retaliation, or not wanting to get involved in what is seen as a private matter.[4] The Report makes a number of recommendations designed to lead sustained intergenerational change and to encourage appropriate intervention by bystanders.[5]

143. Government services and other agencies are not able to respond to most domestic and family violence incidents that occur because they simply are not reported or do not come to the attention of these organisations.[6] It is for this reason that the Report makes the following relevant comment, *'bystanders need to be able to recognise domestic violence and understand they have a moral and ethical obligation to act and how to take action'.*[7]

144. With respect to the Report's recommendations which relate directly to Ms Robertson's circumstances, I am satisfied that the following, if implemented, would have a direct impact on women in similar circumstances to Ms Robertson:

- Recommendation 3 – establishing an advocacy and audit oversight body, comprising representatives drawn from key sectors from the Queensland community (including ATSI representation) and with an independent chair.
- Recommendation 9 - developing a place-based, culturally appropriate integrated response to domestic and family violence in discrete Indigenous communities which includes:

> "*a. A trial of integrated service provision in one discrete Indigenous community utilising a locally-based shelter as a hub for the provision of wraparound support services for women and children affected by domestic and family violence*
> *b. Considering an expanded role of Community Justice Groups in design and implementation of the co-located service response, ensuring that they are properly resourced and supported to undertake this role*
> *c. Increasing the funding for, and availability of community-driven and holistic responses to Indigenous male perpetrators*."

[4] Lazarus, K. & Signal, T. (2013) Who Will help in situations of Intimate Partner Violence: exploring personal attitudes and bystander behaviours, *International Journal of Criminology and Sociology* 199-209.
[5] For example recommendations 12, 16, 18, 20, 21, 22, 23, 30 relate
[6] New South Wales Auditor-General's Report Performance Audit: Responding to domestic and family violence, Audit Office of New South Wales.
[7] *Not Now Not Ever: Putting an End to Domestic and Family Violence in Queensland* – It is critical that this action does not place the bystander at harm.

- Recommendation 15 - recognising the importance of community and government prevention programs for long-term reduction of domestic and family violence and giving a clear commitment to resource and support comprehensive and coordinated prevention. The Queensland Government must ensure both education and prevention initiatives and response programs receive funding.
- Recommendation 16 - leading and promoting sustained, inter-generational communication in the community about the seriousness of domestic and family violence, the community's intolerance of domestic and family violence, and the services available to victims and perpetrators.
- Recommendation 74 - establishing pilots for an integrated response model, incorporating:
    - One urban integrated response to domestic and family violence
    - One regional city integrated response to domestic and family violence, with outreach programs to rural and remote communities
    - One discrete Indigenous community integrated response
- Recommendation 80 - increasing access to domestic and family violence perpetrator intervention initiatives, prioritising those areas identified for the immediate rollout of integrated responses (Recommendation 74) with a view to ensuring Statewide coverage within three years.
- Recommendation 81 - changing eligibility criteria so offenders in custody for less than 12 months and for domestic and family violence related offences are able to access a range of therapeutic intervention programs.

145. It is clear that the overall effectiveness of Domestic Violence Protection Orders throughout the relationship between Ms Robertson and Mr Grannigan was minimal. The mandatory condition, namely not to commit domestic violence on the other, was of marginal effect. In this case, there was one instance in 2004 where there were additional conditions attached to the order, namely for Ms Robertson and Mr Grannigan to have no contact. This condition was also largely ineffective, and at one point Ms Robertson (as the aggrieved) appeared before the Court to apply for the condition to be removed.

146. I accept Ms Beattie's opinion that, apart from the response to the call from Ms Conway on the night of Ms Robertson's death, police officers responded appropriately to the ongoing violence between the couple. Constables Orr and Batticciotto acted professionally when they attended at the scene of the incident.

147. I accept that the recurrent utilisation of protection orders was a much preferred position to their being under-utilised, or not utilised at all. I also accept that there were significant issues in monitoring compliance with any orders, given Ms Robertson and Mr Grannigan's transient lifestyle.

