QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Noelene Marie Beutel**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/2288
DELIVERED ON:	17 November 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 June, 14 August & 3 September 2014
FINDINGS OF:	Mr John Hutton, Coroner
CATCHWORDS:	CORONERS: Inquest – Domestic violence, homicide, privacy, information sharing, police, General Practitioners

REPRESENTATION:

Counsel Assisting:	Mr Anthony Marinac
Senior Constable Jennifer Black Senior Sergeant Gary Brayley Sergeant Neville Horneman:	Mr A Braithwaite of Gilshenan & Luton i/b QPUE
Commissioner of Police Inspector John Lewis:	Mr M Nicolson i/b Public Safety Business Agency
Centacare:	Ms Megan Kavanagh of Minter Ellison
Dr Paul McKibbon:	Mr Harry McCay i/b Avant Law
Senior Constables Craig Hughes Calvin Hartzenberg:	Mr Troy Schmidt i/b QPU

Findings pursuant to s. 45(2) of the *Coroners Act 2003* in relation to the death of Noelene Marie Beutel

The deceased person is Noelene Marie Beutel, DOB 1 October 1974.

Noelene Marie Beutel died as a result of a traumatic blow or blows to the head.

Noelene Marie Beutel died on the night of 29 June 2011.

Noelene Marie Beutel died in Buderim in the state of Queensland.

The principal cause of Ms Beutel's death was a series of assaults perpetrated upon her by Wayn McClutchie.

Evidence and discussion of general circumstances of death

Ms Noelene Marie Beutel was born on the 1 of October 1974, and she died on the 29 June 2011, after she was struck by at least one massive blow to her head. The blow was inflicted by her partner, Wayn McClutchie, who then sought to dispose of Ms Beutel's body by incinerating her in the boot of her car.

This basic account of Ms Beutel's death is uncontested, and is a matter of record. In the course of this inquest I have reviewed the sentencing remarks made by Lyons J in sentencing Mr McClutchie, and there is little for me to add.

Following Ms Beutel's death, however, a Queensland Police Service homicide audit indicated that there had been prior contact between Ms Beutel and police, and that there were errors – perhaps crucial errors – made by police in the course of that contact. This was properly reported by the QPS to the Office of the State Coroner's Domestic and Family Violence Death Review Unit, and a coronial investigation ensued. In the course of that investigation it became apparent that Ms Beutel had engaged with a range of agencies and persons whose purpose was to assist her – and yet despite all of this engagement, she was still subject to fatal domestic violence.

The purpose of this inquest, as I stated at the outset, was to look into the wider systemic circumstances of Ms Beutel's death, in order to determine what if anything could be learned from the tragic circumstances presented in the short summary above.

Jurisdictional Issues

Before I direct these findings to the systemic issues relating to Ms Beutel's death, I must dispose finally of certain submissions which were made to me, to the effect that I was *ultra vires* in conducting this inquest, or that I would exceed my authority under the *Coroners Act 2003* if I were to make certain recommendations.

Capacity to inquire

At the first Pre-Inquest Conference into this matter, I directed Counsel Assisting to engage with the various parties who were then represented, to determine whether there was a consensus among those parties as to the types of systemic recommendations which might be made after considering the circumstances of Ms Beutel's death. The statutory foundation of my direction to Counsel Assisting can be

found in section 37(1) of the Coroners Act, under which I am able to inform myself in any way I consider appropriate.

At my direction, Counsel Assisting circulated some points for discussion, and then convened a round-table discussion of all parties, held on 4 August 2014 in the Brisbane Magistrates Court building. Parties were entitled to bring legal representatives to that discussion. Following the discussion, Counsel Assisting developed a number of possible recommendations, and reported these in a memorandum which was circulated to all parties and then handed up to me at the second pre-inquest conference.

It is important to recognise that these were not the recommendations of Counsel Assisting (who, like all other participants in this inquest, had not at that time had the benefit of hearing oral evidence). Rather, they were a response to my direction, and a best-effort on the part of Counsel Assisting to identify the areas of consensus and difference. In my view, this process substantially reduced the eventual length of the inquest, and also allowed much more direct participation by parties such as social workers and government officials.

