



CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION: **Non-inquest findings into the domestic violence related death of a First Nations woman**

TITLE OF COURT: Coroners Court

JURISDICTION: BRISBANE

DATE: 22 July 2024

FILE NO(s): 2019/5573

FINDINGS OF: Ainslie Kirkegaard, Coroner

CATCHWORDS: CORONERS: non-inquest findings; domestic and family violence related death; First Nations female victim; intimate partner violence; coercive control; multiple service system contacts (police, justice system, health); interagency information sharing; missed opportunities for greater agency collaboration and referral to a specialist domestic and family violence service/integrated service response

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Background

1. Ms M was a 31-year-old First Nations woman who was found deceased at her home on 10 December 2019. Ms M lived with her partner, P, a First Nations man (age 36). They were the only occupants, apart from P's brother, who worked fly-in fly-out in the mines. Ms M has two children. She was unemployed and in receipt of Newstart Allowance at the time her death.
2. Ms M's death was reported to the coroner because she died in suspicious circumstances and the cause of her death was unknown.

Ms M's family history

3. As a child, Ms M and her siblings were placed under long term guardianship orders and lived in out of home care from when she was two years old. Ms M moved placements many times, living with a range of family and carers. Ms M's mother died by suicide in 1998. It is understood Ms M had witnessed her mother's death, an experience that left her with significant unresolved grief and trauma. Child Safety records indicate Ms M had experienced domestic and family violence including sexual abuse while living in a kinship care arrangement growing up. She was a talented athlete, excelling at athletics as well as netball. She described having experienced racism while playing netball and having been denied opportunities as a result of her being Aboriginal.
4. Ms M left school at 15 after completing grade 10. She had periods of employment but nothing long term or stable. Ms M's first child was born in 2005 when Ms M was 16 years old. In 2006 she received her first custodial sentence. She had her second child in 2011. Child Safety services were involved from the time of each child's birth and the two children were being cared for by family members. It appears Ms M had inconsistent contact with them and described feeling remorse and guilt for her own behaviour as a mother.

Ms M's mental health and substance use

5. Records indicate Ms M had experienced significant episodes of depression and been suicidal in the past. She was noted to be exhibiting signs of post-traumatic stress disorder though did not have a formal diagnosis. Medical records describe her having issues with anger, poor emotional regulation and negative perceptions related to shame, guilt, worthlessness, and hopelessness. This was noted to occur against a background of unpredictability and instability arising from her involvement with the child safety system.
6. Ms M had started using drugs at age 12 and was using heroin as a teenager. She felt she experienced severe depression after her first child was born, and this is what turned her to alcohol and drugs. She was using methylamphetamine and cannabis daily and occasionally used Lyrica and Tramadol. She described her drug use as not excessive; rather she used these substances to cope with life stressors and 'chill out'. She had previously been involved with Alcohol and Other Drugs services and been referred to substance use programs.

Ms M's interactions with the justice system

7. Ms M had a youth justice history dating back to 2004 when she was 16 years old, with mostly minor, non-violent offending though she had also been convicted of several obstruct/assault police officer offences. Ms M had been imprisoned on several

occasions, mostly for short periods of several days but had several longer sentences of several months. She had also been subject to community supervision orders and numerous fines. At the time of her death, Ms M was being case managed through the Magistrates Court in relation to a series of minor non-violent offences, with subsequent Murri Court involvement. Ms M also had a significant State Penalties Enforcement Registry (SPER) debt of \$14,500 at the time of her death, accumulated since 2005 primarily due to transport (no ticket) and alcohol consumption on transport fines. Ms M was interested in participating in a SPER Work and Development Order when she first engaged with the Aboriginal and Torres State Islander Service (ATSILS) in early 2019, expressing an interest in working at an indigenous health service.

Ms M and P's relationship history

8. Ms M had been in an intimate partner relationship with P for about a year. They lived together at a property in an "on-and off" basis. P had inherited the house following his mother's death. It appears Ms M's Centrelink payments were being paid into P's account, leaving her financially dependent on him.
9. P had a long history of perpetrating physical and sexual violence towards his intimate partners and their children. He began displaying violent tendencies from a young age. He had grown up exposed to violence and alcohol abuse in the family, housing instability and was the victim of childhood sexual abuse. P had attended a special education school until grade 8, had limited education and was functionally illiterate. He had never been employed. He misused alcohol and illicit drugs. He had been diagnosed with an antisocial personality disorder with psychopathic traits and borderline intellectual functioning. He had never had steady employment.
10. P had a significant criminal history dating back to his early teenage years, including violent and non-violent offending.
11. At age 19, P sexually assaulted a two-year-old girl and assaulted two little boys (aged 4 years and 6 months) who were the children of his partner at the time. All three children suffered repeated, serious physical violence from P with the female child suffering both physical and sexual violence with significant injury. All three children suffered bites, subconjunctival haemorrhages, bruising and burns. P also perpetrated violence towards their mother, had indecently assaulted another 18-year-old woman in a nightclub and committed robbery with violence against a 21-year-old woman not known to him. P was convicted of these offences and served a period of imprisonment after which he was released on a supervision order under the *Dangerous Prisoner (Sexual Offender) Act 2003* for a 10-year period from 2007– 2017. He had been assessed as being at unacceptable risk of committing a further serious sexual offence without supervision. At that time, forensic psychiatric assessment identified "... *the most likely and imminent risk would be of further 'intimate partner violence'. In this regard, [P's] recent presentation in sessions and current situation indicates that he possesses many of the factors associated with increased risk, these being 'recent relationship and employment problems'; 'personality disorder'; 'recent escalation of conflict'; 'extreme minimisation' and 'attitudes that condone spousal assault'*".
12. P received intensive psychological interventions, including fortnightly counselling from the Forensic Psychology Service, over the course of his imprisonment and during the supervision order. It was noted "*Police dealings over the domestic violence allegations hasn't ever led to any type of concrete outcome that can be used makes it easy for him to make a case that he's been wronged. It's not in his interest or personality structure to admit responsibility for that*".

