QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Doreen Gail Langham and Gary Matthew Hely**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2021/867 & 2021/860
DELIVERED ON:	27 June 2022
DELIVERED AT:	SOUTHPORT
HEARING DATE(s):	07 March 2022 – 11 March 2022
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, domestic and family violence; suicide; intimate partner homicide; femicide; Queensland Police Service response; police policies and procedures; police reforms; multi-disciplinary police stations; embedded DV social workers.

REPRESENTATION:

Counsel Assisting:	Mr B Jackson Ms K Ward
Ms Probert (Next of Kin – Langham):	Ms P Morreau instructed by Townsville Community Law
Mr Guthrey (Next of Kin – Hely):	Ms L Reece instructed by Caxton Legal Centre
Commissioner of Police:	Mr M Nicolson instructed by QPS Legal Unit
Det Insp Fletcher, Snr Sgt W Smith, SC Forrest, SC Jones, Const Cacace, Const Langford:	Ms K Bryson instructed by Gilshenan and Luton Solicitors
Detective Sergeant Anthony Bradbury:	Mr C Gnech, Gnech Lawyers
Snr Constable Matthew Down:	Mr J Macdonald, Sibley Lawyers
Dr A:	Ms A Lacey, HWL Ebsworth Lawyers
Dr AR:	Mr Underwood instructed by Avant Law

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Background

1. Doreen Langham was born on 20 March 1971 in Brisbane to parents, Allan James Langham and Glenda McArdle. She was 49 years old when she was killed by Gary Hely. She lived at unit 4, 107 Myola Street, Browns Plains.

2. Ms Langham had two daughters, Tabitha and Shayne, and three grandchildren whom she loved very much. She was very close to her mother, her siblings and her nieces and nephews. Her family became aware of her relationship with Mr Hely and they identified that he was perpetrating domestic violence (DV). They did everything they could to help Ms Langham but neither they nor she could foresee the extent of the danger she was facing or the heinous act he would commit.

3. Gary Matthew Hely was born in Penrith, New South Wales, on 31 December 1971 to parents Glenn Hely and Margaret Hely. He had three siblings including Michelle and Robert. His father was an alcoholic who physically assaulted his mother until they were divorced when Mr Hely was about 13 years old. Ms Langham and Mr Hely's sister were friends from childhood which was when Ms Langham and Mr Hely first met. Mr Hely's brother, Robert Hely, was very supportive of Ms Langham during the breakup with Mr Hely and he and his wife also did their best to support Mr Hely and encourage him to move on. Mr Hely was 49 years old at the time of his death.

4. Ms Langham and Mr Hely commenced their relationship in 2018. They moved from Western Australia to Queensland (Qld) in April 2019 and leased the unit in Myola Street on 15 May 2020. It was a two-storey brick townhouse within a gated community with on-site management.

5. Mr Hely moved out of the residence on 7 February 2021 which was when his acts of coercive control escalated.

6. At the time of Mr Hely's death he was staying at his place of work at Wacol.

Mr Hely's relationship with Ms Langham

7. When they commenced their relationship Ms Langham lived in Western Australia and Mr Hely lived in Orange. He moved to Western Australia to live with her and in early 2019 they moved to Queensland.

8. When they first moved to Qld they lived with Ms Langham's daughter Shayne and her husband Nick. Shayne saw that they used to argue a lot and Mr Hely was very jealous and he would often ignore Ms Langham for days after they argued.

9. Shortly afterwards Ms Hely told her daughter, Tabitha, that they were getting married. She was very excited but Tabitha soon became concerned about Mr Hely's moodiness and controlling nature. In August or September 2019 Tabitha went shopping with her mother and saw that she had been crying. Her mother told her that she had argued with Mr Hely and he had bitten her on the arm. Tabitha was shocked and angry and spoke to her mother at length about DV.

10. Tabitha, Shayne and Ms McArdle continued to be concerned but didn't push Ms Langham as they were concerned they would be cut out of her life.

11. In early 2020 Ms Langham and Mr Hely visited Ms McArdle to help her move. Tabitha saw that they were arguing a lot and he was constantly putting Ms Langham down.

12. In January 2020 Ms Langham told her friend that Mr Hely became abusive when he drank too much. She said he would be verbally abusive, call her names and he had pinned her to the bed and bitten her on the arm.

13. In April 2020 Mr Hely punched Ms Langham in the face repeatedly and kicked her in the back, causing her to flee to a friend's house. He later apologised and said that he had blacked out after drinking too much and couldn't remember doing it.

14. In May 2020 Ms Langham told her friend Dawn Nicholls that she had called off the wedding because Mr Hely needed to fix himself and he needed counselling for his mental health.

15. Ms Nicholls saw that Mr Hely was “insanely jealous” and would throw a tantrum and storm off if Ms Langham spoke to other people. She saw him swear and scream at Ms Langham and punch a wall in anger when they were arguing. She heard him scream that he would rather be dead than live without Ms Langham.

16. On 21 August 2020 Mr Hely attended a medical centre and saw a GP there for “anxiety and anger”.

17. On 29 August 2020 he returned to the medical centre and saw another doctor who recorded that Mr Hely had difficulty controlling his emotion and anger which was affecting his relationship.

18. On 2 September 2020 Mr Hely sent his sister a text message in which he said he didn’t want to live without Ms Langham and he was in a very bad place and wanted to commit suicide.

19. On 5 September 2020 Ms Langham and Mr Hely argued and he stormed off. He sent her a text message saying he was thinking of suicide. He stayed out all night and the next morning Ms Langham went to the Browns Plains police station to report him missing. After speaking to police officers he attended at the station.

20. After that incident a referral was generated for Ms Langham for The Centre for Women & Co but she didn’t engage with the service.

21. On 9 November Mr Hely returned to the GP who completed a mental health care plan and referred him to a psychologist. The GP recorded that Mr Hely had “ongoing difficulty to control emotion/anger.”

22. On 17 November 2020 the GP phoned Mr Hely and explained the mental health care plan to him. Mr Hely did not contact the psychologist who was not in fact practising at that time.

23. In October or November 2020 Ms Langham told Tabitha that she and Mr Hely had broken up. Tabitha was very relieved but not long after that Ms Hely told her that Mr Hely had threatened suicide and they were getting back together as he told her he loved her and couldn't live without her.

24. In late 2020 Ms Langham often stayed with Ms Nicholls during the week to get away from Mr Hely. She didn't want to break her lease but didn't want to stay at home with him.

25. In mid January Ms Langham asked the on-site manager about having Mr Hely removed from the lease as they were separating. She said they were sleeping in separate rooms and he had been taking photos of her whilst she was asleep.

26. On 29 January 2021 Mr Hely told Shayne that he and Ms Langham were separating and he was going to move his belongings into a shipping container at his work.

27. On 1 February 2021 Ms Langham told friends that she and Mr Hely had broken up.

28. Sometime in February Ms Langham was at work and Mr Hely walked in and left flowers on her desk and then walked out without speaking to anyone. Soon after that she told her work colleague that they had broken up but Mr Hely wouldn't leave her residence. She said he went through her phone, diaries and journals and took photos of her while she was asleep.

29. Ms Langham showed her colleague text messages from Mr Hely which started off with him saying he loved her etc and then became abusive when she didn't respond.

30. On 7 February 2021 Mr Hely threatened to kill Ms Langham. She left her unit and went to the residence of her friend, Eletia Edwards. She called the police. They attended that afternoon. A police officer spoke to Mr Hely on the phone later that day and he told them he was moving out and going to live in New South Wales.

31. In fact, from then on, he slept in his truck at his place of work and kept his belongings in a container at that premises.

32. That day Ms Langham told her friends of the threats and also that she was using a new phone number.

33. On 8 February 2021 at 5.57am Mr Hely called Ms Langham but she did not answer her phone.

34. Later that day Ms Langham attended the Beenleigh Magistrates Court and obtained a Domestic Violence Protection Order (DVO). The court ordered that Mr Hely:
    1. Be of good behaviour towards Ms Langham and not commit DV against her;
    2. Not remain at her residence;
    3. Not enter, attempt to enter or go to within 100 metres of where Ms Langham lives, works or frequents;
    4. Not locate her or attempt to locate her;
    5. Not follow or go to within 100 metres of her when she was at any place;
    6. Not use the internet to communicate with or make comments about her;
    7. Not possess guns or other weapons.

35. The DVO provided that he could return to her premises with a police officer to obtain personal belongings.

36. That afternoon she told her friend that she hoped to get out of her lease so that she could move.

37. A court generated referral was received by the DV service, “The Centre for Women and Co” for Ms Langham.

38. Later that afternoon she returned to her residence with Ms Edwards, as she was scared to go there alone. She took some personal belongings and returned to stay with Ms Edwards.

39. She stayed with Ms Edwards that night and then she stayed with another friend, Tanya McKiernan, until Mr Hely was served with the order on 11 February 2021.

40. On 9 February 2021 Ms Langham was contacted by the Domestic Violence Assistance Program (DVAP) from Beenleigh. She said that she believed Mr Hely was calling her from a private number and then hanging up when she answered.

41. Also on 9 February Ms Langham said that she believed that Mr Hely had found her mobile telephone number on the DV paperwork that she had hidden in a drawer in her bedroom.

42. On 10 February 2021 Ms Langham changed the bank account that her wage was paid into as she was concerned Mr Hely could access her bank accounts. Her work supervisor said that whenever she discussed Mr Hely she was very scared and frightened.

43. Around that time she showed her work colleague a page of her diary which was 20 March, her birthday. Mr Hely had drawn a picture of a penis on the page and written the words, “I bet you will have a lot of dick in you by this date”.

44. On 12 February Ms Langham went to Browns Plains police station and obtained a copy of the DVO and then she and Ms Edwards went back to her unit and stayed there that weekend.

45. On 13 February Ms Langham told her friend that Mr Hely must have had keys cut to her unit that he had kept. She said that she had come home to find that he had been in the house, that he had been through her drawers and found her new phone number that he was now using to contact her and he had ejaculated in her bed.

46. That day Mr Hely sent Facebook messages to Shayne stating he loved her mother and her and her daughters and would never do anything to hurt them. He denied he had threatened Ms Langham.

47. Ms Edwards and Ms Langham were at Ms Langham's residence on the morning of 14 February 2021 when they heard a noise. Ms Edwards went out the front and found flowers on the windscreen of Ms Langham's car. She saw that the side gate was open. Ms Langham called Policelink and reported this breach of the DVO.

48. CCTV of the unit complex showed Mr Hely entering the complex at 7.16am on 14 February 2021. He was carrying a bunch of flowers. He walked through the complex and left them at unit 107 and left the complex at 7.21am.

49. Ms Langham and Ms Edwards left the unit to attend the police station to report the above breach and saw that Mr Hely had left a large sign and a rose on a post on the side of the road stating that he would love "Dee" forever. Ms Langham went to the police station and provided a statement about the flowers on the car and the sign.

50. Ms Langham called The Centre for Women & Co and organised to have her locks changed.

51. That night Ms Langham was at home alone. At about 8.30pm she went outside to her back patio and found that the rose that had been on the sign was on her table.

52. CCTV showed Mr Hely return that night at 8.05pm. He waited for a car to enter the complex and entered after the car. He walked to Ms Langham's unit and went around the side of her residence. He was there until 8.35pm.

53. Ms Langham called police to report this. They told her to put the rose inside her unit and she did so.

54. Mr Hely attempted to phone her twice that night.

55. Ms Langham went to the house of her friend, Tania McKiernan. She got there at 9.49pm. Ms McKiernan saw that she was "terrified and shaking." She stayed there that night.

56. The next morning (15 February) Ms McKiernan and Ms Langham went to the Browns Plains police station to report that Mr Hely had been in the patio area of her residence. Ms McKiernan stayed with Ms Langham whilst she gave a statement. They then went and had coffee with Ms Edwards and then went to Ms Langham's residence. They obtained CCTV from the complex manager and made three copies including one for the police. They went to get Ms Langham some more clothes and noticed that both the front screen and wooden doors were unlocked. Ms Langham became very afraid as she realised that Mr Hely still had a key to her unit.

57. They went inside and saw that the rose Ms Langham had left on the table was gone.

58. They immediately returned to the police station and gave another statement to Senior Constable Jolly advising that Mr Hely had entered her unit.

59. Afterwards they returned to Ms McKiernan's house where Ms Langham stayed the night.

60. Ms Langham contacted The Centre for Women & Co again and organised for her locks to be changed on 16 February at 3pm.

61. The next day they went to Ms Langham's unit and met the locksmith who changed the locks and put deadbolts on the front door and the back laundry door. The locksmith saw that there was a split in the laundry door – it looked like someone had kicked it. Ms Langham drove Ms McKiernan home and then went home.

62. As Ms Langham returned to her unit at about 6.30pm she saw Mr Hely's car in the visitor parking in her complex and then saw him walking away from her unit towards her and his car. She drove away and stopped in a side street where she phoned police. As she was on the phone Mr Hely drove up beside her and then drove off when he saw that she was on the phone.

63. CCTV footage showed Mr Hely driving into the visitor parking in his ute. He waited until a car entered the complex then went in on foot at about 6.35pm. He went to Ms Langham's unit and tried to get in the front door. He then went around the side of the house and left the complex at 6.40pm.

64. Ms Langham went home and locked herself inside her unit and tried to sleep as she was exhausted from the events of the previous days.

65. On 17 February 2021 Mr Hely posted on Facebook stating that he was struggling to face the next day and he was "the most hated person in Brisbane for all the wrong reasons."

66. On 18 February Mr Hely had a conversation with his sister who had been told of his conduct by Ms Langham. He denied everything and said Ms Langham was making it all up. He told his sister that he had to go to court for the DVO on 23 February and said, "The only way they are going to get me is in a box."

67. Mr Hely's sister didn't take any notice of this as it was common for Mr Hely to threaten to kill himself but he had never taken any action.

68. Later that day he had a conversation with his employer in which he insinuated that he knew someone who could "sort out" his ex if needed. His employer told him he didn't want to have such conversations with him and Mr Hely said, "I've got away with it once before."

69. Mr Hely's employer then remembered that on a work trip in November 2020 Mr Hely told him that he had got someone to burn down an ex girlfriend's house in Orange, NSW. He said he got away with it, he went to court but was found not guilty.

70. At 5.21am on 19 February 2021 Mr Hely tried to phone Ms Langham twice and at 6.47pm he tried to phone her three times.

Events of 21 and 22 February 2021

71. At 7.07am on 21 February Mr Hely jumped over Ms Langham's back fence. A neighbour saw Mr Hely climb over the fence to get into her yard. He stood on some milk crates to do so.

72. At 7.13am Ms Langham went outside to hang out washing and found Mr Hely crouched down hiding near her table on the back patio. He ran away and jumped back over the fence.

73. Ms Langham messaged Ms Edwards, who said she would come over soon to help her put a lock on the side gate. At about 8.16am that morning Ms Edwards and her son-in-law attended and jammed wood up against the side gate so that it couldn't be opened from the outside. They left there at about 9.11am. Mr Hely was still in the area but his exact whereabouts are unknown. He left the Browns Plains area at about 8.56am.

74. At 9.43am Ms Langham went to the shops. She returned home at about 12.48pm.

75. Mr Hely went to Chinderah NSW where he obtained some cannabis from a friend. He then went to his workplace.

76. At 1.59pm on 21 February Mr Hely purchased some duct tape and rope from Bunnings at Browns Plains.

77. At 2.11pm he attended the 7-Eleven Service Station on Browns Plains Road and pumped 10.41 litres or petrol into two red plastic jerry cans. He drove through the car park of the service station and into the car park of the adjoining Chemist Warehouse where he parked his vehicle. It was parked about 200 metres from the unit complex.

78. At 2.21pm he walked back to the service station and bought a five litre metal Repco petrol can. At 2.28pm Mr Hely left the carpark carrying the petrol can and wearing a back pack. He then went to the back of the Myola Street unit complex and climbed the back fence. Some of his movements in the complex were captured by CCTV.

79. Once inside the complex Mr Hely walked down a concrete footpath and hid in some bushes.

80. At 2.39pm Mr Hely approached the front of Ms Langham's unit but then ran back up the path to the rear of the complex.

81. At 2.57pm Mr Hely jumped the back fence of the complex, went to the service station and bought a bottle of water.

82. Ms McKiernan arrived at the unit at 3.01pm and had dinner with Ms Langham.

83. At 4.26pm Mr Hely again approached the unit and walked through the interior of the complex before exiting via the front pedestrian gate.

84. At 7pm Mr Hely again jumped over the back fence of the complex. He loitered around for 40 minutes and then went to the front of Ms Langham's unit. He walked around and back to the rear of Ms Langham's unit. At 8.10pm he was at the rear of the complex and carried something (possibly the jerry cans) into the bushes beside Ms Langham's unit. At 8.19pm Mr Hely moved toward the front of the unit. He walked through the bushes and was in the vicinity of Ms Langham's unit for about 45 minutes.

85. Ms Langham phoned 000 at 9.21pm and told police she heard noises and saw a shadow at the front of her unit and believed it to be Mr Hely.

86. At 9.22pm Mr Hely moved to the rear of the unit complex then stood on a bench looking toward the road, which suggests that he may have known Ms Langham had called police.