It was put to me in oral submissions, and again in written submissions on behalf of the Queensland Police Service, that a number of the recommendations advanced in Counsel Assisting's summary were beyond my jurisdiction, in essence for two reasons: first, that they were unsupported by evidence; and second, that they were not matters 'connected with' Ms Beutel's death. I will deal with each of these objections in turn.

The question of whether the proposed recommendations were supported by evidence can be disposed of very shortly. There was a substantial amount of evidence in the Brief of Evidence, which could easily have formed the basis of the recommendations contained in the summary produced by Counsel Assisting. Further, it was never proposed that I would make recommendations without hearing oral evidence. Much of the oral evidence before me related to the matters raised in the summary produced by Counsel Assisting. Virtually none of this evidence was objected to specifically (although I recognise that counsel for both the QPS and the Queensland Police Union objected to the inquest proceeding at all). I am satisfied that the recommendations which I will make in these findings, are all appropriately supported by evidence.

The more difficult question is whether the matters canvassed in the summary produced by Counsel Assisting, and the matters canvassed at the inquest itself, were within my power. I acknowledge the submissions of Counsel on this point, and the cases to which I was led in written submissions.

In essence, the argument put by the QPS is that the power of a coroner to make comments and recommendations under s. 46 of the Coroners Act is essentially derivative, and flows from the coroner's functions under s. 45 of the Act. In other words, the submission of counsel is that the inquest, and the evidence heard at the inquest, should be directed to the s. 45 matters, and that comments or recommendations made under s. 46 should proceed from those. This view is well-expressed in *Thales Australia Limited v The Coroners Court of Victoria & Anor* [2011]

VSC 133, to which Counsel for the QPS led me. In that judgment, Beach J stated (at [67]):

It may be accepted that a Coroner is not permitted to inquire for the sole or dominant reason of making comment or recommendation. The power to comment arises as a consequence of the obligation of the Coroner to make findings (if possible) as to the identity of the deceased, the cause of death and the circumstances in which the death occurred.

Allowing for variations in the statutory schemes between Victoria and Queensland, I accept this as a reasonable statement of the position under Queensland law. However I do not accept that the inquest in this matter proceeded beyond Beach J's warnings.

The evidence taken at the inquest, and the evidence obtained during the coronial investigation which preceded it, was directed squarely at understanding the circumstances of Ms Beutel's death. It is in my view self-evident that when a member of the community has a range of contact with police, hospitals, general practitioners, and domestic violence agencies, all within the six months preceding her death, and all relating specifically to her experience of domestic violence, then *all* of these system contacts form relevant circumstances to her death. In answering the question 'How did Noelene Beutel come to die?' one of the most important underlying questions is 'How is it that all of these systems, established to protect victims in her circumstances, ultimately failed?'

To understand how the system failed Ms Beutel, it was necessary for me to obtain a broader, more schematic understanding of the system itself; of how it is meant to work in ideal circumstances; of how it's various elements articulate to one another. All of the evidence which was placed before me in the Coronial Investigation, and in the Inquest, was squarely focused on this function, which I address in substance below.

Having properly obtained this evidence in pursuit of my duties under s. 45, it was open to me to comment and make recommendations. The recommendations which I make in this paper are connected with Ms Beutel's death, because in my view the implementation of these recommendations prior to 2011 would have *reduced or prevented* Ms Beutel's death. I therefore dismiss this first jurisdictional objection.

Recommendations

It was put to me by Counsel for the QPS, both orally and in written submissions that it is beyond my power to recommend changes to police procedures, including disciplinary procedures, because by doing so I would constrain the statutory discretions of the Police Commissioner. Written submissions for the QPS stated:

> Pursuant to section 4.8 of the *Police Service Administration Act 1990*, the Commissioner is responsible for the efficient and proper administration, management and functioning of the police service in accordance with law. Subject to those restrictions outlined in section 4.8(4) of the *Police Service Administration Act* or elsewhere in law, the Commissioner has an unfettered discretion with respect to the discharge of that responsibility.