13. In 2018, the Supreme Court of Queensland dismissed an application to extend the supervision order. P had not committed another sexual offence since the supervision order was made. However, he had been returned to custody for breaches of the supervision order several times including having assaulted his then partner in contravention of a domestic violence protection order in 2015. In this episode, police responded to a disturbance at a bottle shop after being called by a member of the public. P had accused his partner of speaking to other men on Facebook and yelling at her. She had gotten out of his car and run away but P assaulted her and pinned her to the ground in the shopping centre carpark. P was convicted and given a short, suspended sentence. P had also breached a direction given by Queensland Corrective Services not to have contact with this partner, resulting in a further sentence of three months' imprisonment with parole release after one month.
14. In considering the application, the Supreme Court noted a psychiatric assessment of "... a consistent pattern of difficulties in his relationships with female partners associated with jealousy, poor communication, insecurity, and avoidance displayed by P in dealing with relationship complications. On more than one occasion in the past it has led to threatening and aggressive domestically violent behaviour towards his female partner and this pattern was associated with his previous offending. It appears that his insecurity and poor coping with regard to attachment difficulties in his relationships are now his most significant dynamic risk and treatment needs."
15. P was considered to be at risk of committing a sexual offence involving violence in the context of a domestically violent situation, presenting with dynamic risk factors in the areas of relationship instability and a pattern of domestically violent relationships with women. The Supreme Court observed that within this context, it was reasonable to conclude that in a situation of conflict that could escalate to sexual violence in a domestically violent situation and in terms of the consequence of this risk, should it eventuate, it could potentially be very serious, with P's partner being the person at risk, even though he had not been alleged to have committed sexual violence against his partners to date.
16. The Supreme Court dismissed the application on the basis there was insufficient evidence of an ongoing unacceptable risk that P would commit a serious sexual offence without a further supervision order. In coming to this conclusion, the Court observed that the *Dangerous Prisoners (Sexual Offenders) Act 2003* is only concerned with the adequate protection of the community from the unacceptable risk of commission of serious sexual offences; not the risk of general criminal offending or general violent offending, even in a domestic violence context, this being the primary risk posed by P.
17. Within 18 months from the expiry of the supervision order, P killed Ms M who was pregnant with the couple's first child.
18. There were multiple significant lethality risk factors in the couple's relationship, with P's violence increasing in frequency and nature particularly once she knew she was pregnant with his child. Ms M tried to seek help through several agencies to flee the violence. There was no domestic violence protection order in place between the couple at any time prior to Ms M's death.

Ms M's case management by Court Link during 2019

19. Ms M was released from prison in mid-February 2018.
20. In April 2018 she was street checked by police and charged in relation to having a used syringe and a tomahawk in her possession.
21. In December 2018, Ms M was facing bail conditions relating to these and other offences including unauthorised use of a motor vehicle (P was a co-accused), failure to appear and breach of bail. ATSILS subsequently referred her for consideration of her suitability for the Court Link bail program through the Magistrates Court. Court Link is an integrated court assessment, referral, and support program for people on bail for offences that aims to help by connecting offenders with treatment and support services to address housing, employment, drug and alcohol, health, and other social needs. It is a voluntary program and participants are assigned case workers who aim to assist and support them during their time on the program.

First police attendance on the couple – 20 January 2019

22. On the evening of 20 January 2019 police were called out to Ms M and P's property following a report that an Aboriginal man was chasing an Aboriginal woman down the street. Body worn camera footage shows police arriving at the house and speaking with Ms M outside the house. She told them she wanted to collect her belongings from the house. She indicated upfront she did not want P charged, saying "it's not DV", it was just an argument. P was agitated and swearing but with encouragement from the police officers, allowed Ms M into the house to collect her bag, clothes, shoes, and money. He is seen following her throughout the house, agitated and yelling at her. The couple continue to argue, particularly over the whereabouts of Ms M's mobile phone, charger, and cash which P denies having taken. On P's account the incident started when he became agitated because people were staring at them when they went out to buy takeaway food. Things escalated after he told Ms M to hurry up and get inside the house. P explained he was very stressed about family matters and did not react well when he wanted to 'isolate' himself, but Ms M kept asking if he was okay. A verbal argument ensued during which P threw his food on the ground outside the house. The couple were yelling and swearing at each other as Ms M left. P admitted to having gone out on the street after her and did not deny having yelled he was going to kill her, describing this as them just "both going off", "mouthing off" at each other. Ms M does not appear fearful during the police interaction and repeated she did not want to press charges, saying they were both just frustrated and needed to talk. The officers did not seek a version of events from Ms M during the police attendance, even after she refers to P having threatened to kill her and her child while the couple were arguing inside the house as she looked for her belongings. The attending officers assessed both were "as bad as each other" and did not consider either party was in need of protection as this was only a verbal argument. There was no physical violence or property damage and neither party was fearful. The couple were given warnings about their ongoing swearing at each other. Ms M left to catch a bus to a relative's house.
23. The Court Link referral was triaged on 31 January 2019, noting issues relating to education, mental health, substance use, relationships, and general health.
24. Ms M attended a face-to-face appointment with her Court Link case manager on 12 February 2019 to develop a treatment pathway report for the Court. Ms M was noted to be living with P and his brother. She voiced wanting to find her own home where her eldest child could live with her as he was currently living on streets. Ms M described

having been in a stable relationship with P since her release from prison, which she described as a positive influence on her life and taking her away from associating with her 'old crew'. Ms M mentioned P did not allow her to carry her own phone and felt insecure if she spoke with other people, including Court Link staff, alone. When asked whether she had any concerns for her safety after the appointment, Ms M said she did not. When asked about her physical health, Ms M reported injuries 'from accidents' but this was not explored further. The case manager identified Ms M as the victim of domestic violence, noting this as a paramount need given she had self-reported injuries, but was not able to make time for appointments or contact because her partner 'will not let her go'. The case manager documented current discussions with a senior case manager and the High Risk Team, noting there were complex and sensitive issues to be explored and addressed.