87. At 9.51pm Mr Hely walked toward the unit again and then walked back to the rear of the unit complex.

88. At 10.22pm Mr Hely moved towards the unit. At 10.27pm he was at the front of the unit. At 10.29pm he returned to the rear of the complex and remained there for about 30 minutes.

89. At 11.57pm Mr Hely walked towards the unit. Police believe that he stayed in the bushes beside Ms Langham's back fence until he gained access to her unit by unknown means sometime after 11.59pm.

90. Police officers attended the residence at about 1.05am on 22 February in response to the earlier 000 call from Ms Langham. They reported that the ground floor lights were on, the garage door was in the closed position and the front

security screen was closed and locked. They knocked on the door and left when Ms Langham did not answer.

91. Ms Langham's car was parked in her driveway in front of the closed garage door.

92. At about 3am a neighbour, who lived in the same street as Ms Langham, was awake. She heard voices arguing. It went on for about 20 minutes. She went back to bed and about five minutes later heard glass breaking. She woke her boyfriend who looked out the window and told her to call the fire brigade as Ms Langham's house was on fire.

93. That neighbour called 000 at 3.55am. She went outside and saw that the townhouse was burning and other neighbours were out in the street.

94. Between 3.35am and 3.40am the neighbour from unit 10 walked out of her front door to go to work. She walked toward unit 107 as her car was parked near there. She heard a woman crying. As she drew parallel to unit 107 she could hear the crying was coming from inside the unit. The security screen of the front door was closed but the door itself was open. The garage door was closed and Ms Langham's car was parked in the driveway. She could hear that Ms Langham was talking as well as crying. She did not hear any other voices and assumed that Ms Langham was talking on the phone. She got to her car and heard a "thud" noise from unit 107.

95. That neighbour had heard yelling coming from Ms Langham's unit from the end of 2020 – usually about once per week. From the beginning of 2021 she continued to see Ms Langham but did not see Mr Hely and assumed the relationship had ended.

96. At about 3.40am the resident of unit 106, adjoining Ms Langham's unit, heard arguing coming from unit 107. He could not make out words. He could hear a female voice. About 30 seconds later he heard a big window smash. He thought the smashing sound came from the back of unit 107 and it sounded like it may

have been the sliding door as it sounded like a lot of glass. After that he heard Ms Langham's voice – it sounded like she was in distress and that may have lasted about 30 seconds. It was high pitched and sounded like she was in trouble. He then heard silence and then heard the rest of the windows breaking. He looked outside and saw a red glowing light in the reflection of the windows of the unit opposite.

97. Another neighbour heard a female voice yell, "Help me."

98. About a minute later he heard crashing sounds. He looked out the window and saw Ms Langham's unit on fire.

99. At 3.54am the resident of unit 106 called 000 and told the call taker that someone had broken in and set his neighbour's place on fire. He said someone broke in and torched the whole place. He said he heard screaming and glass breaking, windows breaking and then he looked out the window and saw the fire so he left his unit.

100. He said he thinks that "he" broke in and possibly killed her. He heard screaming. He was on the computer and heard screaming.

101. The resident of unit 105 heard a female voice screaming at 3.45am. She then heard banging on her front door and a lady told her there was a fire.

102. When she ran outside she saw that the garage door to unit 107 was open.

103. At about 3.45am the resident of unit 108 heard a female voice screaming, "Help me, Gary, help me, someone help me."

104. She called 000 at 3.52am. She then heard glass breaking and she and her mother looked out the window and saw the fire coming out of the top floor window of the unit.

105. Officers of the Queensland Police Service, Queensland Fire and Rescue Service and Queensland Ambulance Service attended.

106. When the building was cleared and the area excavated, Ms Langham and Mr Hely were located along the eastern side, approximately 3m to the north of the front wall and 1.2m west of the eastern wall. The first body was located lying face up with the head nearest to the east wall. The second body was located face up alongside the first body with the head nearest to the east wall and located beneath the right shoulder of the first body. Located next to the bodies was an open 5 litre cylindrical steel fluid container.

107. After Ms Langham's killing police obtained telecommunications data from Mr Hely's phone revealing that he spent many hours outside Ms Langham's residence watching her in addition to the time he spent there on 21 February:
    - 7.10pm to midnight 7 February;
    - Midnight to 5.57am 8 February;
    - 1.55pm to midnight 8 February;
    - Midnight to 6.17am 9 February;
    - 4.50pm to midnight 9 February;
    - Midnight to 5.18am 10 February;
    - 2.17pm to 3.40pm; 6.41pm to 6.53pm and 7.48pm to 9.10pm 10 February;
    - 7.56pm to 8.11pm 12 February;
    - 8.56am to 9.36am and 6.13pm to 8.01pm 13 February;
    - 6.02am to 6.47am and 7.41pm to 8.04pm 14 February;
    - 5.55am to 6.32am and 6.56pm to 8.18pm 15 February;
    - 9.52am to 10.51am and 5.59pm to 6.30pm 16 February;
    - 8.05pm to 10.35pm 19 February;
    - 7.05am to 7.36am 20 February.

Autopsies

Ms Langham

108. The exact cause of Ms Langham's death could not be conclusively determined from the autopsy. Ms Langham was severely incinerated. She had extensive laceration of the capsule of the spleen with overlying haemorrhage. The precise mechanism of that injury could not be determined. There was no evidence of other significant recent injuries to Ms Langham although there could have been injuries which were not detectable due to the degree of incineration. Ms Langham had soot within her airways and lungs and heat injury to her upper airways which is indicative of deep inhalation of smoke prior to death.

109. Ms Langham was suffering from an enlarged and fatty liver (hepatosteatosis) and moderate degenerative narrowing of two of the main coronary arteries (atherosclerosis) but neither of these contributed to her death.

110. Toxicology of post mortem samples showed Panadol at a non-toxic range and alcohol at a low level (0.021%) which may have been generated post mortem.

Mr Hely

111. An autopsy revealed that Mr Hely died from the effects of fire. The presence of an elevated level of carbon monoxide in his blood and soot in his airways demonstrated that he was alive and breathing at the onset of the fire.

112. He had sustained some kind of injury to his left neck and chest prior to the fire but the mechanism of injury could not be identified due to tissue loss associated with incineration.

113. Toxicology analysis of post-mortem samples revealed the presence of an antidepressant medication and tetrahydrocannabinol.

Mr Hely's History

114. Mr Hely had a history of perpetrating DV on previous partners interstate.

Intimate Relationships

Mrs M

115. Mr Hely married his first wife in 1998. They had one child together. Mrs M was diagnosed with breast cancer and battled the illness for about nine years before she died in 2012. There is no evidence of DV in their relationship.

Ms B

116. Mr Hely met Ms B in March 2012. She was living in Orange and they met on a Facebook page. He was living in Sydney. They went out for some months and in June 2012 she got a transfer and moved to Emu Plains and moved in with Mr Hely.

117. She found that Mr Hely smoked up to 20 cones of cannabis per day.

118. In August 2012 he proposed and they were married on 16 March 2013 and honeymooned in Bali.

119. Mr Hely was made redundant in September 2013 and they decided to move to Orange. Ms B got her old job back. Mr Hely stayed in Emu Plains renovating his house.

120. On 14 March 2014 Ms B was out buying Mr Hely an anniversary present. She dropped in to see a friend. He phoned her and asked where she was. When she got home he yelled at her and punched three holes in the wall.

121. Mr Hely got a job and moved to Orange after his house sold in July 2014.

122. Mr Hely became jealous and controlling and didn't want Ms B to see her friends or family. He refused to allow her to join a gym because "men go to gyms".

123. In 2014 they were arguing and Mr Hely threatened Ms B's son with a hammer and jemmy bar. The police came and arrested him and took out a DVO.

124. Mr Hely constantly asked her to write a letter to the police to have the charges dropped so she gave in and in October 2014 wrote a letter stating that her statement was false and she had made it because the police intimidated her.

125. Mr Hely accused Ms B of having sex with other men. He checked her phone. On one occasion he tried to get her phone and she held it over her head. He grabbed her around the chest from behind and squeezed until he broke her rib.

126. On 27 March 2015 they argued and had a physical altercation and Ms B was taken to hospital by ambulance. She was discharged later that night.

127. Mr Hely moved into another house for a time but he moved in with Ms B again in about July 2015.

128. By February 2016 Ms B wanted to end the relationship. They went to Bali together in March 2016. Other family members also went on the trip.

129. During the holiday they argued and he grabbed her by the throat and lifted her off the ground and pinned her against a wall. He released her after about 30 seconds. Her son and security officers came to the room. He was moody for the rest of the trip and they flew home on 19 March 2016.

130. He stayed at Ms B's house for the next few weeks although she told him that the relationship wasn't working out. In late March or early April they were arguing whilst Ms B was in the shower. She tried to shut the bathroom door and he pushed it open causing the bottom of the door to break. He then grabbed her by the throat. He released her a short time later and left the bathroom.

131. He moved out in mid April 2016.

132. On 6 August 2016 Mr Hely went to Ms B's house. She told him the relationship was over and he hit her coffee cup out of her hand splashing her with boiling coffee. The next day her face was blistered from the coffee.

133. That day he followed her all over town. She became fearful and rang her son. She drove to where her son was. Mr Hely followed her but when he saw her son come out he drove off.

134. The next morning she went home to have a shower and her water had been turned off.

135. On 9 August 2016 Ms B made a complaint to police that Mr Hely had been continually stalking and following her.

136. Ms B went to stay at her mother's house as she was fearful of Mr Hely. On 11 August 2016 she went to her house to get some clothes. Mr Hely came to her house and when she told him to leave he said, "You've got two weeks bitch, guns on order."

137. He was arrested on 11 August 2016 and charged with stalking Ms B.

138. On 12 August Ms B went to her house and found that her clothing had been slashed, prints had been cut, bottles of alcohol had been drunk or emptied, two suitcases had been slashed, two pillows had been slashed, the dining room table was scratched, a new leather lounge had been slashed, a mirror had been smashed, her tall boy had the word "dog" engraved on it, a cupboard had been torn down and there were four photo albums missing.

139. There were no signs of forced entry and Mr Hely had returned Ms B's keys. She believed that he may have had a set cut.

140. Ms B had the locks changed that afternoon and moved back in.

141. About 5.50am on 14 August 2016 she found that her car had been spray painted with black paint.

142. On 15 August 2016 Ms B left her house as she was fearful to reside there due to Mr Hely's conduct. At that time he was on bail.

143. At 4.40am on 16 August 2016 police received a call advising that Ms B's premises was on fire. By the time emergency services arrived the residence was engulfed in fire.

144. At 4.55am on 16 August 2016 Ms B's neighbour called her and told her the house was on fire. She went out to her car and found her windscreen wipers had been bent up. She drove to her house where the fire brigade were working on the fire.

145. Later Ms B went through the house with police officers and noticed that an exercise bike had been moved and the smoke alarms had been removed from the hallway and the kitchen, two knives were missing, mail had been moved, a cabinet had been damaged, clothing had been slashed, valuable china and another ten photo albums had been removed.

146. Ms B gave police a statement on 16 August.

147. Mr Hely was arrested again on 16 August 2016. He admitted to damaging the bathroom door in April but denied assaulting Ms B. He denied making the gun threat. He admitted to grabbing Ms B by the throat whilst they were holidaying in Bali in March 2016.

148. When police arrested Mr Hely they found Ms B's family photo albums and black spray paint in his house.

149. Ms B considered that Mr Hely may have entered the house by smashing a window in the downstairs garage area or through an open upstairs window.

150. Mr Hely was charged with the following offences against Ms B at Orange:

- Common assault (DV offence) between 15 March 2016 and 15 April 2016;
- Stalking with intent to cause fear of physical or mental harm between 15 March 2016 and 15 April 2016;
- Damage/destroy property between 15 March 2016 and 15 April 2016;
- Stalking with intent to cause fear of physical or mental harm between 9am and 5pm on 11 August 2016.

151. A woman Mr Hely was believed to have been seeing at that time told police he was with her when the fire started. Because of that alibi he was not charged with offences relating to the fire.

152. On 18 September 2016 Mr Hely approached Ms B outside her mother's house. He came out from behind a fence and told her to drop the charges or she would never see her stuff again. He was pointing his finger at her as he said that. She ran inside and came back with her phone as she wanted to take a photo of him and he ran away.

153. On 29 September 2016 Mr Hely was charged with enter dwelling, stealing, possession of stolen goods, disposing of stolen goods in relation to the items stolen from Ms B's house.

154. He was later sentenced to a 12 month good behaviour bond for all the offences against Ms B.

Ms A

155. Mr Hely was in a relationship with Ms A prior to meeting Ms Langham. They met in 2016 on a dating site. She thought he seemed very normal. She had four children. After about six months they were engaged at Mr Hely's insistence. They lived with her four children and Mr Hely's 16 year old son.

156. At an early stage in the relationship Mr Hely told her he had to go to court due to alleged DV with his ex partner but said it was untrue.

157. The night they were engaged they travelled to Sydney for the night and argued. Mr Hely smashed the toilet and the bathroom door. He hit her in the face with the hotel phone. The next day the arguing continued.

158. Mr Hely became more controlling and Ms A decided to leave him. He threatened suicide to get her to stay. He checked her phone. He was paranoid about her use of Facebook. He also used her phone to check Ms B's Facebook as she had blocked his phone.

159. Ms A moved out on 25 December 2017. Mr Hely began to pursue her. He stalked her and knew her movements and where she was at all times. He called her and said he had been watching her shower. He took photos of her in the shower and threatened to post them online.

160. Ms A allowed the relationship to rekindle a few times as "in the end it felt safer for me to go back to him".

161. At one stage Ms A was searching for a rental house but could not find one and had nowhere to go. She believed he had access to her phone as he would ask her why she had been to see real estate agents.

162. In May 2018 Ms A decided to leave Mr Hely for good. She went to their residence to remove her belongings whilst he was at work and found that he had barricaded all the doors to prevent her removing anything. She had to break down the back door to remove her belongings. She found that Mr Hely had urinated on her mattress.

163. Mr Hely came home whilst she was there and was furious. He told her she couldn't take the furniture (although she had brought it when she moved in). He pushed her into the wall and hit her in the face. He assaulted her mother who was vacuuming the floor. He damaged the property she had moved into the yard.

164. Ms A called the police and made a complaint and obtained a DVO.

165. She later realised that Mr Hely had taken important documents such as her childrens' birth certificates, jewellery and about $5000 in cash from her.

166. He began to send flowers and jewellery to her place of employment.

167. About six months after Ms A last left Mr Hely she was visited by Ms B who told her about her relationship with Mr Hely.

168. Ms A did not tell Mr Hely where she was living but he eventually found out and left flowers at her front door. She was very fearful and slept on the lounge so she was near the front door. He continued to breach the DVO.

169. Ms A sent Ms Langham a message on 22 September 2019 as she wanted to warn her about Mr Hely but Ms Langham believed Mr Hely when he denied he had been abusive to Ms A.

Criminal History

170. Mr Hely had no criminal history in Queensland. He had a history of interactions with NSW police in relation to DV which would not have been available to Qld police via the QPS database and which they could have obtained only if they requested it from NSW police. The following was obtained from NSW Police records:

Date	Incident	Outcome
5/4/14	Verbal argument with Ms A	No further action as both refused to speak to police
25/10/14	Ms B's son called police. Alleged that Mr Hely threatened to rape her, smashed property and threatened her with hammers. When police arrived Mr Hely was waving two	Charged and DVO applied for and issued

	hammers around and shouting at Ms B and her son.	
3/1/15	Mr Hely reported a verbal argument with Ms B.	Nil police intervention – Mr Hely said he was moving out
27/3/15	Residing together but separated. Physical altercation and Ms B fell and struck her head. Went to hospital.	No charges as conflicting versions but police applied to vary DVO to no contact
19/9/15	Mr Hely attended Ms B's residence to collect property and damaged a rear door	No action
9/8/16	After separation and during divorce discussions Mr Hely increased unwanted contact in the form of expressions of affection, sent text messages which suggested he was watching her. On 6/8/16 told her she was going to die. Continued to follow her.	A new DVO was obtained as the previous order had expired.
12/8/16	Ms B reported that over the last three weeks someone had been entering her property and damaging furniture – no evidence of forced entry. Ms B was fearful of Mr Hely and staying with friends.	Insufficient evidence to charge Mr Hely
14/8/16	Ms B's car was damaged with black paint after she filed for divorce.	Charged with damaging car
16/8/16	Unproven house fire – Ms B was away from the house and it was set on fire. She had recently changed her locks due to him entering the residence and was staying with friends as too fearful to return home.	Charged with malicious damage, assault and stalking. Not charged with arson due to an associate providing him with an alibi.
18/3/18	Verbal argument with Ms A	No action

6/5/18	Mr Hely assaulted Ms A and her mother whilst she was moving out of their residence	Police applied for DVO
7/5/18	Mr Hely abused Ms A at the local shop after he became aware of the DVO application. She said his behaviour was escalating.	No action
8/7/18	Mr Hely had been sending Ms A numerous text messages and she was fearful for her safety. He would not accept the breakup and would not leave her alone.	No action
12/11/18	Mr Hely was texting Ms A constantly, attending her residence, threatened suicide when they broke up, had removed a page from her passport.	Insufficient evidence to charge

171. Mr Hely also had a criminal history in New South Wales which was readily available to Qld police through CrimTrac on both the QPRIME police database and the police QLiTE devices (Ipads which are issued to all operational police officers):

Date	Charges	Outcome
15/3/16	Common Assault (DV)	Not guilty
15/3/16	Stalking (DV)	12 month bond
15/3/16	Damage property	12 month bond
11/8/16	Stalking (DV)	12 month bond
9/8/16	Stalking (DV)	12 month bond
25/10/14	Stalking (DV)	12 month bond
25/10/14	Common Assault (DV)	12 month bond
23/3/99	Negligent Driving	Convicted and fined $500

172. CrimTrac records also revealed that Mr Hely had been the respondent in three final DVOs in NSW – one in relation to Ms A, one for her mother and one in relation to Ms B. Those orders were also preceded by provisional orders.