It is unclear to me how comments under s. 46 of the Coroners Act could possibly constitute a fetter on the discretion of the Queensland Police Commissioner. Recommendations made by a coroner are just that: recommendations. It might be that in the normal processes of democratic accountability a Police Commissioner might be asked – by the Minister, or an Estimates Committee, or the media – why the Police Commissioner did *not* adopt a particular recommendation, but ultimately such impetus comes from parties outside the inquest. I am empowered to make recommendations to the Commissioner. I am not entitled to direct the Commissioner. I know of no proposal, put by any party to this inquest, that I should do so.

With this distinction understood, in my view the making of recommendations intended to improve systems and prevent future similar deaths may well be the very soul of the coronial jurisdiction. When the then Coroners Bill 2002 was introduced, Attorney-General Welford stated, in his second reading speech, that the new legislation would have:

> *a focus on identifying emerging patterns and all our coroners will have powers to recommend changes to prevent future deaths […] Nearly 3,000 deaths a year are reported to coroners throughout the state requiring some level of investigation. An effective and efficient coronial system can play a valuable role in preventing future deaths*.[1]

There is recent authority in relation to the scope of a Coroner's capacity to make recommendations. In *Goldsborough v Bentley* [2014] QSC 141 the Supreme Court was asked to determine whether a Coroner had the power to make comments about whether or not a prosecution should have commenced against a person. The court found [at 21]:

> *that s. 46(1)(b) empowers a coroner to expose something which, in the public interest, could be the subject of an appropriate comment by a coroner. In general, an expectation that offences will be prosecuted is thought to have the potential benefit of deterring others from committing like offences. If there was some policy being applied by the agency which was having the consequence that for no good reason, persons were not being prosecuted by the agency in similar circumstances, then that policy would be a matter relating not only to the administration of justice, but perhaps also to a way to prevent deaths from happening in similar circumstances in the future.*

The effect of this is that a coroner has the capacity to comment upon some of the deepest and most discretionary powers of the executive. If a Coroner is able to comment on the question of whether a prosecution should have been commenced, a Coroner should certainly be able to recommend changes to procedures or processes of the Queensland Police Service. I therefore dismiss this second jurisdictional concern. However I note the concern that my recommendations must be 'connected with' the death. Given the expression of this concern, these findings will make that connection explicit in relation to each recommendation which I make.

[1] Hansard, 3 December 2002, 5220-5221

With these jurisdictional concerns dealt with, I now proceed to findings in relation to this death.

Queensland Police Service handling of Domestic Violence matters

Considerable evidence was placed before the court regarding the handling of domestic violence matters by the Queensland Police Service. A number of specific issues should be dealt with.

Changes to police procedure since the death

I accept evidence which was put to me to the effect that new Operational Procedure Manuals (OPMs) have been implemented since the time of Ms Beutel's death, effectively implementing changes to the statutory framework for domestic violence. I therefore accept that there is little value in me making recommendations based upon the OPMs which were in place at the time of this death.

The current OPMs were not ventilated before me in any depth, and I therefore do not propose to make specific recommendations in relation to them. However the comments which I make below, may (if implemented) require consequential changes to the OPMs.

Officers Hughes and Hartzenburg

Officers Hughes and Hartzenburg attended upon Ms Beutel in hospital after she had been attacked by Mr McClutchie six months prior to her death. Ms Beutel was uncooperative and antagonistic towards them. I consider that the most likely cause of Ms Beutel's responses to police were primarily the product of her fear and distress; both for her own welfare, and for that of her daughter, Trinity, who was at that time in the immediate care of the man who had inflicted her injuries. It appears to be accepted by all parties that the police officers, in turn, responded poorly to Ms Beutel's aggression and 'wrote off' the job rather than endeavouring to see behind Ms Beutel's attitude and investigate further.