25. Ms M's Court Link case management activities were to focus on reinforcing culturally appropriate community connections to support her while she explored her family history, strengthening her relationship with her son, maintaining pro-social friendships, and securing independent housing for herself and her son.
26. Ms M was formally admitted to the Court Link program on 14 February 2019.
27. She did not attend her Court Link case management appointment on 21 February 2019.

Supported referral to a domestic and family violence service (DFVS 1)

28. Ms M attended the Court Link office on 27 February 2019 with injuries to her face and ear. Her case manager made contact with DFVS 1 to arrange safe accommodation for Ms M. Ms M had been unable to take any clothes or other belongings because P was "watching her every move". The case manager spoke with her at length around safety, liaising with services and accessing appropriate supports. Ms M was given a Go Card to enable her to travel into the city where a support worker from DFVS 1 would meet her.
29. DFVS 1's records document Ms M's disclosure about P having hit her that morning leaving her with bruises on her face and legs and cut to her ear, describing herself as looking like Chopper Reid because she thought P had tried to cut her ear off with a pair of pliers. The assault happened quickly, and she was bent over crying, so she didn't know exactly what happened. She also disclosed P having bashed her and busted her lip when she first attended Court Link on 14 February 2019. She described P as very violent, having physically assaulted her many times by punching her in the face and strangling her. He had previously threatened to kill her and her son.
30. Ms M had tried to leave P a few days earlier, jumping out of the car at a set of lights but he followed her to a shopping centre nearby and was yelling at her. She felt embarrassment and shame, so she got back into the car with him. She told them P was holding all her important details hostage (her mother's death certificate, her birth certificate, her bank card) as a way to control her. He had forced her to attend his cousin's funeral the previous week and made her look in the coffin which he knew was traumatising for her.
31. Ms M described a range of coercive controlling behaviours including P thinking and talking for her, bossing her around and telling her what to do, not allowing her to attend her last Court Link appointment, taking and spending all her money, not allowing her to go to the toilet without his permission, isolating her and not allowing her to talk to any of her friends or family, threatening to kill himself and telling her it is all her fault and

threatening to get his family members to bash her if she ever left him. She also described him exhibiting sexual jealousy.

32. She said P had been 'acting different' and was 'more angry' lately as there had been a lots of deaths in his family recently.
33. DFVS 1's intake record noted Ms M "*..felt strongly about not wanting the police involved in her case...her grandparents and [P's] grandparents were a part of the Stolen Generation and she knows her and [P] are both Aboriginal and she hates that Aboriginal's [sic] have a bad name to them in relation to violence and doesn't want to bring shame to her family or his as the elders would view this as disrespectful.*" She stated she was "not a dog" and did not want P to go to jail because having been in prison herself she did not want anyone to go through that. Despite reassurance that DFVS 1 does not share information with police, Ms M remained reluctant to provide P's full name, providing only his surname.
34. On the basis of this information, Ms M was assessed as being at high risk of domestic and family violence. I note DFVS 1's risk assessment document does not appear in Ms M's Court Link case file, suggesting it was not shared back to the referring agency.
35. P turned up at the courthouse and was yelling and screaming at Ms M. Police officers separated her from him and accompanied her in the direction of the train station.
36. Ms M did not ultimately use the hotel accommodation arranged by DFVS 1, apparently staying with family instead. DFVS 1 closed her file and marked her as 'disengaged'. There does not appear to have been any further follow up, and notes indicate that any follow up would have needed to be initiated by Ms M (for instance, if she called the service again).
37. It is not clear from DFVS 1's records what, if anything, it did with the risk assessment despite Ms M being assessed at high risk across all domains. Her assessment was not escalated to a High Response Team and no referral was made to any specialist support services.
38. I am advised that DFVS 1 has made many practice improvements since Ms M's death. Changes relating to the management of a supported referral from another agency for a high-risk client who quickly disengages from DFVS 1 include:
 - requesting safe-to-contact, next-of-kin details at first point of contact
 - providing access to a safe phone through local DFV support services where they transport women to those locations to collect a secure device on her way to safe accommodation
 - completing a referral to an outreach service as part of any immediate safety plan where available
 - if a person is uncontactable, DFVS 1 initiates a safety check response, either through next-of-kin or police welfare check (both would provide another opportunity to confirm immediate safety and share information about supports and services)
 - when high risk indicators are present and there is unexplained inability to contact of a person DFVS 1 would initiate information sharing with the appropriate High Risk Team if available or the Vulnerable Persons Unit; and
 - if there is unexpected ending of services, DFVS 1 will contact the referring person/agency to advise of disengagement and safety plan for next steps if the person was to recontact either agency.