Contact with Support Services

Ms Langham - The Centre for Women & Co

173. On 6 September 2020 Browns Plains police referred Ms Langham to The Centre for Women & Co via the "infoxchange" database. The Centre created a client record on 7 September 2020. Ms I, a DV specialist social worker, attempted to contact Ms Langham on two occasions – 11 September and 15 September 2020. On 15 September 2020 when Ms Langham hadn't phoned back, Ms I sent an information pack to Ms Langham's address. When there was no further contact from Ms Langham the file was archived.

174. On 8 February 2021 the Centre received a referral from the Domestic Violence Assistance Program (DVAP) Beenleigh which assists women through the court process and assists them to complete applications for DVPO. That referral was added to her original file. The referral noted that Ms Langham should be sent a text message prior to phone calls as she suspected Mr Hely was phoning her from a private number and then hanging up when she answered.

175. During the first phone conversation with the Centre on 10 February 2021 Ms Langham sounded fearful. She was willing to accept any assistance she could get. She was unsure whether she wanted to move out of her unit but said that she was staying with her best friend at that time and Mr Hely didn't know where her friend lived.

176. Ms Langham told Ms I that she had allowed Mr Hely to stay at her residence after the relationship ended about four weeks previously because he had nowhere else to go. He had been staying in the spare room but had been checking her phone and taking photos of her whilst she was sleeping. She got a new phone last week and when he realised on 7 February he "lost it" and told her to enjoy the next three weeks of her life because he had paid for someone to take care of her. She said she was terrified and went to her friend's house.

177. She said she reported this to police but they said they couldn't apply for a DVO and she should make a private application (which she did with the help of DVAP). She said she got a DVO on 9 February which had an ouster order and no contact conditions but it hadn't been served as yet and she had only returned to the house once with police to collect some belongings.

178. Ms Langham said she was unsure whether she felt safe enough to return to her residence or whether she should relocate to another.

179. Ms I discussed her options re the *Residential Tenancies Act* and her residence and changing of locks and offered her a new phone but Ms Langham said that she would keep hers as the court had the number.

180. Ms Langham said that Mr Hely was calling her and sending her texts and emails. Ms I advised that once he was served with the order those acts would constitute breaches of the order. Ms Langham said she would call the police station before the end of the week to ensure he had been served so she could report any breaches.

181. In regards to the DV history Ms Langham advised of the following:
    - The relationship continued for two years and ended about four weeks ago;
    - Mr Hely was always controlling;
    - She originally lived in WA and he relocated from NSW to be with her;
    - He constantly accused her of cheating and would make her explain all the contacts in her phone;
    - He installed the "Life 360" app on her phone and always knew where she was;
    - He tracked her social media;
    - She couldn't do anything without him;
    - He verbally abused her and insulted her;
    - In September 2020 he threatened suicide when she ended the relationship and made him leave her house but she let him back after he saw a counsellor and started medication;

- Months later she discovered he was not taking his medication and was smoking cannabis constantly;
- He damaged her property including making holes in the walls and smashing the television;
- In April 2020 he punched her repeatedly in the face and kicked her in the back – she fled to a friend's house – he said he didn't recall due to blacking out due to alcohol and she didn't report that incident to police.

In relation to a safety plan:

- Ms Langham advised that:
  - She had changed her car registration plates;
  - She would call 000 if she felt unsafe or he breached the order;
  - She had removed important documents from her house;
  - He was unaware of where she was staying;
  - She had other friends and family she could stay with;
  - She had changed her bank accounts as he had access to them;
  - She had advised her employer and they would not accept calls from him;
- Ms I discussed with Ms Langham:
  - DV supports;
  - Having her phone charged and nearby;
  - Having fuel in the car;
  - Packing an emergency bag;
  - Turning off location services and changing social media passwords;
  - She should be extra vigilant as post separation is a risky time.

182. On 15 February Ms Langham phoned Ms I seeking assistance to change her locks and said she could not return to her residence until this was done. She spoke about the two DV occurrences over the weekend. She said that on 14 February she found a flower and note on her car in which Mr Hely had stated that he would always love her. She reported this to police. That same evening she found another rose in her backyard – she became fearful and went to a friend's place to stay. She said she was going to make a statement to police.

183. Ms Langham said that she did not wish to relocate at this time.

184. Ms I phoned Mr W, a locksmith, and arranged for him to contact Ms Langham to organise the change of locks to the front door and front screen door and installation of a dead bolt to the front door.

185. Ms Langham phoned back later that day and discussed another incident. She was crying and said she was very fearful. She had returned to her property to get some clothes and found that both the front doors were unlocked and the rose was gone. They discussed having all the locks changed. Ms Langham said that she would report this to police.

186. Ms I phoned Mr W again and organised to have the back door locks changed as well.

187. Ms I noted on the file that she would check in with Ms Langham on 24 February 2021 and that "should risks continue to escalate and Person Using Violence (PUV) continues to breach a HRT referral may be considered".

188. Mr W attended Ms Langham's residence on the afternoon of 16 February 2021. He noted that there were timber doors on the front and back (at the laundry), a sliding door with a security screen in the dining room and a sliding door at the front with no security screen. He fitted deadbolts to the wooden doors and re-keyed all existing doors.

189. Mr W phoned Ms I on 17 February 2021 and confirmed that the locks had been changed and he had installed an additional dead bolt on the laundry door as it had been damaged – it was broken and cracked.

190. Ms I was due to phone Ms Langham again on 24 February 2021.

Mr Hely – Counselling

191. On 19 August 2020 Mr Hely was referred by The Heart Centre to Mr C, a counsellor. Mr C has run Men's Behavioural Change Programs. Mr Hely attended appointments on four occasions but missed his last two on 8 and 18 September 2020.

192. Mr Hely said that he was verbally abusive to his partner but didn't admit physical violence. He was worried his partner would leave him and was insecure and vulnerable but then would blame her. He said he had previously engaged in such behaviours and was now doing it again.

193. On 29 August 2020 Mr Hely told his GP that he had anger issues, difficulty controlling his emotions and anger and this was affecting his relationship. He said he wanted to get better. The GP discussed a Mental Health Care Plan and that was completed on 16 November 2020 and the GP nominated a psychologist. Unbeknownst to the GP the psychologist was no longer in practice, however, Mr Hely's phone records indicate that he did not attempt to contact the psychologist in any event.

Homicide Investigation

194. Fire Investigator Ben Hamilton investigated the circumstances of the fire and produced a report.

195. The Queensland Fire and Emergency Service (QFES) received the first call about the fire at 3.53am on 22 February 2021. The first crew arrived at the fire at 4.05am. The OIC of the first arriving crew reported that the structure was well involved in fire at that time. Three crews in total attended and had the fire under control at about 4.29pm.

196. Officer Hamilton attended the scene that day and commenced investigations to establish the cause of the fire. He conducted the investigation with the assistance of police officers including scientific officers.

197. Initial fire crews reported that the garage door may have been in the open position during initial firefighting activities and video footage taken by a witness showed the garage door in the open position.

198. Officer Hamilton noted that the eastern end of the townhouse had been severely damaged by fire. The upper floor level, roof and eastern brick wall had collapsed down onto the ground floor level. The right half of that side had the greatest level of fire related damage.

199. The security screen door of the laundry was locked. The timber door behind it had been consumed by fire but the door hinges were in the closed position and the deadbolt was in the locked position. He concluded that the rear doors were closed and locked at the time of the fire.

200. The glass sliding door in the living room was in the closed position prior to the fire development.

201. Officer Hamilton found:
    - the fire developed within the eastern half of the structure;
    - the remains of the roof and upper floor collapsed down onto the ground floor level;
    - Ms Langham and Mr Hely were lying on the tiles in the dining room on the ground floor when the fire started;
    - There were volatile organic compounds beneath the bodies;
    - Testing identified petrol on the back sides of the bodies;
    - The lounge room floor area on the eastern side displayed the effects of prolonged exposure to intense heat at ground level;
    - The fire developed on the ground level of the eastern half of the structure;

- After the fire was ignited on the ground floor of the eastern side (loungeroom area) it projected upwards to the ceiling where it spread laterally in all directions;
- The lateral spread reached the front entry void and extended vertically straight to the upper level ceiling where it spread laterally throughout the rooms on the upper level;
- The windows failed due to fire which allowed ventilation which promoted fire growth;
- Fire penetrated the upper level ceiling space and the roof structure, upper level framing and floor structure collapsed onto the ground floor;
- On arrival of fire crews the eastern brick wall collapsed.

202. Officer Hamilton concluded that the area of fire origin was the ground floor loungeroom on the eastern half of the structure. He was unable to identify an exact source of ignition but concluded that it was likely that a fuel (petrol) and a mobile ignition source were introduced to the area of origin and wilfully set on fire.

203. Scenes of Crime Officer (SOCO) Steven Torrisi concluded that Ms Langham and Mr Hely were in the living room when the fire commenced. They were found lying on their backs with their heads closer together – their bodies were at an angle of approximately 90 degrees. Their heads were on or near a couch along the east wall of the living room.

204. Mr Hely was closer to the front door. He had his right shoulder and arm above Ms Langham's head.

205. A petrol tin was within one metre of Ms Langham. No ignition source could be found.

206. He concluded that the most likely source of ignition was intentional human involvement utilising a portable ignition source applied to ignitable items such as petrol and/or furnishings, in the living area on the lower level.

207. Detective Sgt Darren Reilly undertook a comprehensive investigation into the death of Ms Langham and concluded that:
    - The relationship between Ms Langham and Mr Hely was characterised by DV;
    - The fire was deliberately lit by Mr Hely;
    - He formed an intent to cause harm to Ms Langham during the afternoon of 21 February 2021;
    - The intent was manifested in the purchase of tape, rope and petrol;
    - He poured petrol inside Ms Langham's living room and killed her by setting her on fire;
    - His death was either deliberate suicide or unintentional death due to the intensity of the accelerant enhanced fire;
    - Had Mr Hely survived the fire he would have been prosecuted for the killing of Ms Langham.

208. Detective Sgt Reilly opined that the medical centre processes of referring Mr Hely to a psychologist and the lack of follow up when he did not see the psychologist represent a missed opportunity to engage him with a mental health professional at a time when he was apparently receptive to help.

ESC Investigation

209. Due to the numerous contacts she had with police prior to her death, particularly on the night of 21 February 2021, the death of Ms Langham was classified as a death which occurred in the course of a police operation and as such, the circumstances of the death were investigated by officers of the Internal Investigation Group of the Ethical Standards Command (ESC).

210. ESC investigators identified all contacts that Ms Langham had with police. The circumstances of those were reviewed and assessed from a number of perspectives:

- A Quality Assurance Coordinator from Policelink conducted a review of the Policelink operators' responses to Ms Langham's calls to that service;
- Senior Sergeant Wayne Smith, Workforce Management Unit, Communications Group, conducted a review of the police communications officer's response to the 000 call made by Ms Langham on 21 February 2021;
- Senior members of the Vulnerable Persons Unit conducted a desktop review of the police response;
- The ESC investigators reviewed referrals to support services;
- The ESC investigators reviewed the adequacy of the response of police officers.

Ms Langham's Contacts with Police Officers

6 September 2020

211. On 5 September 2020 Ms Langham and Mr Hely argued. He left a suicide note and left the unit in his car and later texted her threatening suicide. The next day when he hadn't come home Ms Langham went to Browns Plains station. The matter was handled by Senior Constable Sean Mykytowycz and his partner Senior Constable Robert McGregor, police negotiators Sergeant Megan Ward and Senior Constable Deborah Rasmussen.

212. Whilst Ms Langham was at the police station Mr Hely called her and spoke to police. He said he was fine, in good health and not suicidal. He hung up when police said they wanted to see him. They phoned him back and convinced him to present to Browns Plains police station where he spoke with police and a mental health service provider. It was determined he did not require any further mental health assistance.

213. Ms Langham told Sergeant Ward where Mr Hely worked, that his ex-wife was in Orange, that since separation Mr Hely had been coming into her room and accusing her of infidelity, and that he was going to continue this behaviour until

she hates him and then he will be happy. She said that he calls and texts her constantly – some days she received forty texts.

214. Police determined that Ms Langham was not in need of a DVO as she said she was not afraid of Mr Hely and there was no property damage or physical violence alleged. Ms Langham accepted a referral to The Centre for Women and Co. Mr Hely declined a referral to support services. The police officers completed a DV Protective Assessment Framework (DV-PAF – see Annexure A)[1].

215. The officers noted risk factors of controlling behaviour and mental health issues.

216. Officer Merrett at Beenleigh Station recorded, "The mental health nurse spoke with [Mr Hely] via phone conversation and confirmed his controlling behaviour appears to be the sole purpose of the suicide note."

217. The incident was recorded as DV and Ms Langham and Mr Hely referred to support services.

ESC Investigation

218. ESC investigators interviewed Senior Constable Sean Mykytowycz who took the report from Ms Langham. He also spoke to Mr Hely on the phone. He considered that Ms Langham was not fearful. He consulted the District Duty Officer (DDO) about triangulation of Mr Hely's phone and arranged involvement of police negotiators, Rasmussen and Ward. They negotiated with Mr Hely and he agreed to present himself at a police station.

[1] OPM 9.4.2 provides:
Domestic violence protective assessment framework

The Protective Assessment Framework (PAF) is a decision-making framework designed to assist officers in assessing the protective needs of an aggrieved. Identifying the presence of risk factors and assessing the aggrieved's level of fear will assist in determining the required response. Officers are to conduct a protective assessment at all incidents or reports of domestic violence and utilise information gathered on risk factors in conjunction with their investigative skills, knowledge and experience to make an informed decision. Officers play a crucial role in identifying and responding to domestic violence and their actions and decisions can have a marked effect on future violence.

219. Senior Constable Mykytowycz said that he didn't check CrimTrac to ascertain whether Mr Hely had any interstate criminal history. He didn't know how to do it – he had never done it and he was not familiar with the process.

220. Logan District Mental Health Co-ordinator Megan Ward was interviewed. She is a trained police negotiator. She believed that Ms Langham was not concerned for her safety at that time. Ms Langham told her that she and Mr Hely had separated five or six weeks ago and were sleeping in separate bedrooms. She wanted her keys back. He had been sleeping in his car at times.

221. Ms Ward spoke to Mr Hely for two hours on the phone and identified that Mr Hely liked to control and direct the situation. Mr Hely came to Browns Plains station. Ms Ward believed his behaviour was more controlling behaviour than suicidal.

222. Detective Senior Constable Deborah Rasmussen told investigators that Mr Hely clearly stated that what he wanted was to return to the relationship with Ms Langham and her residence. Mr Hely was concerned if he came to the station he would be arrested but he would not say why. She would not have looked at CrimTrac although it is easy to use on QLite but not on QPRIME and she didn't know how to access it via QPRIME.

ESC Conclusions

223. Police did not review interstate information available despite a NSW address history being recorded in QPRIME. This was not in accordance with Police Operational Procedure (OPM) 9.4.2 which requires police investigating DV to review and consider previous DV incidents and/or any history of violence.

224. The reporting officer inappropriately recorded the level of risk as unknown within the DV-PAF. That should only occur when an officer is unable to conduct a risk assessment.

225. The mental health co-responder identified DV risk factors in communication with Mr Hely and that information was not sufficiently relayed to the reporting officers or recorded in the DV occurrence.

226. The investigation identified no prominent issues for consideration. Police officers utilised police negotiators and mental health experts. The ESC concluded that the response was within policy and service expectations.

7 February 2021

227. At 1.56pm on 7 February 2021 Ms Langham phoned Policelink. She said Mr Hely had a violent streak, that he was meant to be moving out of the house and a few hours ago he told her she would be killed in the next three weeks. He said she "could get T-boned, sniper shot or bashed."

228. She said she was really uncomfortable about going home. She was transferred to a call taker.

229. Ms Langham told the call taker that she was worried about going home. She said Mr Hely had sent her harassing text messages – up to 30 per day. She got a new phone and when he found out she'd done that he lost it and called her a fat cunt and other names. He made the death threats and said, "Every dog has their day and yours is coming".

230. She was at her daughter's place but was scared to go home. The call taker said that she could see the record of the suicide threat but no other DV occurrences. Ms Langham said they had had quite a few.

231. Ms Langham said that she couldn't go home so she drove to Browns Plains police station but it was closed so she called Policelink.