The two officers subsequently received 'managerial guidance' in relation to their conduct. I comment on the issue of managerial guidance below. In my view, the failure of the police officers to proactively investigate the circumstances which were disclosed to them by hospital staff at the time of this incident, was a lost opportunity.

Intercession by police with Mr McClutchie at that time may well have caused him to reassess his future conduct, particularly as he was not an Australian citizen and might therefore be subject to deportation away from his daughter in the event that he continued to offend. The importance of proactive, dedicated policing in relation to domestic violence simply cannot be overstated. It was absent in this case.

Managerial Guidance

'Managerial Guidance' within the QPS appears to be a very broad administrative tool which is not precisely disciplinary in nature, but rather is directed to identifying and correcting conduct where the officer has fallen short of the service's expectations. Such a tool is entirely appropriate – it would be unwieldy to endeavour to use disciplinary processes every time an officer fell short of expectations.

However, managerial guidance appears to be very ill-defined. It was put to me in evidence that managerial guidance might constitute as little as a brief, verbal

discussion from a senior officer, through to effecting a written reprimand, backed by retraining. In this case, the response was closer to the latter than the former. I am persuaded that the managerial guidance given to the offices was appropriate, however this occurred because of the diligence of the station OIC, not due to any systemic factors.

I accept that a certain amount of discretion is necessary for a process such as managerial guidance to work, but I am concerned that it appears so ill-defined. Counsel Assisting put to me in written submissions that managerial guidance which follows a failure to follow procedures in a DV matter should result in corrective training, unless the station commander determines otherwise.

I accept the spirit but not the detail of this submission. In my view, isolating domestic violence failures and treating them differently from any other form of poor performance may result in a more unwieldy, less useful system of managerial guidance. However the QPS should consider implementing, and promulgating to station officers-in-charge, examples of the types of training and consequences which might properly accompany managerial guidance, and guidelines on the considerations which the station OIC should have in mind when determining the appropriate form of managerial guidance.

This observation is 'connected with' the death of Noelene Beutel because it arises directly from evidence about the managerial guidance given to two police who had attended upon her.

Domestic and Family Violence Coordinators

In the course of the inquest oral evidence was given by Sergeant Scott Woodward, the Domestic and Family Violence Co-ordinator (DFVC) who conducted the homicide audit into this death, and by Senior Constable Jennifer Black, the Nambour station Domestic Violence Liaison Officer (DVLO). Both of these witnesses were professional and straightforward, and I have attached substantial weight to their testimony.

I found both of these officers to be extremely impressive, in particular their knowledge of, and dedication to, the policing of domestic violence. If they are representative of the DFVCs and DVLOs throughout the state, then then the service would do well to encourage and empower these officers. Evidence before me, however, is that these officers are too few in number, and are unable to effectively carry out all of their duties, particularly in areas where domestic violence is prevalent. I accept the evidence that domestic violence is not evenly spread throughout the state, but is more characteristic of some communities than others. Evidence before me also indicated that there is no longer a state wide coordinator for these officers that function having been rolled into the Public Safety Business Agency, with the operational functions of that position rolled into the far-broader duties of an Assistant Commissioner.

Both Sergeant Woodward and Senior Constable Black indicated that more resources were required, and a state wide coordinator whose duties were either solely or primarily focused on domestic violence, would assist them in their duties.

I therefore recommend that additional DFVC positions should be established in parts of Queensland where domestic violence is prevalent, and that a state-wide coordination role should be re-implemented within police headquarters.

This recommendation is 'connected with' the death of Noelene Beutel as the recognition of police involvement hinged almost entirely on the work of Sergeant Woodward, whose audit identified the relevant deficiencies. More work of this type, identifying and seeking to correct deficiencies, will undoubtedly prevent future similar deaths.

It was put to me that a recommendation of this type is beyond my power, as it may seek to direct the Commissioner in the application of police resources. For reasons already stated above, I reject this submission.