39. A senior representative of DFVS 1 advises that now in a situation like Ms M's, with the caller's consent, DFVS 1 would communicate with both the caller and the referring agency in the initial planning. If the referring agency is not a DFV specialist or DFV informed agency, DFVS 1 will assist them to understand the presenting risk and appropriate safety responses. It is now the Service's process to make contact with the initial referring party on disengagement with a person who they believe is at serious and high-risk harm. The senior representative advises that this level of risk presentation would now involve consultation with a Team Leader and possibly Service Delivery Manager, and a request for information from police about risks from the perpetrator to support better planning and system responses (such as QPS engagement and High Risk Team referral).

Court Link's subsequent domestic violence risk assessment

40. Ms M attempted phone contact with Court Link several times through the day 1 March 2019, but the calls kept dropping out. She contacted Court Link on 6 March 2019 advising she was safe with family. Ms M phoned on 8 March 2019 to arrange a further appointment but didn't want to come in due to her partner.
41. Ms M did not attend the progress mention in the Magistrates Court on 14 March 2019. Efforts to contact her by phone on 18 March 2019 were unsuccessful.
42. During a phone call on 25 March 2019, Ms M disclosed she was fleeing domestic violence.
43. Ms M attended court for her second progress mention on 11 April 2019, accompanied by P. She asked for a further opportunity to engage with the program, so her matter was adjourned to 2 May 2019. She was asked to attend an appointment the following day, 12 April 2019, for case planning as a matter of urgency. Ms M did not attend that appointment. Her case manager spoke with a senior practitioner that day about Ms M's safety and risk assessment for referral to the High Risk Team. Efforts to make phone contact with Ms M on 16 April 2019 were unsuccessful, so a letter was sent to her with dates for her next two Court Link appointments.
44. Ms M attended her case management appointment on 23 April 2019, presenting with a swollen lip and large bruise on her thigh. She asked for help to get away from P because the domestic violence was ongoing.
45. A High Risk Team level 2 domestic violence risk assessment tool was completed by Court Link staff though it is not clear who completed the assessment. The document is undated but is understood to have been completed on or around 23 April 2019. There appear to have been two people involved in the risk assessment, distinguished by different handwriting in different colour ink and queries against some of the notations made on the document prompting further details not initially obtained.
46. Based on Ms M's disclosures, this risk assessment identified multiple high-risk factors in the couple's relationship including:
- pending separation
 - threats to kill
 - stalking including P following her to the bathroom, the bus, court, her Court Link appointments, Centrelink, and her employment agency appointments
 - verbal abuse
 - damaging her property (ripping and burning her clothes, damaging her mobile phone)

- physical violence including assaults with a weapon – Ms M had disclosed P had cut the top of her ear with secateurs in early 2019
 - intimate partner sexual violence – Ms M described submitting to sex saying she “doesn’t fight it”
 - strangulation which she described as P holding her by the throat saying words to the effect of “do you realise I can kill you if I hold tight/just press here” (dates unknown)
 - threats of suicide and violence if Ms M leaves him
 - multiple forms of coercive control including withholding her personal property (including her bank card, her birth certificate and her mother’s death certificate), controlling her Centrelink payments, forcing her to attend family events against her will, controlling where she could go and who she could see, monitoring her movements, requiring her to ask permission to go to the toilet, hiding her drug utensils
 - accusing Ms M of sleeping with other men
 - P not liking her spending time with her son; and
 - P’s history of violence towards previous partners.
47. The risk assessment identified cultural barriers in Ms M’s previous access to services, “shame” and Ms M “*thinks she should be able to it herself*”.
48. The risk assessment notes Ms M believed P was capable of killing or seriously harming her, and the case manager’s assessment was she was at risk of lethality or serious harm. Ms M was supported to leave through the back of the courthouse without P’s knowledge and she was given a Go Card for transport. Her appointment with her employment agency was rescheduled. It was understood Ms M was going to a family member’s home. The case manager’s note of these events documented ongoing discussion with a senior practitioner regarding “*accessing HRT team and any information and referral [sic]...further contact to be made by Ms M to Court Link staff.*”
49. High Risk Teams comprise staff from both government non-government agencies with an appointed lead domestic and family violence specialist service provider to deliver multi-agency responses. Victims who have been assessed as being at high risk of serious harm or lethality are referred to High Risk Teams, whose members collaborate to share information and develop multi-agency safety plans to support victims and their children.
50. As part of her JobSeeker obligations, Ms M had been engaged with an employment agency for some time. The Court Link case manager contacted the agency on 23 April 2019 to inform them of the situation and advise Ms M would not be attending her JobSeeker appointment the following day.
51. Approval was given on 24 April 2019 to buy a mobile phone for Ms M, with a plan to discuss this with her if she attended Court Link the following week. There is no record of her having attended the scheduled appointment that day.
52. There was no further contact from or with Ms M by Court Link staff.
53. Ms M’s final report for the Court Link program was tendered and she was exited from the program on 2 May 2019. It transpired that Court Link received access to the High Risk Team referral portal that same day, but Ms M’s referral was never completed by Court Link before her case was closed. It appears this was because the senior practitioner did not have up to date information regarding Ms M’s imminent risk.