232. The call taker advised Ms Langham to go to a friend's house and wait for the police.

233. Ms Langham told her that Mr Hely had threatened to come to her work the other day.

234. The call taker noted that Ms Langham was "extremely frightened and feared for her life."

235. A job was created and allocated priority 3 (routine) response. [2]

236. At 3.19pm an officer recorded, "The informant has switched off her PH. I want her to immediately attend Logan Stn re DV. Pls contact her through friends etc. What is her ETA to counter? I will ring her to check she is there safely; S"

237. At 4.08pm a call taker recorded on the incident log, "Nil answer on inf ph – CT uncomfortable calling inf friends or associates re DV matter and accessing QPRIME re this."

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[2] Priority Codes

As at February 2021 there were five priority codes which could be allocated to police jobs by the Communications Centre:

- Code 1 – for very urgent matters when danger to human life in imminent;
- Code 2 – for urgent matters involving injury or present threat of injury to person or property;
- Code 3 – for direct response;
- Code 4 – for alternate resolution;
- Code 5 – for no police tasking.

Chapter 14.24.2 of the Operational Procedures Manual of the QPS relevantly provides:

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

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

(i) danger to human life is imminent; or

(ii) an officer/s or member/s of the public is in need of immediate help in circumstances where life is actually and directly threatened and there is an imminent danger to human life.

(See also s. 15.3.3: 'Use of flashing warning lights and siren' of this Manual)

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

(i) incidents similar to those above and any other urgent situations (e.g. escaping prisoners) without the element of imminent danger to human life being apparent

(ii) in any other urgent situation when it is known that danger to human life is not imminent; or

(iii) incidents involving injury to a person or present threat of injury to a person or property.

(See also s. 15.3.3: 'Use of flashing warning lights and siren' of this Manual)

Code 3 – 'Direct Response' – may be assigned to all other matters which are considered as not requiring classification of Code 1 or 2, however a direct police response is required. This may include the following circumstances:

(i) the incident is happening now, and persons involved in the incident are still present; and

(ii) the incident may escalate if police do not attend the incident location now; or

(iv) Evidence of a crime is present at the incident location which is likely to be lost if police do not provide a timely response.

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238. At 4.16pm a general duties crew from Crestmead Police station (Senior Constable Kaye Forrest and First Year Constable Michael Cacace) attended on Ms Langham at her friend's house and obtained a notebook statement.

239. Constable Cacace recorded the events on his body worn camera (BWC) which reveals that Ms Langham and the officers had a conversation which relevantly included the following information:
    - She and Mr Hely separated 3 weeks ago;
    - She was bombarded with texts and messages;
    - She got a new phone which was not on his plan;
    - Last night she'd had enough of his messages and cleared the old phone completely;
    - He threatened to kill her;
    - He is on medication and seeing a counsellor;
    - His ex wife and girlfriend both have DVOs against him – she should have taken notice of that earlier
    - She felt physically ill when she left after his threats and the call taker told her not to go back there; he has smashed stuff in the house and put holes in the walls before, "How far he would go, I don't know";
    - She went to Browns Plains police station to get the Policelink number;
    - In September he threatened suicide and went missing;
    - He sent her 30 texts in one day in the last couple of weeks;
    - He lost it today because now he has no control as she got a new phone;
    - She woke up this morning to more text messages so reset her phone and left the old phone for him;
    - She went for a shower and he knocked on the bedroom door ;
    - When she finished her shower she went downstairs and he was there;
    - He said he had tried to send her a text and she thinks he saw the old phone;
    - She made him a coffee and he commented that he saw she had a new phone and he hoped she'd "paid out the fucking plan";
    - They had a conversation about rent he owed and that he could use that for phone payments;

- He was being verbally abusive and ranting and calling her names and so she “switched off”;
- He said, “If you’re not going to listen to what I say you should listen to this,” and then made the death threats – he was not yelling but it was “pure venom”;
- She hopes he’s not still at her address;
- He told her daughter he’d have to live out of his car at his work site;
- After making the threats he walked off and she grabbed her stuff to leave;
- She heard him on the phone to a counsellor crying and saying she was being mean to him;
- She said, “I had a good teacher,” and he swore at her;
- Both names are on the lease and she had spoken to the agent about it;
- He snuck in her bedroom and took photos of her at night sleeping and then showed them to her – that “creeped” her out;
- He stalked his ex girlfriend for a long time;
- She is reporting just in case something does happen to her – she thinks he’s probably full of shit and she has given him the benefit of doubt before;
- “He was accused of setting fire to his ex-wife’s house”.

240. Senior Constable Forrest advised Ms Langham:

- If Ms Langham has contact with Mr Hely, she should record him;
- As the police don’t have any physical evidence they can’t take out a PPN;
- All Senior Constable Forrest can see is that they had an argument;
- Ms Langham can apply for a DVO and can refer to anything that has occurred but the police can’t get one because she’s not injured or covered in blood and that is a bad thing because they need to prove beyond reasonable doubt that DV occurred but she doesn’t ;
- Any controlling behaviour is DV;
- His threat to commit suicide is emotional DV;
- “Please fill in the form for a DVO and submit it to Beenleigh court”;
- Once that goes through if he refuses to leave Ms Langham can go to the real estate agent and get him taken off the lease;
- Ms Langham can get a non contact condition when she gets the DVO;

- If the police take out a Police Protection Notice (PPN) they can only get a condition that he be of good behaviour;
- They will go find him and give her a call and let her know what's happening;
- He will tell them a different story.

241. Constable Cacace told Ms Langham the following:
    - If he checks your phone that is DV;
    - There is more emotional abuse than physical;
    - Just go in to the court house and you will see it all there.

242. Later that afternoon Senior Constable Forrest and Constable Cacace went to Ms Langham's residence. They walked around looking for Mr Hely. The back sliding door was open and the security screen was unlocked. They called out but nobody answered and then entered the residence through the unlocked door. They looked through the unit but Mr Hely was not there. They commented that his clothes had mostly gone but some clothes were still there. They locked the house and exited via the front door. Senior Constable Forrest said they would call Ms Langham and tell her to call police if he comes back.

243. They telephoned Mr Hely who denied making threats and said that he was moving out. The officers recorded that the matter was finalised as Ms Langham was "not fearful" and both parties confirmed they had separated and Mr Hely had collected most of his belongings and was moving to NSW.

244. Senior Constable Forrest and Constable Cacace briefed their shift supervisor Sergeant Annette Pearce who agreed that no further action was required.

245. They completed a DV-PAF and recorded one factor in category 1 (separation) and "not present" for category 2.

ESC Investigation

246. ESC investigators interviewed Senior Constable Forrest who stated she was sworn in in January 2009. She was the Field Training Officer for Constable

Cacace on 7 February. She saw the job on QLiTE and then police comms called requesting they attend the job.

247. They went to Ms Langham's friend's address. Ms Langham had a bubbly personality, she was very jovial, laughing and joking.

248. Ms Langham told them that Mr Hely threatened to kill her that morning. They both had a bit of a laugh about the sniper comment.

249. Senior Constable Forrest said she phoned her shift supervisor Sergeant Pearce who told her to try to speak to Mr Hely.

250. Senior Constable Forrest confirmed that she told Ms Langham that police needed to prove beyond reasonable doubt that DV had occurred and they could only rely on what happened that day whereas if she took out her own application she could rely on any information to obtain the order.

251. She said they went to her residence and couldn't find Mr Hely. She called Mr Hely and he said they had a verbal argument and the relationship was over. He said he was in Tweed Heads and he would return later in the day to retrieve his property. He denied making any threats.

252. She called Ms Langham and told her what Mr Hely said and Ms Langham said she was going to stay with friends.

253. They went back to the station, discussed the matter with Sergeant Pearce and completed a "DV Other Action"[3] record because it did not appear Ms Langham was in fear, Mr Hely was in NSW and not at home.

254. She did not ask Ms Langham about the content of the text messages or ask to see them.

[3] DV Other Action is recorded on the QPS database when police make a referral to a DV support service but take no other action i.e. do not issue a PPN or apply for a DVO on the basis that there is insufficient evidence of DV or no need to protect the aggrieved or the aggrieved is not in fear.

255. She saw on QLiTE that there had been a previous incident in September 2020 and confirmed that it involved Ms Langham but she did not open the occurrence or read it.

256. She did not ask Ms Langham whether she was scared. She didn't ask about the previous DV that Ms Langham mentioned. She didn't review QPRIME re Mr Hely or Ms Langham. She didn't check Mr Hely's criminal history.

257. Senior Constable Forrest told ESC investigators that she believes that police have to prove DV beyond a reasonable doubt to get a DVO and she learnt that in her first year of policing.

258. First Year Constable Cacace was interviewed by ESC investigators. He was sworn in on 18 November 2020. At time of Ms Langham's death he had 12 weeks service.

259. He said that as Ms Langham relayed her complaint she laughed and was jovial. She said she was more than happy to go home. It wasn't "all doom and gloom", "protect me".

260. He confirmed that he was aware that Senior Constable Forrest told Ms Langham there wasn't sufficient for them to get a PPN but she could make a private application and that police could only deal with what happens on the day in a DVO application but Ms Langham could go back two years in a private application.

261. Constable Cacace said that after attending Ms Langham's unit he believed Mr Hely was in the process of moving out.

262. Since he joined QPS he has been to DV jobs most days – they are the most frequent types of jobs he attends. On the vast majority of them some action is

taken from PPN to breach. Most of his experience is re breaches, PPNs. He can only recall one matter being finalised as "No DV[4]".

263. Constable Cacace said that he had DV training at the academy re DV but has had no training since then apart from a training day with officers of the Vulnerable Persons Unit (VPU) when they spoke about their role and high risk matters.

264. He said that prior to attending joining the police service he studied law for six months. He understands that the standard of proof required to obtain a DVO is the civil standard i.e. the balance of probabilities (not the higher standard of beyond a reasonable doubt).

265. He did no searches on his QLiTE on Ms Langham or Mr Hely and at that time didn't have any idea what he was doing as he had only recently received his iPad. He said he now knows how to search for a criminal history but he did not then and he still is unaware how to search interstate criminal history on QPRIME although he can do it on his QLiTE.

266. Constable Cacace said that he hopes he handled the matter correctly but even now he "couldn't really tell" whether he did.

267. Sergeant Pearce was interviewed by ESC investigators and stated she was sworn in January 2003.

268. She agreed that the crew would have briefed her but she had no accurate recollection of the matter because she failed to take any notes of the matter or her decision. She said that it is her normal procedure to make no record at all of decisions she makes as shift supervisor. She said she would "probably" make notes from now on.

[4] "No DV" is recorded on the police database where it is established that there was no actual DV committed

269. She said that it was correct to record the matter on QPRIME as DV Other Action as Mr Hely was moving out, there was only a verbal argument and there were inconsistent versions. In that case there was insufficient information on which to obtain a PPN. Senior Sergeant Pearce said that after viewing the BWC footage she remained of the view that there was insufficient evidence to issue a PPN.

270. She said she doesn't know how to check interstate history on CrimTrac and doesn't know if it was done in this case.

271. Sergeant Pearce has had no specific training in DV apart from the Online Program (OLP) that was available after a change in legislation. She has had no specific training in the duties of a shift supervisor.

272. She said that the majority of jobs that general duties police attend are DV incidents.

273. She said that the DV-PAF is completed at the end of the job when officers are uploading the occurrence to the database.

ESC Conclusions

274. The Policelink Review concluded that the phone call of 1.56pm was handled correctly and it was recorded that Ms Langham was extremely fearful and did not want to return home.

275. The review by the Vulnerable Persons Command found that Senior Constable Forrest and Constable Cacace did not take the threats seriously and dismissed them. They did not thoroughly investigate the allegations of Ms Langham including threats made, property damage and the level of fear of Ms Langham in the original phone call. They dismissed claims because Ms Langham "did not appear fearful and was joking and laughing about the incident". The officers failed to acknowledge Ms Langham's statement that Mr Hely had previous DV history with previous partners. They did not review CrimTrac holdings and it was

incumbent upon them to do so following the specific information provided by Ms Langham.

276. The reviewers stated:

> *The officers improperly dismissed the information provided by the aggrieved, failed to appropriately recognise the fear and concern held by the victim and failed to assess the risk to the life, health and safety to the victim in light of all the information provided or available to them.*

277. The advice provided to Ms Langham to make a private application was a failure of the officers to fully investigate the matter and take action to protect the victim and in contravention of OPM 9.3.3[5].

278. There was sufficient information to support a PPN or application for DVO to the requisite standard. Senior Constable Forrest incorrectly stated the standard of proof required for a PPN or DVO. The officers failed to justify why a protection order was not necessary or desirable and did not accurately record the allegations of threats to kill, substance abuse, controlling behaviour, mental health issues, history of violence, destruction of property, suicidal and violent

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[5] 9.3.3 Directing a person to a court house to make a private application

When an officer receives a report of a domestic violence, the incident is to be fully investigated. If the officer establishes there is insufficient evidence to support a police domestic violence application or QP 0899: 'Police Protection Notice' (PPN), the officer:

(i) should consult with a supervising officer prior to advising the person there is insufficient evidence to support a police application;

(ii) may advise the person to attend a court house to make a private application for a protection order;

(iii) should provide appropriate advice and support information to the person; and

(iv) is to comply with the provisions of subsection 'Where there is insufficient evidence to support an application for a protection order' outlined in s. 9.4.3: 'Police action to be taken where applying for a protection order, PPN or temporary protection order is not appropriate' of this chapter.

ORDER

If the officer is in any doubt a person is in need of protection, the officer is to investigate the report and if appropriate, take action under the DFVPA.

threats. They disregarded that Ms Langham advised she felt physically ill due to the threats. They should have classified her level of fear as fearful and her level of risk as high but they failed to identify the relevant DV-PAF factors due to their failure to undertake a thorough investigation.

279. ESC investigators concluded that the response by Senior Constable Forrest and Constable Cacace was "less than optimal". They failed to acknowledge Ms Langham's fear level and important information that she told them including that Mr Hely had previous DV history and had tried to burn down his ex-partner's residence. They did not check interstate information available to them.

280. The officers failed to undertake a sufficient investigation eg did not check her text messages.

281. They wrongly believed there was insufficient evidence to make an application for a DVO.

282. They didn't place warning flags against her name on the database which would have changed the priority of subsequent jobs.

283. Investigators stated:
The actions of Forrest and Cacace are subject to a discipline investigation in relation to the allegation they "failed to adequately investigate apparent risks of domestic violence and criminal allegations." The discipline report is currently being authored.

284. ESC investigators concluded that it could not be determined whether further investigations would have changed the outcome for Ms Langham.

8 February 2021

285. Ms Langham attended the Beenleigh Magistrates Court and applied for a DVO. She provided the following information in the application in relation to her relationship with Mr Hely:

- They had been together three years and separated about three weeks ago but were still living together;
- Mr Hely had threatened to kill her;
- He sent multiple harassing and inappropriate texts each day;
- He exhibited aggressive behaviour when she blocked him on social media and changed her phone number;
- He had taken photos of her whilst she slept in her bedroom;
- He had been going through her personal items;
- She feared for her safety.

286. The matter was listed as an urgent application for the following day.

287. At 4.51pm that afternoon the application (along with all others lodged that day) were forwarded to the Logan High Risk Team (HRT).

9 February 2021

288. Ms Langham appeared in the Beenleigh Magistrates Court. She was represented by a duty solicitor. There is no evidence that there were any police officers in the court room.

289. The Magistrate made a temporary protection order (TPO) and noted that Mr Hely was “erratic” and “extremely unstable” and asked the solicitor whether the matter should be referred to the HRT.

290. The TPO contained conditions which prohibited Mr Hely from:
- remaining at the Myola Street unit;
- going to within 100 metres of Ms Langham’s place of work or residence;
- locating or contacting Ms Langham by any means whatsoever;
- going to within 100 metres of Ms Langham when she was at any place;
- using the internet to communicate with or publish comments about Ms Langham.

291. The matter was adjourned to 23 March 2021 (see Ex C4.3.1) for Mr Hely to be served with the application.

ESC Investigation

292. ESC investigators noted that there was no evidence police were present in the court room when the Magistrate commented that Mr Hely was "erratic" and "extremely unstable". At that time private DVO applications were not reviewed by police.

293. The ESC stated that an opportunity for improvement was identified to ensure the contents of private DVO applications are brought to the attention of police and recent state-wide changes now require the timely review of all private DVO applications by police districts.

11 February 2021

294. First Year Constable Mitchell Langford served Mr Hely with the TPO at 5.40pm at the Browns Plains police station. The interaction was recorded on his BWC.

295. Constable Langford explained all of the conditions of the order.

296. Mr Hely said that he had moved out. He appeared to be very agreeable and reasonable. He said he was shocked as there had never been any violence and she had never had to fear for her safety. He said he loved Ms Langham but he would walk away.

297. The ESC investigation identified no concerns with the service of the DVO on Mr Hely.

14 February 2021

298. Ms Langham had numerous contacts with police on 14 February 2021. In the morning she phoned Policelink and reported that Mr Hely had breached the DVO. At midday she attended the Logan Central police station. In the afternoon police

officers attended her residence. That night she phoned Policelink and reported a further breach of the DVO.