Identifying DV incidents

Evidence before me, particularly from Senior Constable Black and Senior Sergeant Brayley, indicated that there remains a potential problem with the identification of domestic violence incidents. In essence, if a matter is reported to police communications as an *assault* rather than as a domestic violence incident, and is detailed to the attending officers with the assault job code, then the incident may never be flagged in the QPS system as being DV-related. Ideally, the attending officers will reclassify the job, but there is no safeguard in the system if this does not occur. The result would be that the secondary review processes (by, for instance, the DVLO) would not be engaged. In the current case, the assault on Ms Beutel six months before her death never came to the attention of DV specialists for this reason.

Evidence before me is that this vulnerability remains, despite the recent changes to police OPMs.

Counsel Assisting submitted that police obtaining a 'notebook statement' to the effect that a person does not wish to pursue an assault complaint, should be required to specifically include words to the effect that no DV relationship exists between the parties (and should be required to undertake reasonable inquiries in this regard). There is merit in this submission, but I am cautious about being prescriptive at this level. Instead, I recommend that the QPS should note this potential vulnerability in its processes and identify an appropriate and realistic way to ensure, so far as possible, that domestic violence assaults are not misclassified as non-domestic violence assaults.

This recommendation is 'connected with' the death of Noelene Beutel as the failure to correctly classify her initial assault complaint meant that there was no involvement in her case by QPS DV specialists until after her death.

Police culture in relation to domestic violence

Finally, evidence was led in relation to police culture regarding domestic violence. In particular, I noted the evidence of Dr Silke Meyer, to the effect that many victims of domestic violence have problematic relationships with police generally; and that many of them do not present as 'ideal victims' who are otherwise law-abiding. I recognise that many victims in these circumstances (including Ms Beutel) may present as aggressive and uncooperative. I recognise, as testified by Senior

Constable Black, that many police find this to be extremely frustrating, especially in circumstances where they may be called to intervene in the same relationship time and again, following contraventions of protection orders (which are not then formally pursued by the victim).

I recognise also, however, evidence from the QPS that the QPS as a whole expects every victim to be dealt with on the same terms, regardless of their background, circumstances, or prior history with police.

The assembled evidence suggests to me that while there is an organisational expectation that all victims will receive the same support the reality of policing domestic violence is far more complicated, and police continue to experience continual frustration. It seems almost inevitable that this frustration will result – as it did in Ms Beutel's case – in police adopting a minimalist approach, 'writing off' complaints where they believe this can be accomplished.

In my view, the best way to align front-line policing with organisational expectations is to provide greater oversight by the DVLOs and Domestic and Family Violence Coordinators, which emphasises the importance of appropriately resourcing and leading these positions.

The role of General Practitioners

Considerable evidence was presented to me regarding the role of the General Practitioner, Dr McKibbon, and the role of GPs in relation to domestic violence generally. It is clear to me that Dr McKibbon was in an unenviable situation. He was managing the complex medical circumstances of both the perpetrator and the victim of this domestic violence situation. It appeared to him that it would have been improper medically for him to cease seeing Mr McClutchie, who had serious and ongoing workplace injuries; at the same time, he received crucial information about the progressing domestic violence against Ms Beutel, and felt unable to do anything more than encourage her to leave.

I have noted the Royal Australian College of General Practitioners publication *Abuse and Violence*, which was unknown to Dr McKibbon at the time he was treating Ms Beutel. However I note that even in this publication, there is no attempt to be prescriptive. Ultimately, a GP will still be required to balance the overall medical circumstances of each patient, in determining whether to treat one, both, or neither party to a domestic violence relationship. To that end I accept Dr McKibbon's written submission that even if he had known of the guidelines, his decisions may have remained the same.

In my view the question of whether a GP should treat one, both or neither party; and the question of what protocols should apply, is an extremely important question which has been exposed, but not resolved, by the evidence before me. This question requires far more ventilation and discussion at a policy level. The appropriate recommendation for me to make, as a result, is that the medical profession itself, along with the Queensland Government (including the current inquiry underway by Her Excellency Dame Quentin Bryce) should explore this issue further with a view to establishing simple guidelines to assist GPs. The publication *Abuse and Violence* is a good start, but this case suggests that further work to clarify and promulgate appropriate advice is necessary.