54. Retrospective review by the Department of Justice and Attorney-General of Ms M's Court Link case management identified that her case manager completed safety planning with Ms M on 23 April 2019 and scheduled an appointment for her the following day, 24 April 2019. The case manager debriefed with a senior practitioner who spoke with the department's High Risk Team representative and a domestic and family violence service (DFVS 2) seeking advice about safe ways to make contact with Ms M and help her engage to link with supports. There is a phone note indicating DFVS 2 required Ms M's consent (which she did not give) but the High Risk Team did not, with advice to put P's name in a referral. At this time, there was no established process for referrals by Court Link to the High Risk Team and the senior practitioner did not have access to the High Risk Team referral portal, so Ms M's risk assessment was not entered in the High Risk Team system. This was a missed opportunity for the local High Risk Team to become aware of and endeavor to respond to Ms M's domestic and violence support needs.
55. I am advised that when Court Link is supporting a participant who is recognised as being at imminent risk of domestic and family violence, Court Link staff are required to consider referral to an Integrated Service Response, for example a High Risk Team, in consultation with a Team Leader or Senior Practitioner. If the victim-survivor does not consent to the referral, staff are to liaise with their Team Leader about submitting the referral without consent. I understand the referral process to involve liaison with the Department of Justice and Attorney-General Domestic and Family Violence Integration Officer who will add the risk assessment into the High Risk Team information exchange system. If the participant is already engaged with a High Risk Team or if the referral is accepted, Court Link staff request to be an associate member at the High Risk Team meeting to discuss the matter and safety planning. Court Link staff are to follow up with the Domestic and Violence Integration Officer on subsequent actions and keep senior staff members informed.

Ms M's engagement with an employment agency

56. Ms M had been registered as a JobSeeker with an employment agency since April 2018. At the beginning of her engagement, Ms M was referred to an Indigenous counselling service for linkages to accommodation support and support regarding family conflict and violence. In 2019 she was referred to a drug and alcohol treatment program with an Indigenous health service.
57. Ms M attended her JobSeeker appointment on 15 May 2019. She is noted to have had personal issues involving domestic violence but was now back with her partner and was happy and stable. She was advised to access counselling sessions and was given information to engage with an Indigenous support service.
58. At her next JobSeeker appointment on 22 May 2019, Ms M was documented as "*not in a good situation with her current partner, he is very abusive and controlling and she is trapped in this relationship. She has a DVO on him had has being recused [sic] from DVO abuse and put into emergency accommodation twice now but keeps going back to him.put into emergency accommodation twice but keeps going back to him...to she stressed the fact that she needs help in gaining her own accommodation, she needs to connect with housing and engage with them to get on the list for homes. She needs her own phone – funding will be requested.*" The agency had previously bought a mobile phone for Ms M in November 2018 as part of getting her job ready.

59. Ms M attended a local medical centre that afternoon about a sore tooth. She requested scripts for two antidepressant medications which she said she had been taking until last year and felt she needed them again. She told the doctor she thought she might be pregnant. She did not return for medical review in two weeks' time as planned.

Ms M's acceptance for Murri Court

60. In late June 2019, Ms M was assessed as eligible to participate in Murri Court. She was arraigned in Murri Court on 27 June 2019. Ms M signed a bail undertaking with eleven conditions including participation in the Women's Yarning Circles held by the local Community Justice Group, counselling at an Indigenous counselling service, linking with an Indigenous health service for a mental health treatment plan and engaging with the Alcohol and Other Drug Service.
61. While the assessment leading to Ms M's acceptance contains questions about whether the person has or is currently expressing domestic and family violence, these questions are not answered on the form for Ms M. The Department of Justice and Attorney General confirmed that Court Link did not communicate Ms M's domestic and family violence needs to the local Community Justice Group involved in the Murri Court and it does not appear the Court Link staff were aware that Ms M had become a Murri Court participant. There is no record of the local Community Justice Group having requested information from Court Link.
62. The Magistrates Court Service Division has since advised that in general across its specialist programs, domestic and family violence risk information can be shared between entities for the purpose of risk assessment or safety planning, ideally with the aggrieved person's consent, under the *Domestic and Family Violence Prevention Act 2012*. The extent to which departmental staff participate in this is limited to programs where staff are working directly with the participant, such as Court Link, and program policies, procedures and protocols cover the processes by which program staff are to manage domestic and family violence risk and information sharing, including instructions for case managers on how to undertake assessment, case management and referrals to respond to domestic and family violence risk and support the safety of victim survivors.
63. On 10 July 2019, Ms M phoned DFVS 1 seeking a crisis payment from Centrelink as P had returned to his community for Sorry Business, leaving her without any money. She did not have a mobile phone and was using someone else's to make the call. She told the call taker an incident had occurred at the shops the previous Friday, but she had left before police arrived. There was no record of her having contacted DFVS 1 about the incident. She was advised to speak to police or get supporting evidence from store security so the Centrelink social worker could contact them for evidence of the incident.

Events over August – October 2019

64. Ms M was to meet with the Elders of the Murri Court on 8 August 2019, at which time her matters were adjourned again. She was noted to have family members in hospital and was travelling to and from P's community. Ms M was reportedly receiving grief counselling from a relationship support service (though it appears she did not ever engage with them) and her mental health care plan was expected to be in place the following week.
65. Ms M attended the employment agency on 15 August 2019 advising she had not attended her appointments for a while because her housing was unstable, and she was

“all over the place”.

Second police attendance on the couple – August 2019

66. Police attended Ms M and P’s property on 19 August 2019 in response to a report about a verbal argument at the house. Officers attended the address multiple times with no answer at the door. The occurrence documents *“...Police are aware of the occupants of the house and the persons involved do speak very loudly with occasional swearing by both parties involved. In cases that police have attended it is always a verbal and they eventually calm down with names calling by both persons.”* The incident was finalised as *“a verbal altercation between the two parties with nil evidence of property damage as the house is normally in disarray and messy inside.”* They did not consider it to be a domestic violence call out because the occupants were known to police as having loud voices and using ‘colourful language’ when arguing.