299. At 8.13am Ms Langham called Policelink and reported that at about 7.45am she and Ms Edwards heard a noise from the front of her unit. They investigated and found flowers on her car and her side gate open. There was no card.

300. Ms Langham said that she had a TPO in place but she couldn't confirm that it was Mr Hely who left the flowers.

301. She was transferred to a call taker.

302. She advised that her unit complex has surveillance footage and she took a photo of the flowers on the front of her car.

303. She said she was pretty sure it was Mr Hely but she could be wrong.

304. She said she would get the side gate padlocked that afternoon.

305. She advised that Mr Hely told her a DVO was only a piece of paper but the Judge said she should report every breach.

306. The job was classified priority 4 and she was told to report the possible breach of DVO to her local police station.

307. At about midday Ms Langham went to Logan Central police station and spoke to First Year Constable Stuart Crews and reported the breach.

308. The BWC footage of Constable Crews reveals that Ms Langham was taken into an interview room at the station.

309. She told him about the flowers and the side gate being opened and showed him a photo of the flowers on her car which was on her phone.

310. She told him that on leaving her house to go to the station she saw a sign on a pole at the front of her house on which someone declared their love for her. She showed him a photo of the cardboard sign.

311. She told him that although she had changed her phone Mr Hely now had her new phone number. She said that she changed her number due to Mr Hely sending her up to 70 inappropriate text messages per day.

312. Constable Crews looked up the DVO on his QLiTE whilst they were talking. He commented that it was a private DVO, not taken out by police.

313. Ms Langham told him about the threats made by Mr Hely on 7 February 2021.

314. She said she later realised he had gone through her belongings that morning and found her new phone number.

315. Constable Crews asked whether Mr Hely had been served with the DVO and Ms Langham confirmed that he had been served.

316. Constable Crews said that he would take a statement from her and Mr Hely would be flagged as wanted for questioning so when they caught up with him he would be offered an interview.

317. He said the first time someone breaches an order it is only a simple offence and he would be fined.

318. Constable Crews asked Ms Langham whether she could get CCTV from her complex. She said she hadn't enquired as yet.

319. Constable Crews said Mr Hely would be listed as a suspect on the police database but if he denied being there they would need the CCTV.

320. Ms Langham told Constable Crews that Mr Hely took every power board from the house, her tool set and all her good towels. She told Constable Crews that she went to get into bed and found that he had ejaculated on her sheets.

321. She said that she is speaking to The Centre for Women & Co.

322. She found that Mr Hely had written in her diary.

323. Constable Crews asked about physical violence – Ms Langham said he was physically violent once. Constable Crews ignored that and asked for her phone number.

324. Constable Crews took a notebook statement. He said he would create an occurrence on the police database and send Ms Langham the number. She should take the CCTV to a police station with the occurrence number and their investigation could continue.

325. Ms Langham said that she called Policelink and they told her she could go to Browns Plains the next day when it would be open or go to Logan Central today. She said her work had been disrupted massively because of all of this so she could not go to Browns Plains tomorrow.

326. She said she would be buying a padlock on the way home to secure the gate.

327. She said Mr Hely was living out of his car at his workplace at Wacol. Constable Crews did not ask for the address.

328. At the end of the conversation Ms Langham started crying and apologised for wasting the time of the police. Constable Crews reassured her that was not the case.

329. Constable Crews continued with counter duties and the matter was later tasked for further investigation.

330. Constable Crews recorded that Ms Langham declined victim referral.

331. Constable Crews completed a DV-PAF.

332. At 12.42pm Constable Crews sent Ms Langham a text message advising of the QP number so that she could cite it when she delivered the CCTV to a police station.

333. At 3.48pm Constable Corin Barry and Constable Michael Lawrance from the Browns Plains station attended Ms Langham's residence to take a report due to the initial report to Policelink remaining active on the system.

334. The conversation was recorded on BWC which shows that, as usual, Ms Langham was friendly and happy. She said she felt like she was overreacting but kept remembering that the "judge" told her to keep reporting everything.

335. Constable Lawrance asked for a photo of the sign and Ms Langham explained that she showed it to the Constable Crews but he didn't ask for a copy. Constable Lawrance asked whether she recognised Mr Hely's handwriting and she confirmed that she did. He asked whether the sign was still there. He said it was "lovely, but unwelcome".

336. Ms Langham said that after inappropriate text messages she changed her phone and that really "pissed him off" resulting in the death threats which she described again. She said that after he was served that was the first time she went back home. She went to get into bed and found that he had ejaculated on her sheets. Her girlfriend was still there. She then threw out all her personal items. Constable Lawrance said "Alrighty, well sorry to come out and bother you".

337. The officers updated the initial report placing a photo of the sign on the occurrence.

338. The statement taken by Constable Crews had not been uploaded to QPrime at that time (Crews uploaded it on his next shift which was on 18 February).

339. At 8.41pm Ms Langham called Policelink and reported that she had just found a rose on her back patio table. She said she had a TPO on her ex-partner, and this morning there were roses left on her car and now she had found a rose on her table out the back.

340. Ms Langham was put through to a call taker. She said she was frightened. She said she has a TPO with no contact condition. She said she didn't think he was outside but she didn't know, he "seriously cannot be stable".

341. The call taker asked whether she could obtain CCTV footage and she advised that the police from Browns Plains were going to get it for the breach this morning.

342. Ms Langham said that she felt vulnerable.

343. She advised that Mr Hely was living in his car at his place of work in Wacol. She said he drove a silver Holden Rodeo ute and the registration was either YWN507 or YWN506.

344. She said she had changed her registration number and her phone number but he found her new phone number in her drawer.

345. The call taker asked if she was frightened and she said she was, "Feeling really, really not good."

346. Ms Langham was crying.

347. The call taker said she was going to talk to the Sergeant. She came back on the line and told Ms Langham to put the rose in a bag and take it inside. Also the Sergeant wanted to know if there was someone who could stay with her that

night or could she go somewhere else for the night. Ms Langham said she could. The call taker told Ms Langham to phone 000 if he came back.

348. The call taker said she would contact Browns Plains police station and let them know that Ms Langham was coming in the next morning to report another breach.

349. Ms Langham said she would go to the station as soon as it opened at 8am.

350. The matter was given a priority 4.

ESC Investigation

351. Constable Crews was interviewed by ESC investigators and stated he was sworn in November 2020. He said he briefed his shift supervisor about his conversation with Ms Langham. He did not look at Mr Hely's criminal history or CrimTrac history, however, he may have checked for flags on the system and didn't see any. He agreed he should have checked CrimTrac. He assumed the breach would be investigated by Browns Plains officers.

352. Constable Lawrance was interviewed by ESC investigators and stated he was sworn in June 2017 and had been on general duties at Browns Plains nearly the entire time of his service.

353. He attended Ms Langham's residence on code 4. He thought they were going to take a statement but she had already given one. He interpreted her as stating that Mr Hely masturbated in bed at the time they were separating – he didn't think it was a recent event. He was being vague about it "for everyone's dignity". If he thought it was a new incident he would have taken a new report and obtained a new statement from her.

354. He said she seemed to be in good spirits. They stopped and took photos of the sign on way out of complex. They didn't have an address for Mr Hely but he had already been flagged as wanted.

355. Constable Lawrance said that a day or two later the case was assigned to him. He opened the case file and saw that no statement had been uploaded so he sent an email to Constable Crews requesting the statement be sent to him or uploaded to the occurrence. He saw that Ms Langham had provided more information than was included in the statement.

356. There was nothing in the job that made him think it couldn't wait until he returned from leave. He considered it a minor contact breach and the first breach of the DVO. It didn't raise any alarm bells and that was probably based on her reaction – she was quite calm – not hysterical and begging for help. He went on days off for about the next week and was planning to contact her when he came back but the fire happened during that time. He wouldn't have looked at Mr Hely's criminal history as it wouldn't help the decision as to whether the matter was urgent. He would have been looking for him anyway when he returned from leave. He can't recall whether he looked at the associated occurrences.

357. Constable Barry was interviewed by ESC investigators. He said he saw no indications that Ms Langham was in fear or at immediate risk. He did not look at CrimTrac. He knows how to do it but in this case there were no flags re Mr Hely. In hindsight he considered that it would have been of benefit to check CrimTrac.

358. He was not aware that Mr Hely had threatened to kill Ms Langham – if he was he would have checked a bit further eg for weapons licences, notified VPU, advised her to stay elsewhere and placed flags on the system. He didn't look at the DVO application on the system.

ESC Conclusions

359. The 8.51pm call was given priority 4 on the basis that Mr Hely was no longer in Ms Langham's vicinity however, the reviewer found that there was no evidence that he had left the area and did not have access to Ms Langham.

360. ESC investigators stated that police procedures have now been revised and any DV matter is given a priority code 1, 2 or 3 response which requires at the least,

police attendance as soon as a unit is available. In this case the call would have been allocated as priority 3.

361. The ESC investigation found that Constables Crews, Barry and Lawrance failed to deal with Ms Langham's complaints appropriately.

362. The review identified that the officers failed to appropriately review the level of risk posed to Ms Langham, in contravention of OPM 9.4.2[6]. The risk should have been identified as "high" which required a proactive police response.

363. Mr Hely had the potential to cause serious harm if there was further perpetration of violence and/or risk and/or a change in circumstance.

364. The previous inaccurate assessments and recording of risk within QPRIME may have impacted the officers' ability to gain a full understanding. The DV review

[6] 9.4.2 Investigating domestic violence (initial action)

Where a report of domestic violence has been received, the investigating officer should:

(i) commence an investigation in accordance with Chapter 2: 'Investigative process' of this Manual;

(ii) determine if any domestic violence orders (DVO) or release conditions are in existence (see s. 9.4.6: 'Contravention of domestic violence order, release conditions or police protection notice' of this chapter);

(iii) electronically record and/or take a written statement from the aggrieved (see Appendix 9.1: 'Domestic violence protective assessment framework' of this chapter);

(iv) interview any witnesses to the incident;

(v) conduct an electronically recorded interview with the respondent (Action should not be stopped or delayed due to the inability to locate or interview the respondent);

(vi) if justified, take the respondent into custody (see s. 9.5: 'Domestic violence custody' of this chapter);

(vii) where there is sufficient evidence, issue and serve a QP 0899: 'Police protection notice' (PPN) or apply for a temporary protection order (see s. 9.6: 'Domestic violence orders, police protection notices and conditions' of this chapter)

Domestic violence protective assessment framework

The Protective Assessment Framework (PAF) is a decision-making framework designed to assist officers in assessing the protective needs of an aggrieved. Identifying the presence of risk factors and assessing the aggrieved's level of fear will assist in determining the required response. Officers are to conduct a protective assessment at all incidents or reports of domestic violence and utilise information gathered on risk factors in conjunction with their investigative skills, knowledge and experience to make an informed decision. Officers play a crucial role in identifying and responding to domestic violence and their actions and decisions can have a marked effect on future violence.

identified Ms Langham's fear level as fearful and the level of risk as high whereas the officers identified her fear level as not fearful and the risk as medium.

365. Although Constable Crews commenced an investigation, created an occurrence and took a statement from Ms Langham he failed to identify the risk factors noted, including history of violence, previous contraventions and frequency.

366. ESC investigators concluded that Constable Crews failed to adequately investigate apparent risks of domestic violence and criminal allegations and he was subject to a discipline investigation.

15 February 2021

367. At about 9am on 15 February 2021 Ms Langham attended Browns Plains police station to report the breach of DVO by Mr Hely the previous night. She spoke to Senior Constable Jolly at the front counter and provided a statement.

368. Senior Constable Jolly completed a DV-PAF recording separation and change in circumstances in category 1 and controlling behaviour and stalking in category 2. He reported her fear level as "fearful" and risk as "high".

369. Senior Constable Jolly did not activate his BWC.

370. The statement included that:
    - Ms Langham had been in a relationship with Mr Hely for two years and separated in January 2021;
    - She obtained a TPO due to concerning behaviour by him;
    - On 14 February she saw a bunch of roses on her car;
    - She took them inside and put them on the washing machine;
    - On the way to the police station she saw a sign "Happy Valentines day Dee, will always be in love with you" with a rose attached;
    - She took a photo of it;
    - She knew it was from Mr Hely;
    - At 7.30pm she went out to the back patio area;

- At 8.30pm she went outside again and saw single rose sitting on patio table;
- She was immediately scared as she knew Mr Hely had been in her yard;
- The rose was the same as that on the poster earlier;
- She took a photo of the rose;
- She called police and was advised to take the rose inside;
- She did not see Mr Hely;
- She found hand-written notes inside her house the other day eg a note inside a box of popcorn.

371. At about 2pm that day Ms Langham again attended Browns Plains station and reported to Senior Constable Jolly that the rose she had secured inside her unit the night before had been stolen and her front door had been left open i.e. that Mr Hely had entered her unit whilst she was out.

372. Senior Constable Jolly completed a DV-PAF and in category 1 recorded separation and threats to kill and in category 2 recorded controlling behaviour, ongoing conflict and stalking. He recorded Ms Langham's level of fear as "fearful" and the level of risk as "high."

373. Senior Constable Jolly took a further statement from Ms Langham which included the information provided that morning as well as further information:
    - After she found the rose on her back patio table at 8.30pm on 14 February she took it inside and put it in a shopping bag and left it on her kitchen bench;
    - She then went to a friend's house as she did not feel safe;
    - At about 1pm on 15 February she returned home and found her front screen door and door closed but unlocked;
    - The shopping bag was still on the table but the rose had been taken;
    - His behaviour is concerning and she is scared to go home – she is unsure what he's capable of.

374. At 2.41pm Senior Constable Jolly emailed Constable Crews and stated that Mr Hely's behaviour was "beginning to border on stalking and any further complaints will prompt a significant response to try and locate" him.

ESC Investigation

375. Senior Constable Jolly was interviewed by ESC investigators and confirmed that he took a statement from Ms Langham. He said that he accessed QPRIME and looked at the previous breach on 14 February which had been reported to Logan Central.

376. He said Ms Langham appeared "fed up" with Mr Hely but she was very friendly.

377. Ms Langham came back after lunch time to report another breach – after leaving the police station she went to Optus and when she went home after that someone had entered her unit and taken the rose out of the plastic bag and left her front doors unlocked. He took a new statement as it was another breach offence and put another report on the database.

378. Ms Langham gave him CCTV on a USB stick which she had obtained from the on site manager's office – she had footage of both entries by Mr Hely i.e. 14 and 15 February. Ms Langham said she believed it was Mr Hely in the footage. He put copies of the footage on evidence.com and uploaded still images onto both reports.

379. Ms Langham gave him details of Mr Hely's vehicle. He recorded that Mr Hely had no fixed address.

380. Senior Constable Jolly notified the 2pm crew of Senior Constable Jones and Constable Langford of the DV report and that there was a pattern of behaviour and requested they conduct patrols during the shift and try to locate Mr Hely and his vehicle. He asked the crew to update him so he could let Ms Langham know of any developments as she was staying with a friend. He did not hear back from

crew by the time he finished his shift at 5pm. He then went on days off and came back on 22 February 2021 and found out about the fire.

381. He checked Mr Hely's criminal history and noted nothing relevant and no previous DV matters. He did not check CrimTrac. Ms Langham did not advise that Mr Hely had lived interstate or had any DV history.

382. Senior Constable Jolly believed that Mr Hely was trying to "woo her back" on Valentine's Day – he had no history, she didn't think he was capable of harming her (although she didn't say that expressly but he inferred it from Ms Langham's attitude that she did not believe Mr Hely would harm her).

383. He asked the crew to patrol the area as he may have been watching her. It was a bit concerning that he'd gone into her unit. He doesn't know whether they did conduct the patrol or not; they may have been too busy.

384. Mr Hely's phone number was on the system but he did not phone Mr Hely that afternoon as he did not have time to do so – he had four or five other DV breaches to deal with that day as a lot of people come into the station with DV breach reports on a Monday morning.

ESC Conclusions

385. The Vulnerable Persons Command review considered that Senior Constable Jolly correctly recorded the matter and commenced the investigation in a timely manner. However it was considered that Senior Constable Jolly:

- Failed to commence further inquiries;
- Did not conduct interstate checks in contravention of OPM 9.4.2;
- Did not appear to identify the two previous contraventions over the past week;
- Failed to identify the risk factors of previous contraventions and frequency and Mr Hely's history of violence.

386. The reviewer stated, “Failure to identify these relevant risk factors may impact the risk assessment process and the policing response, however, it is noted [Jolly] correctly identified the level of risk to the aggrieved.”

387. ESC investigators concluded that Senior Constable Jolly took detailed reports from Ms Langham, reported the pattern of behaviours to his OIC and oncoming crew. His response was within policy and service expectations although there was a failure by Jolly to check Mr Hely’s interstate history.

388. The officers to whom Jolly passed the information conducted patrols but failed to locate Mr Hely. There was a missed opportunity to escalate the investigation as there was no further action taken when he could not be located.

16 February 2021

389. At 6.40pm on 16 February 2021 Ms Langham called 000. She was obviously extremely upset and fearful. She said that she had just arrived home and saw Mr Hely walking away from her front door. She drove off because she was scared. She then said, “He’s beside me.”