This recommendation is 'connected with' the death of Noelene Beutel as it arises directly from observations of the difficulties encountered by Dr McKibbon in treating her.

I noted the evidence of Dr McKibbon that he did not, at any time, feel that Ms Beutel was in such immediate peril that he would have been justified calling the police and reporting her circumstances. He could only have done so with her consent – and her consent was problematic during the relevant period, as her consent would have been continually circumscribed by the domestic violence inflicted upon her (or threatened towards her).

Counsel assisting submitted that a GP who becomes aware that a victim of domestic violence has engaged with support services, should be able to share information with those support services, even without the consent of the victim, and even in circumstances where there is no immediate, direct or imminent threat of harm. This submission is problematic, however, as those agencies themselves may encounter difficulties in terms of how they use and record such information. Such a broad capacity for GPs to circulate information may in my view have a perverse effect, by inhibiting victims from going to the GP in the first place.

I consider the more appropriate option to be allowing GPs to report their concerns to police. This information could be passed in the nature of a confidential intelligence submission. Under those circumstances, police involved in supporting the victim, or involved in the interagency support model I recommend below, could be more fully informed. The implementation of this recommendation would require appropriate legislative amendments, and no doubt the broader community consultation processes with accompany such amendments.

This recommendation is 'connected with' the death of Noelene Beutel as it arises directly from observations of the restrictions upon Dr McKibbon in passing on information for her welfare and protection.

Domestic and Family Violence Orders

Following the incident of violence six months before Ms Beutel's death, she made a private application for protective orders. She was assisted in the preparation of her application by SCOPE, an agency of Centacare. It was put to me, and to a number of witnesses, that the (successful) application for protective orders effectively cured any deficiencies in the conduct of officers Hughes and Hartzenburg. There is some logic in this submission.

However, the statute clearly contemplates that persons who are the victim of domestic violence may be unable to effectively represent themselves in such application processes. Even with SCOPE's assistance, Ms Beutel applied only for the most basic of protective orders. Other options which the court might, on application, have considered might have included (most obviously) an ouster provision. Beyond this, protective orders are extremely flexible, enabling the court (with an appropriate application) to frame specific orders suitable to protect the vulnerable parties.

I do not consider that the failure of police to seek protective orders on Ms Beutel's behalf was cured by her private application. The material which officers Hughes and

Hartzenburg might have placed before the court – particularly if they had properly and fully investigated the matter – would have enabled the court to consider orders more effectively adapted to Ms Beutel's circumstances.

Other agency involvement

I acknowledge the considerable assistance provided to Ms Beutel and to this inquest by various other agencies, most notably DV Connect, SCOPE, and the Nambour Hospital. Within the constraints of resources, and with the information available to them, these agencies did what they could to assist Ms Beutel. They have all also undertaken reviews of their own processes following her death. Nothing in these findings should be taken as adverse comments in relation to them.

Models for improvement

With the above findings in mind, I turn specifically to ways in which future similar deaths might be prevented.

The 'SCAN Team' approach

Where a child is at risk in Queensland, a 'Suspected Child Abuse and Neglect' (SCAN) team may be formed to protect that child and manage their circumstances. In evidence before me, it became clear that the series of deficiencies in Ms Beutel's only came to light because of SCAN team reporting mechanisms inspired by concern for Ms Beutel's daughter Trinity. The SCAN model appears to allow information sharing, and cooperative action, in a way which has no parallel in the DV system (at least in relation to adult victims).

I recognise that SCAN teams operate in relation to children, who have no legal personality. As a result, the SCAN team model on its own may not be appropriate in relation to adults, who expect to be able to make decisions in their own regard. As a result, a SCAN-type model would require substantial adjustment in order to be effective in relation to adults. Identifying and testing those adjustments was well beyond the scope of this inquest. However my view, based on the evidence before me, is that such a model offers the prospect of better protection for the victims of domestic violence.