Third police attendance on the couple – 10 September 2019

67. On 10 September 2019 Ms M attended the employment agency and passed a note asking staff to contact the police. P had accompanied her to the appointment and was present when police arrived. The officers spoke to the couple separately. It is documented that Ms M said all she wanted was to be allowed to go and stay with her aunty but the only way she could get away from P was by calling police. She told the officers she lived with P as her boyfriend but she needed a break from him, but he did not want her to leave. She needed her keys and shoes from his car. She said she had been experiencing mental and physical abuse and P would not allow her access to her own money. Unfortunately, there is no body worn camera footage of this part of the police interaction with Ms M. The footage in which she does appear shows her displaying timid, upset body language. Footage of the other officer’s discussion with P shows P becoming agitated over the course of the police interaction. When told Ms M wished to leave and go to her aunty’s place without him, P begins swearing, stating words to the effect he was ‘over it’ and didn’t want anything to do with Ms M. After initially suggesting Ms M didn’t need the key because her aunty would be there, he subsequently retrieved the key from his car. The police officers and the employment agency’s staff encouraged Ms M to go with police to her aunty’s house. P was outside and despite an officer having earlier warned him not to get fired up, he is seen speaking aggressively to Ms M, telling her not call him anymore. The police officers determined there was no evidence of any dispute or domestic violence, but noted Ms M did state she was fearful of P. The incident was categorised as a DV – No offence call out.
68. Ms M attended the Murri Court on 26 September 2019, after which she was seen at the employment agency. She reported doing much better. She said she was staying with an uncle while she was looking for places to rent for herself as she wanted stability and independence.
69. Ms M next attended the Murri Court and the employment agency on 10 October 2019, at which time she was still staying with family while trying to find stable accommodation. Murri Court documents note there was serious domestic violence with P and the couple had separated. She failed to attend her Work for the Dole induction at a charity shop on 15 October 2019.
70. Ms M’s final attendance at the Murri Court was on 31 October 2019.

71. Ms M did not respond to repeated efforts by her case worker from the Indigenous counselling service to make contact with her throughout October 2019.
72. Ms M presented to a local health precinct on 13 November 2019 stating she was pregnant. She had not had any antenatal care to date. She was thought to be about 28 weeks' gestation. Ms M was referred to the local public hospital for obstetric review and ultrasound. Ms M missed two antenatal appointments during November 2019.

Bystander awareness of violence occurring at the couple's home

73. Various neighbours had heard P verbally and physically abusing a woman at the address. One neighbour described hearing him yelling and screaming at someone, swearing constantly and a female voice trying to calm him. This increased in frequency over several months prior to Ms M's death. Another neighbour reported hearing P regularly scream "*You dog*" and "*You fucking dog, you black dog*". A neighbour once saw P hold a metal rod threateningly towards a woman and yell "*I'll fucking kill you*".
74. Around six months earlier, this neighbour heard P physically assaulting a woman, during which she said words to the effect of "*Stop leave me alone you will kill me.*" A month or so later, this neighbour saw the young woman (Ms M) and told her P was a "*nut case, he will kill you*" to which Ms M replied she was going to live with her aunty. The neighbour warned her P was getting worse and would kill her. She told him P was taking her social welfare payments.
75. In the month preceding her death, Ms M was seen on at least two occasions to have an injury to her lip which she told others P had caused.
76. On 1 December 2019, a neighbour saw P in the front yard of the property, going in and out of the house and at one point yelled "*I'm not going to miss you you fucking [indistinct].*" During the first few days of December 2019, neighbours heard things "*get bad again*" at the house with arguing and the sound of physical assault coming from the house. Ms M was heard crying, telling P to leave her alone. A different neighbour had been approached by Ms M at a local shopping centre approximately two weeks earlier, asking whether the neighbour had contacted police about her. The neighbour confirmed this, to which Ms M replied she had her eye "busted open" as a result. At around this time, an associate of P had seen Ms M with a lump on the side of her head. Ms M told her P had 'bashed' her.

Events of December 2019 leading up to the discovery of Ms M's passing

77. Ms M met with a midwife from the local public hospital's Indigenous midwife service on 4 December 2019. Through purposeful yarning, she expressed her mistrust in many government services and her hesitance to attend clinics, though it was noted she had seen a general practitioner and was booked for an obstetric ultrasound in two days' time. P was also present.
78. Ms M attended an antenatal appointment at the local public hospital, accompanied by P, on the afternoon of Friday 6 December 2019. An Indigenous Liaison Officer participated in clinic appointment. Obstetric ultrasound scan estimated her to be at 24 weeks + 6 days gestation and its findings were reassuring as to the baby's condition. She was booked for another antenatal clinic appointment on 13 December 2019. The couple were seen together at some nearby shops later that day, shoplifting.