390. She said that he had just driven off when he saw she was on the phone.

391. She said she was terrified as he broke into her residence yesterday.

392. She then began to apologise to the call taker – “I’m so sorry.”

393. She advised that there was a current DVO in place with every condition possible.

394. She was told to phone back if he came back and they would organise for someone to attend to take a statement. Ms Langham was very grateful – “thank you so much, thank you so much”.

395. The job was recorded as a priority 3 with arrangement for a crew to attend.

396. The occurrence log recorded that there were no previous breaches and "Frequency: First Instance".

397. At about 8pm Senior Constable Down and Senior Constable McGregor from Browns Plains station attended Ms Langham's unit and completed a report and recorded a breach DV occurrence.

398. Senior Constable Down activated his BWC which recorded the following:

- Ms Langham asked them inside as she said she would be more comfortable with the officers inside;
- She said she had all her locks changed today – she took a girlfriend home and was driving up to the complex gate and saw Mr Hely walking down from her unit;
- She drove backwards and he drove up beside her and saw that she was on the phone and made a gesture and drove off;
- This was the fourth time he had been here since she got the order;
- She got the order on Tuesday 9 February and he was served two days later;
- She gave Senior Constable Down a copy of the order;
- She has already asked the manager to get the CCTV for tonight;
- He was there for 40 minutes on Sunday night when she found the rose on her back table;
- The lady from Policelink told her to keep the rose;
- Senior Constable Down said they don't know whether Mr Hely left the rose;
- She told him he came back and broke in and took the rose;
- She told them how many reports she had made;
- She told them she didn't have a new address for him;
- She told them she had made reports of other breaches;
- Senior Constable Down said they would need her to go to the station and give a statement;
- She asked whether she could go tomorrow as she was uncomfortable going out at night;
- She said she has to go to work tomorrow so will go to station after work;
- She began to cry;

- They told her they could write out her own statement and take it to the station;
- She said the police had all been amazing;
- She apologised to the police;
- Senior Constable Down said he would be at the station until 11am but after that she could speak to the counter officer;
- Senior Constable Down said it's not ideal because at the end of the day a DVO is a piece of paper but if she calls 000 they will get there as soon as they can;
- She said she has changed her phone, her rego, her locks – Hely now has her new phone number;
- When she changed her number he threatened her life and said she had three weeks left to live;
- When she was lodging paperwork for the DVO he called her on the new phone and she realised he had been through her drawers and found it;
- She is scared and she wants her life back;
- She doesn't want to give up her job but he knows where she works;
- She continued to cry;
- She provided details of threats eg that she could get t-boned so she has changed her rego – now he knows her new rego;
- Not that she thinks it's going to happen but "you don't threaten someone's life";
- She told them about the bed;
- Senior Constable Down said, "That's nasty".

399. Senior Constable Down completed the DV-PAF and under category 1 recorded "frequency" and nothing under category 2. He noted Ms Langham was fearful and the risk level was high.

ESC Investigation

400. Senior Constable Down was interviewed by ESC investigators. He said he is in general duties at Browns Plains. He was sworn in February 2014.

401. He looked at the other reports when he returned to the station after speaking to Ms Langham. He viewed the CCTV the following day. He conducted a patrol around the area when he left her house. He did not refer the matter to VPU as he considered it to be minor.

402. Ms Langham came in about 4pm the next day, he prepared a statement and took it to her the next evening and she signed it – he gave her a link to evidence.com and she uploaded the CCTV and he watched it and uploaded stills to the occurrence.

403. Ms Langham didn't seem overly concerned – just the fact that he was there and there were two previous incidents the day before – nothing was standing out that made him think he needed to do anything.

404. He did not read the private application. He did not brief any other officers or do anything else as it did not seem to be a breach they needed to be concerned about – it seemed quite innocent and minor – there was no assault – it hadn't happened numerous days in a row.

405. He told Ms Langham that if a matter was urgent to call 000 but if the breaches weren't serious to "pool the breaches together and then come to the station when she can" – he thinks he told her that on 16 February when she returned with her statement.

406. She said she didn't know where Mr Hely was and that he worked at Acacia Ridge but didn't know what the business was or where it was and she had no idea where he was staying. He didn't ask her for a phone number. He didn't do Telco checks as it didn't seem necessary. He didn't know whether Mr Hely still had keys to her residence.

407. He checked QPrime and Mr Hely had no criminal history – he did not check CrimTrac.

408. Senior Constable McGregor was interviewed by ESC investigators and stated he was in general duties and sworn in 2010. On 16 February he was the senior officer but Senior Constable Down did most of the talking. He recalls Ms Langham talking about previous breaches including leaving flowers on Valentine's day. He did not see Ms Langham when she signed the statement. He believes he would have looked up Ms Langham and Mr Hely on his QLiTE whilst at her residence – he recalled there were a number of previous outstanding breaches but not the specifics of them – he doesn't recall looking at the DV application. He does not recall looking at CrimTrac.

409. Nothing stood out about the matter – Ms Langham didn't mention any violence.

410. He believes Senior Constable Down flagged Mr Hely as wanted for questioning – they didn't have any further discussion about trying to find Mr Hely.

411. Ms Langham was emotional and she seemed genuine. He believes she was fearful and recalled that she had changed her locks.

ESC Conclusions

412. The Vulnerable Persons Command review found:
    - There was appropriate QPRIME reporting by Senior Constable Down and Senior Constable McGregor;
    - They did not comply with OPM 9.4.2 in that they failed to:
        - Conduct neighbourhood inquiries;
        - Conduct interstate checks;
        - Establish that Mr Hely was wanted for three contraventions over three days;
        - Identify risk factors including:
            - Previous incidents;
            - Separation;
            - Severity;
            - Controlling behaviour;
            - Stalking;

        - Respondent history of DV.
- They should have identified Ms Langham's fear level as very fearful and the level of risk as extreme.

413. The ESC concluded that there were missed opportunities for further investigation to be conducted as this was the fourth recorded breach within three days and the fifth call for police service since 7 February.

414. The report was treated in isolation without further investigation of any linked or previous investigations, or previous history and it was not treated with appropriate urgency.

17 February 2021

415. Ms Langham attended Browns Plains station and provided a statement in regard to the events of 16 February. Senior Constable Down took notes for a statement and later returned to Ms Langham's residence to have her sign it.

416. In the statement Ms Langham recounted the events of 16 February 2021 and stated that when she saw Mr Hely at her residence she was, "terrified". She waited in her car for a while to make sure he was gone and then went back to her unit and deadbolted the door and waited for police to arrive.

21 February 2021

417. Ms Langham called 000 at 9.15pm and spoke to Communications Officer Huggins. Ms Langham said that she has a DVO on her "ex" and "he's out the front of my house right now". She sounded teary.

418. She said her house was locked. She told the call taker Mr Hely's name and date of birth. She said he parks his vehicle out the front and then comes into her gated community.

419. She said that he had been on her patio that morning but she didn't report it then as she had been advised by police officers at Browns Plains station to only call them once per week to report breaches of the order as there were so many incidences.

420. She said he is out there tonight, he has tried the side gate and she saw him outside the front door and it is definitely him.

421. Ms Langham then started crying.

422. The call taker told her to stay in the house, the police would be there as soon as possible. She told Ms Langham that if she felt unsafe she didn't have to wait to report breaches once per week. Ms Langham said Mr Hely was outside crouching under her table while she was hanging out her washing this morning.

423. She said she later saw him outside her window.

424. The call taker told her she could also call Police Link on 131444 – she doesn't have to go to the station – but if he was at her house she should definitely call 000.

425. She said she could still hear noises at the gate. She was sobbing.

426. The call taker asked how he was getting in. Ms Langham said he waits for a car or jumps over the bush. She has caught him coming in so many times. She had her locks changed and put deadbolts on because he kept keys. She said it was beyond a joke.

427. Ms Langham was clearly in fear and extremely upset – she could not help sobbing audibly. She said, "I'm scared".

428. The call taker told her that police would be there as soon as possible but if she was scared she should call back. Ms Langham said that she appreciated that the police were "under-staffed and under-appreciated".

429. She said, "Thank you so much."

430. The Incident Log indicated that Mr Hely was recorded as "wanted for questioning" on 14 February, twice on 15 February and on 16 February 2021 and was linked to three alleged breaches of the DVO.

431. The job was created as a priority code 3 (direct response) but was sent to the Police Communications Centre Communications Coordinator (Comco) as a "partial" job for immediate attention as the call taker identified a need for expedited response.

432. The job was reviewed by Logan Comco Stuart McConaghy and police dispatchers Ms B and Mr M.

433. The Logan District Tasking and Coordination Centre (DTACC) was operating that night and Sergeant Linda Smith was working in DTACC but she was not aware of Ms Langham's call and did not have any involvement in the investigation.

434. No police officers attended Ms Langham's address that night.

ESC Investigation

435. The call taker was interviewed by ESC investigators and said that she gave the job priority 3 as the doors were locked and Mr Hely wasn't banging on them and Ms Langham had changed the locks. She "partialled" the job so it would pop up on the dispatcher's and Comco's screens for immediate assessment. She noted it was a DV and the previous incident and call history. She encouraged Ms Langham to call back if she did not feel safe.

436. Senior Constable McConaghy, the Comco that night, was interviewed by the ESC and stated that he saw the call at 9.21pm and approved it immediately. He continued to watch it and was aware that Browns Plains only had one general duties crew on duty. He did not see any reason to upgrade the priority of the job. About five minutes later he handed over to the next Comco (Proctor) but did not discuss that job specifically and had no communication with the crew.

437. Dispatch Officer Ms B was interviewed. She was the radio dispatcher when the call from Ms Langham came through. She didn't have any crews to send straight out so she discussed it with the Comco and they decided to hold the job until the next crew was available. The dispatcher who took over from her was Mr M. She gave him a handover and told him this job was the next to be dispatched. She said it was not uncommon to have 60 or 70 priority 3 jobs in the queue waiting for a crew to attend.

438. Dispatch Officer Mr M was interviewed and said that when he took over from Ms B the job was already in the queue. He did not review it. At 9.49pm he took the partial tag off it so that it dropped down his screen leaving the higher priority jobs at the top of the screen. When the crew attended and requested it be delayed until the next day it became a priority 4 job.

439. Senior Constable William Proctor was interviewed and stated that the job was correctly allocated code 3 and then 4.

ESC Conclusions

440. Senior Sergeant Wayne Smith reviewed the incident log for the call for service on the evening of 21 February 2021 and produced a report dated 23 September 2021.

441. Senior Sergeant Smith concluded:

- The call taker obtained pertinent details, correctly identified the matter as a DV incident and correctly assigned a priority code of 3 based on the information she was given;
- The call taker does not obtain any in-depth information from the system;
- At 6 minutes and 33 seconds into the call (9.24pm) the call taker created the job as a partial i.e. when Ms Langham said that Mr Hely was still in her yard the call taker sent the job through to the supervisor and the dispatcher so that they could review it and search for a crew to attend it whilst she was still obtaining information from Ms Langham;
- Senior Constable McConaghy (supervisor) viewed the incident 12 seconds after it was created and approved it as code 3 for dispatch which was appropriate;
- Ms B, dispatcher, viewed it 21 seconds after creation and did not put a broadcast over the radio for a unit to attend;
- Mr M took over from Ms B and first viewed at 9.49pm – he did not broadcast either but instead removed the partial tag which moved it into the list of unsourced incidents which was not appropriate;
- Senior Constable Proctor took over as Comco at 10pm – he did not view the prompts that were generated when this job continued as unsourced after 20 minutes;
- That was not in accordance with procedures;
- At 1.10am Senior Constable Proctor changed the job to code 4 – that was appropriate as he did it on advice from attending police.

442. Ms B sighted the job but did not dispatch a unit as would be expected, however, she explained that she did not have a unit to dispatch the job to and therefore, handed over to the oncoming dispatcher to action when a unit was available. The ESC investigation concluded that this was appropriate.

443. The second dispatcher, Mr M, removed the “partial” tag and did not dispatch the job. This was inappropriate as it removed the job from a prominent location on the screen awaiting priority tasking to a regular position with other jobs with no urgency.

22 February 2021

444. At 12.44am (3 hours and 23 minutes after Ms Langham made the 000 call) a Browns Plains general duties crew (Senior Constable Lachlan Jones and Senior Constable Langford) allocated themselves the job on their QLiTE device and went to her address.

445. They arrived at 1.07am (3 hours and 56 minutes after the 000 call). They knocked on the front door and when Ms Langham didn't answer the door they immediately left and requested the job be held over for the day crew to attend.

446. First Year Constable Langford activated his BWC as they approached Ms Langham's front door. The officers can be seen to walk up to the door. Constable Langford knocked on the door once whilst Senior Constable Jones stood off to one side looking at the screen of his mobile phone. There was no answer at the door and the officers had no discussion at all in relation to taking further action. They both walked away from the front door and got into the police car.

447. Constable Langford said, "Probably have a call in a minute saying – oops," and then turned off his BWC.

448. They left the address and looked for Mr Hely's car but did not see it.

449. No further police action was undertaken prior to Ms Langham's death.

450. At 3.55am the first 000 call reporting the fire was received.

451. First responding police found the unit fully involved in fire. They could not approach the unit. District Duty Officer Senior Sergeant Philip Hughes attended and took control of the scene.

452. At 5.06am a crime scene was declared.

453. A homicide investigation was commenced by the Logan District CIB and the Homicide Investigation Group. Officers from ESC were advised and that investigation commenced also.

454. In the hours after the fire police found Mr Hely's car a short distance away parked in a nearby shopping centre.

ESC Investigation

455. Senior Constable Jones was interviewed by ESC investigators and said that he first became aware of Ms Langham on 15 February when he was asked by Senior Constable Jolly to conduct patrols for Mr Hely's vehicle in the Browns Plains area. He was aware that there had been a breach in relation to leaving flowers. He was aware there was a DVO in place. He believed the breaches were minor in nature. At that time they looked around for Mr Hely's car but didn't go to Ms Langham's address. He had no further involvement in the matter until 21 February.

456. He started his shift at 9pm on 21 February. His first job was a DV job at Heritage Park where he relocated the aggrieved, took out a PPN and then attended to paperwork at the station.

457. At 12.44am he went to Ms Langham's address as it was the next job on the system. They arrived at about 1.07am. They did not see Mr Hely's vehicle as they drove in. He saw Ms Langham's car in the driveway and lights on in both floors of the unit. Constable Langford activated his BWC and they knocked on door. As there was no response they concluded Ms Langham had probably gone to sleep. They had no concerns.

458. They didn't go around the back of the unit or check side access. He did not look inside the unit. He thought it was a "prowler job". The job was four hours old, there were no obvious signs of any incident, no neighbours were awake, they

were not flagged down by anyone so they had no concerns. They left the complex, patrolled for Mr Hely and then had a meal break.

459. When he heard about the fire later that morning he looked up Mr Hely on his QLiTE and saw four previous breaches.

460. Constable Jones said that as the FTO that night, he made the decisions and advised Constable Langford what to do. He was aware of the flags indicating that Mr Hely was wanted for questioning. He did not use his QLiTE to look into other occurrences or ask Constable Langford to do so. He didn't try Ms Langham's door to see if it was open.

461. Constable Langford was interviewed by the ESC. He was sworn in 18 September 2020.

462. He said that he didn't try the door to see if it was unlocked. He couldn't see any damage to windows or doors. He could see through the glass beside the front door and there was nothing moving inside (he accepted at inquest that a white curtain behind the glass obscured his view, but maintained he couldn't see any movement nor shadows). They decided she had gone to sleep so they left. They didn't see Mr Hely's car anywhere. He didn't check Mr Hely's criminal history or CrimTrac. He didn't have any concerns for Ms Langham's safety. They decided there was no point in calling her at 1am. They didn't consider looking around the back of the unit.

463. Senior Sergeant Phil Hughes – Logan DDO – was interviewed by ESC investigators. He said that he was the DDO from 10pm on 21 February. He said that after midnight the Comco from Beenleigh was looking for a crew to attend a missing persons report – at that time there were 44 unresourced jobs – nine were priority three, 34 were on delay. There were eight units already at jobs. He said there are usually 40 or more jobs on LCAD and it's almost impossible for a DDO to get across all of them.

464. Senior Sergeant Hughes said that he would have been concerned on the night had he seen the number of breaches that were on the system but he was completely unaware of the job. He said DDOs had been concerned that DV jobs could slip through the cracks.

ESC Conclusions

465. The ESC report stated:

> *If officers attended the job sooner, noting Mr Hely was observed walking around the complex prior to midnight, there may have been opportunities to disrupt his planned actions that evening. Furthermore, contact with Ms Langham on the evening may have provided her opportunities to seek advice from police officers or actions to take moving forward.*

466. Mr M was subject to a discipline investigation in relation to the allegation that he "failed to adequately investigate apparent risks of domestic violence and criminal allegations". Mr M has resigned from the QPS.

467. Senior Constable Proctor allowed the job to be held over until the morning as the officers were unable to locate Ms Langham. The ESC report stated that this was within police and service expectations at that time but since that time risk management strategies have been introduced preventing DV jobs being delayed without identifying safety risks and without the approval of the aggrieved.

468. Under the new rules the attending officers would have been required to make further inquiries prior to putting the job on hold.