I therefore recommend that appropriate government agencies should examine the SCAN model and, using that model as a base, should develop a similar team-based approach to supporting victims of domestic violence.

This recommendation is 'connected with' the death of Noelene Beutel as it squarely addresses the information sharing difficulties which, in my view, made it impossible for various agencies to respond optimally to Ms Beutel's circumstances.

A one-stop shop

The inquest heard evidence in relation to a 'One-stop shop' for Domestic Violence in San Diego, in the United States of America. This agency contains offices from various organisations (government and non-government) whose purpose is to assist victims of domestic violence. Instead of a vulnerable person being required to repeat their circumstances over and over to various agencies, and instead of them being required to attend separately upon various agencies, they are simply able to go to one place and access everything from police support, to health support, to housing and welfare support, to legal support and advocacy.

Evidence did not reveal substantial detail about this model, or how it operates. However at a conceptual level, this idea appears to have considerable merit. In my view, one of the circumstances which contributed to Ms Beutel's death was that she was dealing with various agencies, none of whom knew her full circumstances, and none of whom were able to cooperate. A central, collaborative, empathetic space containing all of these agencies may have made a substantial difference. In particular, an institution of this type may have enabled her to exit her relationship with Mr McClutchie safely instead of tragically.

The key recommendation for this inquest is that the relevant government Departments should establish an appropriate interdepartmental process, with engagement from appropriate community organisations, with a view to establishing a pilot 'Domestic violence centre' in an appropriate part of Queensland. This process should be informed by these findings.

This recommendation is 'connected with' the death of Noelene Beutel as it squarely addresses the information sharing difficulties which, in my view, made it impossible for various agencies to respond optimally to Ms Beutel's circumstances.

Common assessment tool

Finally, it emerged in evidence that the various government and non-government agencies in Queensland use quite different assessment tools when assessing a relationship characterised by domestic violence. For instance, different 'risk factors' might be considered by police, and by an agency like DV Connect.

This variation is not intrinsically bad. The various organisations have different functions, and therefore may have different informational needs. Some of the agencies work at the immediate point of crisis; some work to strengthen relationships and reduce risk. I understand from the evidence before me, however, that other Australian jurisdictions have developed a common assessment tool, which means that when agencies cooperate with one another in relation to a vulnerable person, they are 'speaking the same language' and communication difficulties are reduced.

There is considerable merit in such a tool, and I recommend that one should be developed (or at least assessed) for Queensland.

This recommendation is 'connected with' the death of Noelene Beutel as it squarely addresses the information sharing difficulties which, in my view, made it impossible for various agencies to respond optimally to Ms Beutel's circumstances.

Summary of recommendations

The key recommendation for this inquest is that relevant government Departments should establish an appropriate interdepartmental process, with engagement from appropriate community organisations, with a view to establishing a pilot 'Domestic violence centre' in an appropriate part of Queensland.

This recommendation should align with the implementation of a model similar to a SCAN team for victims of domestic violence; and the implementation of a common assessment tool for agencies dealing with domestic violence victims.

I recommend that General Practitioners treating victims of domestic violence should be able to report concerns about their patients confidentially to police, even in circumstances where there is no immediate and severe threat to the patient's life.

Further, I recommend that the medical profession itself, along with appropriate government agencies should establish simple guidelines to assist GPs who are treating victims of domestic violence.

In relation to the policing of domestic violence, I recommend the following:

- the QPS should consider implementing, and promulgating to station officers-in-charge, examples of the types of training and consequences which might properly accompany managerial guidance, and guidelines on the considerations which the station OIC should have in mind when determining the appropriate form of managerial guidance;

- that additional DFVC positions should be established in parts of Queensland where domestic violence is prevalent, and that a state-wide coordination role should be re-implemented within police headquarters; and

- the QPS should identify an appropriate and realistic way to ensure, so far as possible, that domestic violence assaults are not misclassified as non-domestic violence assaults.

I close the inquest.

John Hutton
Coroner
Brisbane
17 November 2014