79. At around lunchtime on Saturday, 7 December 2019, P's older brother and his son visited the couple at the Ms M and P's property. They showed him a scan of the baby and suggested he could look after the child.
80. A neighbour heard an argument at the property on 6 December and 7 December 2019 (in which the woman was crying) and on Sunday, 8 December 2019, she heard P calling the woman "a dog" to which the woman replied, "*You're not worth it.*" At around 12:45pm on 8 December, another neighbor heard a screaming match at the house during which they heard a male voice say "*Get up, you dog. Come on, get up.*"
81. At around 3:23pm that afternoon, P messaged a friend, saying he needed him. P went to the house of an associate asking if he knew anyone with a ute and a big steel box. He later sent the associate a series of text messages wanting money for petrol.
82. P's friend went to Ms M and P's property in the early hours of Monday, 9 December 2019. P told him words to the effect of "*It's [Ms M]. She's inside. She's OD'd. She has taken heaps of pills.*" The friend suggested they call an ambulance, but P told him it was too late for that.
83. P sent messages to relatives early that morning asking if they had seen Ms M. He sent a message to Ms M's mobile phone number asking why she always takes off when she is the only one he loved, and telling her he was going to put his children first from then on. P continued messaging the friend that afternoon and into the evening, wanting to know if he could get a car from him. He went on to suggest someone might have put out a hit on Ms M with the associate.
84. P visited his older brother on Monday, 9 December 2019 and told him Ms M had 'taken off' again the previous day. P's brother thought P was acting strangely that afternoon.
85. On the afternoon of Tuesday, 10 December 2021, an anonymous caller phoned the QPS Criminal Investigation Branch and spoke with an officer advising there was a dead woman at Ms M and P's property. The informant knew this because a friend of hers had been approached by P for help getting rid of the body. The caller said P had murdered the woman. P had reportedly said the woman had overdosed and indicated lots of people knew about this. The informant declined to reveal their identity and terminated the call.
86. Detectives subsequently attended the property. No one was home. The front door was locked, so they had to enter the back yard to access the house. There were a number of vehicles parked in the back yard, all in disrepair. Officers noticed a strong odour coming from a black Holden Commodore parked in the yard and discovered a woman's body in the boot of the vehicle. She was clothed, lying on her back, slumped to the left, on a red and blue striped doona. She was obviously deceased.
87. A crime scene was declared at the property and a forensic investigation was commenced. Detectives observed the interior of the house to be generally unclean and unhygienic apart from the tiled areas in the kitchen and dining room, which appeared to have recently been mopped as there was cleaning chemical residue on the tile surface. There was a new mop in the house, and it was evident furniture had been moved to enable the floors to be cleaned.
88. A car belonging to P's brother was in the carport and appeared to be packed ready to leave. The battery was dead, and it was out of fuel. It was the only vehicle at the property otherwise in working order.

89. The deceased woman was formally identified as Ms M by fingerprint comparison. There was also a distinctive tattoo on her leg.

Autopsy findings

90. External examination including CT scan and full internal examination noted advanced post-mortem changes. There were minimal surface injuries including an injury near the tip of the chin. There were multiple traumatic injuries including a fracture to the bridge of the nose, fractured left cheek bone, fractures of laryngo-hyoid structures (hyoid bone, thyroid cartilage and cricoid cartilage) and fracture of the right leg tibia and fibula. The extent of post-mortem change made examination of the brain impossible. Only the right leg bone fractures had accompanying soft tissue haemorrhage (evidencing definite anti-mortem injury). The fetus was estimated to be at 27-30 weeks gestation. The fetus (with the placenta) had separated from its normal place within the uterus, potentially as a result of post-mortem processes. The presence of blood in the abdomen indicated possible abdominal trauma but no source of bleeding could be found. It was possible there had been injury to the uterus (laceration or contusion) which may have facilitated its expulsion from the uterus as part of the post-mortem processes. There was no natural disease sufficient to account for death. Toxicological analysis of liver tissue detected the presence of methylamphetamine (and its metabolite amphetamine) and evidence of cannabis use. Reliable interpretation of the levels detected was not possible due to post-mortem processes.
91. The pathologist advised the right leg fractures were definitely caused before death and while the facial fractures could have been sustained in life, it was not possible to rule out them having occurred after death. These injuries would have required substantial force. The fractures of the laryngo hyoid structures indicated pressure had been applied to the neck, potentially due to manual strangulation or arm lock. The pathologist advised that ligature strangulation was a possibility, but a ligature mark could not be seen, and manual handling of the body, for example by holding the neck after death could possibly cause these injuries but would require a firm grip onto the neck.
92. The extent of post-mortem changes was such that the pathologist was not able to determine a definitive cause of death. The pathologist identified possible causes including pressure applied to the neck, head injuries or uterine injury/rupture.

Police investigation

93. When told that police were at the Ms M and P's property, P was observed by his older brother to be acting 'wild'. P returned to the property with his brother, spoke to police and was arrested that night. Police determined he wasn't in a fit state to be interviewed so he was released from custody without charge on 12 December 2019 as the police investigation continued.
94. Examination of telecommunications data extracted from P's mobile phone revealed a series of SMS messages sent to a named contact on the evening of 8 December 2019 from 7:31pm onwards, and call logs indicating lengthy phone calls between P and this person.
95. It also revealed P was using dating apps and accessing sex workers regularly. Messages between the couple evidenced jealous tension.
96. P was re-arrested on later that day, 12 December 2019, and transported to a police station where he was cautioned. He told police he was aware Ms M was pregnant with

the couple's child and was looking forward to being a family. He said he would sometimes get 'stressed' with her and they would argue, but adamantly denied ever being physically violent with her. He claimed to have last seen Ms M on the evening of Friday 6 December 2019 when he went to sleep and had not seen or heard from her since. He said Ms M occasionally 'took off' from him but wouldn't elaborate why. He was vague in outlining his whereabouts since 6 December 2019. When challenged about witnesses consistently describing him to be highly aggressive, volatile, and physically abusive, P said he didn't know why people would think that. He denied any involvement in Ms M's death. P eventually declined to any further questions and the interview was terminated. P was then formally charged with murder, assault causing their unborn child to die and interfering with Ms M's body.

97. DNA evidence later confirmed P's DNA on Ms M's body and her clothing. No other DNA was detected, suggesting he acted alone in placing Ms M's body in the vehicle.
98. P was subsequently also charged with 25 offences relating to mistreatment of dogs at his property.