469. The ESC report stated that the response to the call for service was "less than optimal" and further investigation should have been undertaken to attempt to locate Ms Langham.

470. The officers stated they thought the job sounded more like a trespass matter and didn't want to wake Ms Langham.

471. Jones did not consider looking out the back of the unit or phoning Ms Langham. They failed to sufficiently consider the option of entering the premises to prevent an offence or DV under s609 *Domestic and Family Violence Protection Act* 2012.

472. The actions of Senior Constable Jones and Constable Langford are subject to a discipline investigation in relation to the allegation they "failed to adequately investigate apparent risks of domestic violence and criminal allegations."

473. The ESC report concluded that it was unable to be determined if any further investigation would have changed the outcome.

ESC Interviews with Senior and DV Officers

474. Acting Sergeant Tracy Keys is in the Logan District VPU stationed at Beenleigh. She told ESC investigators that she was the Domestic and Family Violence Coordinator (DFVC) in Logan from 15 February 2021 and her duties included conducting a daily review and audit of all QPS DV applications, PPNs and breaches – she did not review DV Other and No DV occurrences. She used the DV-PAF to analyse if subjects meet the threshold of high risk to be managed by the VPU and to determine what they can offer the person.

475. She reviewed the DV occurrences relating to Ms Langham and Mr Hely. She could not recall reviewing all of the occurrences but did not categorise the matter as high risk or conclude that it needed to be discussed with her supervisor. It did not meet the requirements for referral to the HRT. It was not her job to review the actual DV applications – only the QPRIME entries.

476. Acting Sergeant Keys said she had no formal training for her role as DFVC and was trained "on the job".

477. Senior Constable Joanne Sandor of the Logan District VPU was interviewed by ESC investigators. She had been in the specialist role since 2016. Her role within VPU was to complete audits and reviews of DV incidents in Logan. She

reviewed DV incidents every morning to identify matters to be included in a 9am meeting. She would skim the police applications and breaches prior to the meeting then go back and audit the files after the meeting. Private DVO applications were not audited as a matter of course due to lack of resources. Every occurrence was reviewed to ascertain whether the parties were in a high risk relationship (HRR). There were no specific criteria used to evaluate the matters. Officers used their own judgement and experience.

478. Matters classified as HRR were forwarded to the VPU who would visit the aggrieved.

479. In Logan, matters were also supposed to be reviewed if they involved repeat calls for service (RCFS) i.e. three breaches or more in three months. However, in February 2021 QPS had insufficient resources to fulfil this requirement. The RCFS files were handled by the DV Liaison Officers (DVLO) at the police stations. Some DVLOs were provided training to run reports using an analysis tool but they were all operational officers so they may have only had a shift or two per month to complete all the DVLO jobs.

480. Senior Constable Sandor said that creating RCFS case management files was impossible due to the VPU workload.

481. When reviewing matters she would look at what occurred and the risk factors identified by the reporting officer in the DV-PAF and use that information to decide whether further investigation was warranted.

482. Senior Constable Sandor said she had no specific training for the DV role and there was no template for reviewing matters.

483. She said that after 22 February 2021 shifts were changed and there were more staff to audit DV occurrences and all private applications were also audited. She said the RCFS review is completed weekly by VPU officers who create the case management plan for the station to action.

484. Senior Constable Sandor said there should be more training in DV response and more personal and emotional support for the DV unit.

485. Detective Acting Inspector Paul Fletcher, the OIC of the Logan District VPU was interviewed by ESC officers. He was sworn in July 2002.

486. He said that within the VPU Senior Constables and Sergeants audit DV incidents:

- They audit the majority of DV incidents in the district;
- They review breaches and applications for compliance;
- They identify if incidents to be classified as High Risk Response (HRR);
- HRR are taken on by VPU engagement team and possibly the investigation team;
- In managing the HRR the VPU contact the aggrieved and provide support and assist with a safety plan;
- HRRs are kept within the VPU;
- All HRRs are forwarded to the HRT for review – via QPRIME;
- VPU can also refer to HRT;
- On rare occasions referrals may come through the courts to the HRT via private applications;
- If a matter is determined not to be HRR but it is RCFS they are sent to the DVLO at the station;
- The normal criteria for a matter to be a RCFS is 3 or more DV occurrences in 6 months, but in Logan they changed it to 3 or more occurrences in 3 months due to lack of resources, however, at that time they would leave them all and look at them maybe once per month and then refer them if required;
- The whole unit had a briefing every morning to discuss new HRRs.

487. Acting Inspector Fletcher said there had been no state-wide DV training for a long time. The two DFVC officers were auditing about 250 incidents per week. At the time of the interview he said that the Commissioner had directed 100%

audit of DV incidents and that task was taken on by VPU in Logan to build consistency. There had been an increase in staff to enable this.

488. He set out the changes undertaken by the unit since February 2021:
    - 100% audit of DV occurrences;
    - DFVC auditing now 7 days per week – previously they would have to catch up on 30 to 40 on a Monday as they only worked five days;
    - RCFS are completed daily then forwarded to station DVLO for action;
    - Improved training of DVLOs;
    - VPU runs three day awareness training for general duties officers;
    - Standardised reporting processes for DFVC;
    - State DV unit has introduced the DV high risk high harm dashboard to assist the VPU to make decisions re HRRs;
    - VPU have a DV checklist for DV other and no DV matters to brief supervising officers;
    - Logan District is focussing on cultural change to encourage officers to look at the bigger picture and not just the incident by itself.

489. Acting Inspector Fletcher said that the DV-PAF is subjective and does not provide a next step. No officer has been trained in the DV-PAF.

490. He said that the sheer volume of serious DV in Logan including very serious violent offending meant that police had to elect where to send their resources at any given point in time.

491. Acting Sergeant Blake Cherry was the Browns Plains DVLO in February 2021 and reviewed all DV occurrences. He said he usually did it monthly and he was only rostered to carry out that role once or twice per month. He had no shifts as the DVLO in February 2021.

492. Acting Senior Sergeant Shane Clark was the Browns Plains Shift Supervisor and Acting OIC in February 2021. He was doing both roles on 15 February. He didn't recall ever hearing about Ms Langham.

493. He said that in a serious DV situation officers would gather evidence, look at the history and the course of events and whether the DV was escalating then this would be the trigger to take further action such as in a high risk case, the next crew may try to locate the offender.

494. He said there was no system in place to identify RCFS cases other than proactive reviews by shift supervisors.

495. He said that the QPS makes it clear that officers should not investigate QPRIME so people are reluctant to investigate a person's profile. He said officers don't want to look anyone up in case they get investigated for it and have to justify it.

496. Sergeant Linda Smith, Logan District Tasking and Coordination Centre (DTACC) and Team Leader was interviewed. She was the DTACC in Logan from 6pm to 2am on 22 February 2022. At that time DTACC were not generally involved in DV matters.

497. She said that DTACC has "changed massively" since this incident – they now manage all priority 3 DVs – they would now phone Ms Langham – if she didn't answer they would do more checks, try to ring a neighbour, and ring the shift supervisor to recommend upgrading priority.

498. After the fire there was an expansion of DTACC so that it operates 24/7 and drills down into jobs – their primary role is now DV jobs. If Logan gets snowed under the Brisbane Police Communications DV coordinator can also pick up some DV jobs – they may have 15 on the go at the same time.

499. The DTACC adds messages on the job card within LCAD and records a log of events which they didn't do before. However, sometimes there are 45 code 3 jobs on the system and ten code 2 on top of those – the jobs in Logan are phenomenal.

500. She considered that after the Service Delivery Redesign Project QPS may not continue to resource DTACC to check priority 3 DV jobs in the future.

501. Sergeant Smith said she would like to see a DV specialist in DTACC at Logan – Brisbane have a DV specialist.

ESC Findings

502. ESC investigators identified that there were extensive relevant records contained within the CrimTrac database in relation to Mr Hely's DV history. They were accessible to police. No officer involved in the case checked the CrimTrac database.

503. Ms Langham was referred to the "Centre for Women & Co" on 6 September 2020. They attempted to contact Ms Langham but she did not engage.

504. She was next referred to the same service on 8 February 2021 when she attended the court at Beenleigh. She continued to engage with the service who assisted her with changing her locks.

505. The service intended to follow up with Ms Langham on 24 February 2021 at which time, should the risk continue to escalate, a referral to HRT was to be considered.

506. No other referrals were made by police, however, she told police that she had been referred to the service.

507. The ESC considered Chapter 9 of the OPM which sets out policies and procedures for DV investigations and noted that the policy is comprehensive with clear definitions, first response procedures and several safeguard provisions including senior officer oversight and authorisation.

508. The Logan District DFVC completed a review of all DV occurrences relating to Ms Langham.

509. It was concluded that the DFVC failed to identify the presence of additional risk factors and other offences reported by Ms Langham eg burglary.

510. The DFVC did not take action regarding the repeat calls for service as required by OPM 9.15.3.

511. The combination of the high risk DV-PAF indicators such as frequency, stalking, separation, previous incidents are predictors of high risk of lethality. Given those indicators the DFVC should have identified the matter as high risk and it was incumbent on the policing response to take immediate action to protect Ms Langham from further DV. That response could have included investigating criminal offences, flagging Ms Langham and her address as high risk and flagging all calls to be treated as urgent.

512. The DFVC should have considered referral to the Logan HRT for review and case management as per OPM 9.15.5.

513. The DFVC could have liaised with local operational police to prioritise the locating of Mr Hely due to the lack of proactive action whilst the frequency and severity of his DV continued to escalate.

514. Given Ms Langham's fear of returning to her home and her extreme level of fear identified in the 000 call, DFVC officers should have canvassed with her the possibility of entering emergency accommodation until Mr Hely was located and dealt with for the breaches.

515. The review identified that there was a failure of officers to differentiate between breaches of the TPO and criminal offences.

516. A member of the Ipswich HRT independently completed a retrospective desktop review. The overall assessment identified that Ms Langham was “at high risk of lethality”.

517. The Logan VPU was established in January 2020 with the primary aim of providing a policing response, advocacy and to ensure the safety of victims of high risk DV situations and vulnerable persons abuse through a holistic best practise approach.

518. In February 2021 DFVCs from Logan district VPU conducted reviews of all DV breaches and police DVO applications to identify RCFS and high risk relationships. Further checks were conducted when time allowed. Two DFVCs conducted all reviews during week days and did not work on weekends. The unit identified the high rate of serious DV incidents in the District prevented a 100% audit of DV occurrences.

519. DFVCs from Logan conducted a review of the DV breaches reported by Ms Langham between 14 February and 16 February 2021. They did not identify any indicators of a high risk relationship.

520. The ESC investigators concluded that the response of the reviewing officers was not deficient due to the nature of offending by Mr Hely and the subjective nature of the reviews.

521. The ESC investigators finally concluded:
    - No member of the QPS took the matter past initial interactions prior to the killing of Ms Langham;
    - No officer conducted investigations, attempted to locate Mr Hely or speak with him about the DVO breaches that occurred between 14 and 16 February 2021. This removed opportunities for intervention and the disruption of his actions on 22 February 2021;
    - Had Mr Hely been located prior to the fire it is unknown whether he would have been held in custody and it is therefore impossible to draw

conclusions as to whether contact with him or his arrest would have prevented the incident;

- The action of Mr M removing the partial tag was against policy but it is impossible to conclude that it affected the time officers attended Ms Langham's residence;
- CCTV footage identified a person believed to be Mr Hely around the unit complex prior to midnight which indicates that police attendance and investigation prior to midnight may have provided an opportunity to locate him;
- The actions of Senior Constable Jones and Constable Langford on the morning of 22 February were less than optimal and there were opportunities for them to conduct further checks to attempt to locate Ms Langham and Mr Hely which may have affected the outcome. However, it was impossible to conclusively determine whether the deaths of Ms Langham and Mr Hely were preventable by the actions of QPS officers;
- There were multiple instances where officers had not taken an opportunity to investigate this matter further which may have afforded Ms Langham a level of protection from the actions of Mr Hely.
- A discipline investigation into the actions of the following officers was being conducted:
    - Senior Constable Forrest
    - First Year Constable Cacace
    - First Year Constable Crews
    - Senior Constable Down
    - Dispatch Officer M (resigned)
    - Senior Constable Jones
    - First Year Constable Langford.

Changes Recommended by ESC Investigators

522. OPM 9.3.1 should be amended to state that officers "are to" view a person's interstate records for every DV related matter – the OPM currently states officers "should" review the records;

523. A detailed training package be created for officers to fully explain the DV-PAF and its use and the importance of accuracy due to flow on effect with future assessments and future responses.

Changes stated to be implemented by QPS since Ms Langham's Death

524. Senior Sergeant Smith set out the following actions taken by QPS as a result of Ms Langham's death in relation to Police Communications Centres:
    - Initially the Commissioner instructed that all DV incidents would be code 3 or higher until resolved;
    - A working group was established which resulted in the following changes:
        - Any resource can be assigned to a DV incident regardless of its assigned priority code;
        - Members of the DFVC are to be embedded in Brisbane PCC and undertake operational shifts to provide support to supervisors in decision-making when assigning priority 4;
        - A DV incident can only be scheduled for later attendance (i.e. priority 4) if:
            - It is requested by the aggrieved personally; and,
            - It will not increase the risk to the aggrieved.

525. VPU has taken action to raise awareness with officers about the use of CrimTrac.

526. The SDFV&VPU implemented extensive strategies in relation to officers' roles, responsibilities and duties under legislation and internal policy documents including the identification of risk factors, application of the DV-PAF, access to interstate DV history and relevant information:

    - The commencement of a dedicated Domestic, Family Violence and Vulnerable Persons Command (DFV&VPC);
    - An additional four sergeant DFVC's within the Brisbane PCC to provide support to the frontline response to DV across the whole state by

reviewing LCAD jobs along with QPRIME and CrimTrac history at the time of creation of the LCAD job;

- Information sharing to officers and "DFVC all" network information in relation to accessing interstate DVO and criminal history information and the DV-PAF;
- A focussed deterrence strategy to proactively engage and disrupt known recidivist DV perpetrators using the QPS Harm Ranking & Evaluation Tool (THReT) to identify and targe the highest risk and highest harm DV offenders;
- Notebook sized DV-PAF tri fold information cards and promotion of DV-PAF through links within QLiTE and desktop computers;
- Operational Advisory Note 2-2021 "DFV Areas of Focus" was disseminated state-wide highlighting lessons learnt from policing response to previous DV significant events;
- In May 2021 a QPS DV training plan setting out immediate, short-term, medium-term and long-term training initiatives was approved for delivery over the next 18-24 months;
- The SDFV&VPU and police media created and released a DV documentary style production to increase awareness – it was viewed almost 500,000 times;
- On 28 June 2021 DV Policing Enhancement Training Online Learning Product (OLP) was released to provide members with a better understanding of the complexities of DV and relevant legislation and procedures when investigating DV, completing a PPN and DVO application and how to use the DV-PAF – this training is mandatory for police and relevant civilian members;
- A Coercive Control OLP is being developed and was scheduled for release in 2021;
- The development and delivery of a Cultural Enhancement Programme which will explain to members why behaviours and attitudes towards DV impacts the outcomes for victims;

- QPRIME enhancements including amendments to the use of headings within grounds for PPN and DVO; enhancement of visibility of interstate CrimTrac information;
- In June 2021 members from all districts attended a DV conference to increase awareness and share learnings;
- Districts have delivered DV culture and compliance sessions to frontline police;
- SDFV&VPU have conducted DV training with new PCC operators;
- QPS has recently implemented a HRHH Dashboard which enables DV specialist police to identify and rank perpetrators;
- QPS is exploring the concept of multi-disciplinary reception centres to open alternative referral pathways for DV victims and their families. It is envisaged that by embedding police officers within non-government DV Support Service entities, victims seeking assistance can be diverted away from sterile police stations and received in a more comforting and nurturing space. It is anticipated this will facilitate information sharing efficiencies, which will increase victim safety and perpetrator accountability;
- QPS has partnered with UQ to devise a randomised controlled trial for a gendered service delivery model that will entail the deployment of Mobile Police Facilities to targeted high-demand locations to provide a high visibility presence within that community.

State Domestic & Family Violence and Vulnerable Persons Unit

527. Inspector Martain has 24 years experience and in February 2020 was appointed as Manager of State Domestic & Family Violence and Vulnerable Persons Unit (SDFV&VPU) which guides and enhances strategic policy across eight QPS portfolios including DV and DV Co-ordinators within Brisbane PCC and HRTs. He provided a statement setting out the changes QPS has made and intends to make in relation to DV.

528. In March 2021 DFV&VPU established six DFVCs in Brisbane PCC to provide near to 24 hour, seven day per week support to frontline police responding to DV

across the state. Prior to March 2021 there were only two DFVC in Brisbane. They assist officers to make decisions when responding to DV incidents by interrogation of data systems including LCAD, QPRIME and interstate and domestic DV history and provision of advice.

529. Prior to March 2021 DFV&VPU was under Road Policing and Regional Support Command but has been moved to the newly formed DFV&VP Command which oversees all QPS DV policy and systems.

530. All staff except HRT staff operate out of headquarters. HRTs are led by DJAG and operate in Logan/Beenleigh, Mount Isa, Cherbourg, Brisbane, Ipswich, Cairns, Mackay and Caboolture. The QPS DFV Strategy was approved by the Commissioner on 21 January 2022. The DFV&VPC has responsibility for leading the implementation of the DFV Strategy.