148. With respect to the court process, and its overall effectiveness in dealing with domestic and family violence, I am satisfied that the implementation of the following recommendations will go some way to addressing the deficiencies:

- Recommendations 96-97-100 – establishing specialist domestic violence courts with appropriately trained Magistrates, particularly in rural and remote areas;
- Recommendation 117 – amend the *Domestic and Family Violence Protection Act 2012* to require a court, when making a DVPO, to consider whether a condition excluding the perpetrator from the home should be made, having regard to the wishes of the victim;
- Recommendations 118-121 – sufficiency of penalties for repeat contraventions of DVO's and consideration of the creation of further criminal offences and circumstances of aggravation for domestic violence related offences;
- Recommendation 123 – trialling the use of GPS monitoring for high risk perpetrators;
- Recommendations 124-125 – employing various court support workers at all Magistrates Courts for domestic and family violence matters;
- Recommendations 126-128 – implementing a State-wide duty lawyer service specifically for domestic and family violence matters;
- Recommendations 131-133 – consideration by the QPS of other investigation strategies and ways of gathering evidence for domestic and family violence matters;
- Recommendation 134 – that QPS adopt a pro-active investigation and protection policy requiring the consideration of the safety of the victim as being a paramount factor
- Recommendation 138 – a review of training packages available to police officers, with a view to assessing the appropriateness and frequency of compulsory professional development opportunities relevant to domestic and family violence; and
- Recommendation 140 – for a review of the *Domestic and Family Violence Protection Act 2012* to ensure a cohesive legislative framework for domestic and family violence, that incorporates the recommendations made in the Report

Police response

149. I asked that information be provided by the QPS about how Ms Conway's call would be dealt with if it occurred today. That information was provided to me by the Inspector of Policelink, Michael Volk and the A/Superintendent, Commander of the Police Communications Group, David Nevin. I am satisfied that where there was a deficiency in the police response, that has been adequately dealt with.

150. That information confirms that, since Ms Robertson's death in March 2013, the following reforms have taken place:

- All communications centres in Queensland have been moved under a centrally functioned model, with the effect that the Cairns PCC became one of 19 police communication centres which now fall under the organisational command of the Communications Group within the Community Contact Command;
- Seven of these communication centres (including Cairns) utilise the QCAD system, which is now linked throughout the seven communication centres so that priority incidents can be entered and displayed simultaneously between those centres across the State;
- When Policelink transfer an urgent incident to police communications centres by phone, these incidents are also transferred by the call taker via computer onto the QCAD system. Therefore, the information they are entering does not need to be duplicated as it appears on the screen of the call taker at the communications centre;
- The Cairns PCC has had an increase of seven staff since 1 July 2013.

151. The priority codes listed for urgent response within the QPS OPM's are priority code one for 'very urgent matters when danger to human life is imminent' and priority code two for 'urgent matters involving injury or present threat of injury to persons or property.' With respect to responses to calls for service relating to domestic violence, this process now ensures that computer checks and further information is obtained while the crew is on the way to the job, reducing the response time.

152. With respect to the Report's recommendation 138, relating to training of police officers in relation to domestic and family violence, I note that in this case the call from Ms Conway was handled by administrative officers, before the response was passed on to sworn police officers.

153. I recommend that the QPS extend the implementation of recommendation 138 to all officers within the QPS who are likely to have contact with domestic violence situations, irrespective of whether they are administrative or sworn officers.

154. Given the Government's commitment to the implementation of all of the recommendations from the *Not Now Not Ever: Putting an End to Domestic and Family Violence in Queensland*, and the response received from the QPS to the specific issues identified by this matter, I do not consider that there are any further recommendations I could reasonably make at this time to prevent a similar death from occurring in the future. The circumstances of Ms Robertson's death are a timely reminder of the need for major reforms such as these to be implemented.

155. I close the inquest.

Terry Ryan
State Coroner
CAIRNS
23 October 2015