Criminal proceedings

99. Three years after Ms M's passing, P pleaded not guilty to murder but guilty of manslaughter, having destroyed the life of an unborn child and improperly interfering with Ms M's body. He received convictions and was sentenced by the Supreme Court of Queensland on 15 March 2023. The trial judge observed that P's pleas of guilty did not show true and genuine remorse for his actions, noting P's subsequent lies and efforts to conceal Ms M's death; rather the trial judge inferred P's pleas were primarily motivated by self-preservation in order to avoid a conviction for murder and mandatory sentence of life imprisonment.
100. On the evidence available to him, the trial judge inferred:
 - there was a violent argument between the couple on the afternoon of Sunday 8 December 2019 in the course of which P choked Ms M using a chokehold, applying moderate pressure to the left side of her neck, causing the fractures of the left-side laryngo hyoid structures found at autopsy.
 - the other facial fractures occurred during this altercation.
 - there was no evidence of a sustained attack by P on Ms M.
 - when P's friend attended the house in the early hours of Monday, 9 December 2019, P knew Ms M was dead and intended to remove her body from the house; and
 - P acted alone in killing Ms M and placing her in the boot of the car at the property.
101. P was sentenced to 13 years imprisonment with a parole eligibility date of 4 September 2030.

Consideration by the Domestic and Family Violence Death Review Advisory Board (DFVDRAB)

102. The circumstances in which Ms M died were considered by the DFVDRAB during the 2021-2022 reporting period as part of its examination of collaborative responses to risk, safety and dangerousness.
103. The Board observed the breadth of Ms M's service system contact during the 12 months preceding her death with ATSILS, the Magistrates Court of Queensland, Court Link, Murri Court, DFVS 1, Queensland Police Service, the employment agency and

Queensland Health. When she did have contact, P was often also present. This impacted her ability to seek or receive support in relation to the violence he was perpetrating against her.

104. There were Domestic and Family Violence Information Sharing Guidelines already in place during this period of service system contact. These guidelines were intended “..to support practitioners and other to make informed decisions about sharing information appropriately in order to assess and manage domestic and family violence risk” and “..provide practical guidance on the interpretation and application of the information sharing provision to promote consistent responses that help keep the victim-survivor safe and hold the person using violence to account.”
105. The Board identified significant information sharing issues noting information about the DFVS 1’s high risk assessment was not shared back to Court Link, the Court Link high risk assessment was not shared with other services with which Ms M was working and the Court Link high risk assessment did not result in Ms M being referred to the local High Risk Team. DFVS 1 closed Ms M’s file without attempting safety planning with her about what would happen if P was to locate her. These were missed opportunities for greater agency collaboration and referral to a specialist domestic and family violence service to better manage her safety in the short and longer term.
106. This aspect of Ms M’s experience illustrates the broader findings of the Board and the Women’s Safety and Justice Taskforce which found that the information sharing provisions under the *Domestic and Family Violence Protection Act 2012* were not being used in the most effective way to keep victim-survivors and children safe. Consequently, the guidelines have since been revised to increase awareness, understanding and consistent use of the information sharing provisions.
107. The Board recognised the efforts of Court Link staff to assist Ms M’s with referrals and brokerage support to escape acute episodes of violence, noting Ms M often refused referrals for ongoing engagement with formal support services. It observed this is not unusual for women experiencing domestic and family violence and is more common among First Nations women who are less likely to seek formal assistance from services due to a distrust of services or a fear of criminal consequence for the perpetrator.
108. The Board observed that while Ms M was variously documented as ‘not engaging’, ‘disengaged’ and ‘anti-intervention’, this was in the context of a range ongoing coercive controlling behaviours by P. Despite her disclosures about these features of her relationship, there did not appear to be consideration about how this may have affected her ability to engage with the various services.

Findings required by s.45

Identity of the deceased – [de-identified for publication]

How she died –

I find that Ms M died when P applied pressure to her neck during an argument on the afternoon of 8 December 2019. The couple’s relationship was characterised by significant domestic and family violence including coercive controlling behaviours. Ms M felt shame and embarrassment about being the victim of violence perpetrated by P who had a long history of perpetrating violence against women and not ever accepting accountability for his behaviours. She did not trust government agencies and felt she needed to deal with it on her own.

Ms M did not want to involve police in her situation as she did not wish to bring shame on her family and her elders, nor did she want P to go to prison, a common experience for First Nations women experiencing domestic and family violence.

Ms M was engaged with the justice system over the 12 months preceding her death. Notwithstanding her mistrust of government agencies and strong reluctance to involve police, she sought and accepted some assistance in an effort to escape the violence perpetrated by P during this time. Her domestic and family violence support needs were appropriately identified and acted on by Court Link staff who endeavoured to link her with specialist domestic and family violence supports while she was participating in the Court Link program. However, there were missed information sharing opportunities by both DFVS 1 and Court Link that could have brought Ms M's situation to the attention of a specialist domestic and family violence service/integrated service response to manage her safety, particularly given P's coercive controlling behaviours which significantly impacted her ability to escape his violence and more so once he became aware she was pregnant to him.

Research has shown pregnant women are at high risk of intimate partner violence. Ms M's pregnancy represented an additional factor to her already high risk, evidenced by indications of increasing violence with physical assault in the home in the weeks preceding her death. She had presented for antenatal care for the first time only two days before she was killed by the father of her child.

There has been significant domestic and family violence system reform since Ms M's death with much ongoing.

Place of death –	[de-identified for publication]
Date of death–	22/11/2019 - 10/12/2019
Cause of death –	1(a) Not ascertained (Body Decomposition)

I close the investigation.

Ainslie Kirkegaard
Coroner
CORONERS COURT OF QUEENSLAND
22 July 2024