531. The DFV Action Table outlines a number of immediate, medium and long term actions aimed at enhancing the policing of DV.

532. Specialist DFVC positions at the rank of Sergeant are located in each of the fifteen police districts. They are responsible for coordinating and monitoring the policing response to DV within their district. They are assisted by a Senior Constable or Constable. They are responsible for conducting quality assurance of all DV occurrences in their districts and identifying high risk cases for referral to multi-agency HRT.

533. There are eight District Domestic and Family & Vulnerable Persons Units (District DFVVPU) in Qld. They actively engage with victims and perpetrators of DV at a police district level. The District DFVVPUs in Logan had embedded specialist DFV support service workers working alongside police. The QPS intends to have DFVVPU in all fifteen police districts. They are managed by the district and report to the OIC of the district.

534. DV specialist officers in DFVVPU also identify cases for referral to HRT.

535. Where three or more DV related calls occur within six months officers are required to create a repeat calls for service case management file within QPRIME.

536. From July 2021 police across the state are now required to consistently record all DV related criminal offences in the same incident within QPRIME.

537. A review of QPS DV training by the Qld Centre for DV Research of CQU provided the following recommendations:
    - Develop a state-wide DV education and training framework;
    - Annual DV refresher training, continual education for DFVC network and development of an evaluation strategy;
    - Review of delivery methods of current training programs;
    - Addressing identified training gaps.

538. The QPS has introduced several training and education packages to assist police:
    - Vulnerable Persons Training Package – developed in 2017 – delivered to all officers up to the rank of Inspector – comprises an online learning product and face-to-face workshops;
    - DV Specialist Course – a five day, face-to-face course for specialists working in the area of DV such as DFVCs, DFVOs and HRTs
    - DV Culture Change Program – to promote positive cultural and attitudinal change to DV across the service through leadership and mentoring – delivered in late 2019 to selected champions throughout the 15 police districts;
        - The SDFV&VPU have used key themes from the training in messaging QPS members via “Workplace” and development of “Officer in Charge Packages” to be delivered to frontline police by local OICs;
    - Further Culture Change Coaching Program to be delivered in 2022;
    - Recruit and first year constable training programs;

- DV Policing Enhancement Training was released on 28 June 2021 – Online Learning Product (OLP) for mandatory completion by all police officers up to rank of Inspector – as of February 2022 it has been completed by 9,345 officers;
- Coercive Control OLP training was released on 31 January 2022 and is mandatory for all officers. As of 24/2/22 4,396 officers had completed the course. Future face-to-face training is to be delivered to all QPS members;
- The QPS DV training plan was developed in 2021 by DFV&VPC outlining training over next two years.

539. The DV-PAF was introduced to QPS in 2013 to assist frontline police with assessing risk and needs at the scene of an incident. It has been amended and now requires police officers at a scene to consider:
    - A total of 22 Category 1 and 2 risk factors;
    - Victim's fear level and;
    - Provide an assessment of overall risk.

540. Police are to record details at the scene in their notebook and then enter on QPRIME. They now have trifold information cards to assist them in their use of the tool.

541. The QPS has engaged external experts to explore options for a more holistic actuarial process for identifying and responding to DV.

542. In March 2021 the QPS Total Harm Ranking and Evaluation Tool (THReT) was piloted in five police districts as part of a "focussed deterrence" DV operation Tango Alessa. The evaluation is anticipated to be completed in the first half of 2022.

543. QPS has developed the DV Predictive Model (DPM) which uses data from QPRIME to build a profile and produces a risk score between one and ten that a

couple will have a severe, harmful or dangerous domestic violence incident within 12 months. A pilot will commence in two police districts in 2022.

544. The QPS HRHH was implemented on 1 November 2021 and is accessible by all officers and 31 training sessions have been delivered in its use.

545. In the first half of 2022 the QPS intends to enhance DV service delivery by a 12 month pilot of embedding a DV specialist police officer within the Brisbane DV Service and the Ipswich DV Action Centre to:
- remove barriers and increase access to justice;
- provide a safe location for victims to engage with police;
- increase reporting rates of DV to police;
- enhance satisfaction of victims;
- enhance sharing of information;
- enhance the timely provision of wrap-around services;
- reduce trauma for victims in seeking assistance of police;
- enhance the collaborative relationship between DV support services and QPS.

546. In the first half of 2022 the QPS and UQ intend to pilot a randomised controlled trial of a gendered service delivery model providing for a staffed mobile police facility in a high visibility location like a traditional “shopfront” police beat but with the ability to move in accordance with demand. It is intended to assess whether there is an increase in reporting when they are staffed with female officers only. UQ will evaluate the pilot.

547. The QPS has DV co-responder models in two police districts in partnership with DV support services. Police and a DV social worker attend a DV incident together after the initial police response. Expansion to other districts is being explored.

548. On 2 April 2020 the QPS commenced an online portal for requesting non-urgent police contact in relation to DV. Victims can specify their preferred contact

method and request a specific police officer if they have had prior contact with QPS.

549. Frontline police are able to refer victims to external support providers at the scene via QLiTE or at a police station computer. The QPS has recently developed the capability to share DV-PAF indicators to DV support service providers which will enable finite DV service provider services to be delivered to high risk victims in a more timely manner. The sharing of DV-PAF is scheduled to commence on 4 April 2022.

550. Inspector Paul Fletcher provided a list of improvements in DV processes at Logan District which have been implemented since February 2021:

- DFVC auditing 7 days per week (instead of 5);
- RCFS case management daily;
- 100% audit of all DV matters;
- VPU detectives follow up with high risk aggrieved identified through the audit of private DVO applications;
- Station DVLO refresher training – one roster through VPU with DFVC;
- Three day awareness training with general duties officers coming to VPU and working with VPU officers;
- Standardised reporting process for VPU when reviewing DV matters;
- Use of the High Risk / High Harm DV dashboard in assessments;
- Improved reporting of criminal offences associated with DV matters;
- Introduction of a District DV checklist to be completed and briefed to supervisor for all No DV and DV Referral matters, which is then uploaded to QPRIME;
- The District Officer conducted station visits to get feedback in relation to issues with DV;
- A district instruction was created for DV response for Logan district;
- Creation of the Scenic Rim High Risk Group;
- A three month trial with funding applied for by the Centre for Women & Co, of a QPS/DV Specialist co-responder model targeting repeat calls for

service couples within the Logan Central Division to address DV issues and provide assistance for long term positive outcomes;

- Nextgen QLiTE for improved DV information.

Independent Reviews obtained by CCQ

Professor Kerry Carrington

551. At the time of inquest, Professor Kerry Carrington was a Research Professor in the QUT Centre for Justice with a PhD from Macquarie University. Professor Carrington has since retired from that role. Over the last three decades she has been established as a world leading expert on gender violence and its prevention. Her team has undertaken a world first study on how Women's Police Stations in Argentina respond to and prevent gender violence and what Australia can learn to improve its policing response to gender violence.

552. The most recent evaluation of women's police stations in Brazil found that where such stations existed the female homicide rate dropped by 17% for all women but for women aged 15 to 24 years in metropolitan areas the reduction was 50%.

553. Women's police stations in India have resulted in a significant decrease in dowry deaths.

554. In 2019 one in five police stations in Buenos Aires Province were specifically designed to respond to and prevent gender violence. They employ both female and male police officers as well as some LGBTQI officers to cater for complainants from sexually diverse backgrounds. They do not provide services to women only.

555. These stations provide childcare and reception rooms tailored to welcome women and children. They are designed to receive victims, not offenders and they do not have holding cells. They have emergency provisions of clothing and separate spaces for children. They employ multi-disciplinary teams of police,

social workers, lawyers, psychologists and counsellors who work collaboratively with other agencies to respond to and prevent gender violence.

556. These stations offer a gateway to a range of supports instead of dealing with every matter as criminal.

557. The province has one of the lowest rates of femicide in Latin America and lower than the global average. Argentina is ranked 30th in the world for gender equality. Australia is ranked 44th. For women's political power Argentina is ranked 22nd and Australia 57th but for women's health and survival Argentina is ranked equal one in the world whilst Australia is ranked 104th.

558. Professor Carrington has considered the creation of specialist victim-centres police stations specifically designed to deliver an integrated response for victims of DV staffed by suitably qualified multi-disciplinary teams of police, DV workers, social workers and legal advisors. She notes that currently:

Most police stations in Qld, indeed across Australia, are designed to receive and process alleged offenders. They are spartan, uncomfortable and unwelcoming spaces, especially for victims and children.

559. Professor Carrington is of the opinion that it is essential that leaders of specialist victim-centred police stations designed to respond to DV report to a supportive QPS command structure that promotes a police culture that values and rewards this model of victim centred policing. She notes that the QPS has developed a Domestic and Family Violence Command led by an Assistant Commissioner which would be appropriate to take on this responsibility.

560. Professor Carrington states that such police stations would need to be staffed by culturally diverse police and other workers mirroring community demographics. In a Qld context it is critical that a culturally appropriate workforce is employed in indigenous communities. Such an approach also creates employment and career path opportunities in those communities.

561. Such police stations would have capacity to build trust and rapport at a neighbourhood level, of the kind recommended by the Qld Productivity Commission, which concluded, after an exhaustive inquiry into the Qld criminal justice system:

> *A system more focussed on the restoration of victims may also benefit offenders, and the general public, through lowering reoffending and the prison population.*
> (QPS, 2019:251)

562. Professor Carrington recommends that perpetrators be given the opportunity to attend perpetrator programs instead of being subject to a DVO. This could encourage reluctant groups, such as migrant and indigenous women, to come forward earlier in the cycle of DV.

563. Women who attend such stations should first be assessed by a DV worker and then given the choice of speaking to a female police officer, should they wish to make a complaint.

564. Police who work at such police stations would have to undertake specialist DV training. Professor Carrington is of the opinion, and the evidence in this case supports the conclusion that, in-house QPS training is not sufficient.

565. Professor Carrington compared Ms Langham's wholly unsatisfactory and inappropriate experience with QPS with that she may have experienced in a specialist DV police station and commented that Ms Langham was not provided with a victim-centred trauma informed multi-agency response as she would have in a specialist police station:

- Under s100 of the *Domestic Family and Violence Protection Act* 2012 if a police officer reasonably suspects that DV has been committed they must investigate or cause the complaint to be investigated and issue a PPN, apply for a DVO, take the respondent into custody or apply for a TPO and

if they decided not to do any of those they must justify their decision in writing;

- Ms Langham had interactions with sixteen or more police officers from three different police stations and phoned emergency lines four times pleading for help (two to Policelink and two calls to 000);
- Very few of these officers had the will, the skill or the expertise to respond effectively to her escalating need for assistance;
- Forrest and Cacace gave her incorrect advice and told her there was insufficient information for them to apply for a DVO as well as ignoring the information she gave them and assessing her as not in need of protection;
- They trivialised her fears, under-estimated the level of lethal risk and based their assessment on their subjective assessment of her jovial manner overlooking the objective risk factors;
- They clearly did not understand how to identify coercive control, how to assess the need for protection and did not take her seriously.
- Other QPS officers repeatedly mistakenly assessed her as not at high risk of lethal violence despite compelling evidence of coercive control, stalking, threats to kill, suicide threats, previous history of DV, recent separation and ongoing conflict.

566. Professor Carrington concluded that:

> *Ms Langham's experience of the QPS as a victim of domestic violence fell far short of minimal expectations of an effective or competent police response. They also fell far short in dealing with the perpetrator, missing many opportunities to disrupt or prevent his plans to kill her.*

567. Had Ms Langham reported to a specialist police station Professor Carrington believes that:

- She would have seen the same counsellor and multi-disciplinary team members;
- She may have been able to see the same police officer on each occasion;
- She would have been seen by a trauma informed counsellor and believed;

- She would have been interviewed by a police officer who understood coercive control and DV;
- She would have been provided assistance to remove Mr Hely from her home;
- Police would have applied for a DVO;
- The team would keep a file for easy access for the entire team to ensure information sharing;
- She would have been offered a gateway of support to legal assistance, access to emergency provisions and connected with a support group and follow up meetings with a counsellor;
- If she had children they would have been cared for whilst the above took place;
- When Mr Hely breached the order she would have returned to the same station and the team would have reacted immediately;
- The case manager assigned to Ms Langham would have undertaken an investigation into Mr Hely's DV history as reported by her on 7 February to Forrest and Cacace;
- They would undertake a risk assessment and upon breach seek a warrant for his arrest;
- If he was bailed and re-offended they would arrest him again and again object to his bail.

568. The above actions would have reduced Ms Langham's level of risk of lethal DV.

569. Professor Carrington stated that the police had no interaction with Mr Hely before he killed Ms Langham. Specialist trained police would have taken action against Mr Hely to prevent him from carrying out his threats to kill her.

570. The police with whom Ms Langham had contact lacked the specialist knowledge to respond to her effectively. They misapplied the law, did not properly assess the risk, under-estimated the risk of lethal violence and did not appear to comprehend coercive control and DV. They gave equal weight to Mr Hely's denial that he threatened to kill her.

571. The police who attended on 22 February did not have a complete picture of the events that had preceded that night and no knowledge of Mr Hely's history of DV.

572. Professor Carrington noted that Senior Constable Jolly was the only officer who seemed to have an understanding of DV. He assessed the risk as high and Ms Langham as fearful. He recorded the appropriate risk factors, took a statement from Ms Langham, assisted her to access support to have her locks changed, access a DV service and he reported a breach of the TPO. Unfortunately he went on leave and nobody followed up the matter prior to her death reflecting the lack of continuity, lack of information sharing, lack of case management and auditing by VPU.

573. Professor Carrington concluded that the failures were symptomatic of a systems failure to protect victims of DV stemming from a singular focus on a law enforcement approach to specific incidences rather than a predictable cycle of DV and coercive control. She stated:

> *No one officer or team took responsibility for Ms Langham's case. Vital information was not passed on, diluted, misunderstood, went missing, not followed up or fell through the cracks of so many different QPS officers and communication systems. There were so many errors, mistakes and lost opportunities in this case to respond effectively to potentially lethal DV that leads me to conclude these short-comings are systemic, structural and institutional, and not attributable to the failings of any single individual police officer. In fact, some QPS police were set up to fail being given no or insufficient background of the history of the matter.*

574. Professor Carrington points out that:

> *Academic and government inquiries across Australian and other like English speaking jurisdictions have repeatedly identified system failing in traditional police responses to DV. Numerous studies and government*

inquiries have consistently found that police in Australia have continually failed victims of DV. The shortcomings are well documented and include:

- *Ambivalence and lack of empathy toward the victims;*
- *Failure to provide women with adequate information or follow up;*
- *Lack of referral to appropriate support services in emergency and non-emergency situations;*
- *Victim blaming and reluctance to take victims' complaints seriously;*
- *"siding" with the perpetrator and regarding victims' complaints as "too trivial and a waste of police resources";*
- *Mis-identification of the person in need of protection.*

575. Conversely, DV Death Reviews have stressed that effective police front-line responses may save the lives of those who experience DV.

576. Professor Carrington is of the view that:

Multi-disciplinary victim-centred women's police stations will address the systemic problems of traditional law enforcement models of policing violence against women. In turn, this will enhance reporting to police, satisfaction with the police, widen access to justice while enhancing the safety of survivors of DV. In sum, women's police stations offer an integrated victim centric response from a multi-disciplinary team of police, social workers, counsellors and lawyers, in a one stop shop, a model proven to reduce the risk of lethal domestic violence.

Professor Heather Douglas

577. Professor Douglas is a Professor of Law at the University of Melbourne and has been involved in gender-based violence research for 20 years, primarily focussing on domestic and family violence. She has published over 100 papers describing the findings from DV research on a range of topics. She is the coordinator of the National Domestic and Family Violence Bench Book for judicial officers.

578. Professor Douglas noted the definition of DV in s 8, DFVPA:

> *(1) "Domestic violence" means behaviour by a person (the "first person") towards another person (the "second person") with whom the first person is in a relevant relationship that—*
>
> *a. is physically or sexually abusive; or*
> *b. is emotionally or psychologically abusive (see also s11, DFVPA); or*
> *c. is economically abusive (see also s 12 DFVPA); or*
> *d. is threatening; or*
> *e. is coercive; or*
> *f. in any other way controls or dominates the second person and causes the second person **to fear** for the second person's safety or wellbeing or that of someone else.*
>
> *(2) Without limiting subsection (1) , domestic violence includes the following behaviour—*
>
> *a. causing personal injury to a person or threatening to do so;*
> *b. coercing a person to engage in sexual activity or attempting to do so;*
> *c. damaging a person's property or threatening to do so;*
> *d. depriving a person of the person's liberty or threatening to do so;*
> *e. threatening a person with the death or injury of the person, a child of the person, or someone else;*
> *f. threatening to commit suicide or self-harm so as to torment, intimidate or frighten the person to whom the behaviour is directed;*
> *g. causing or threatening to cause the death of, or injury to, an animal, whether or not the animal belongs to the person to whom the behaviour is directed, so as to control, dominate or coerce the person;*
> *h. unauthorised surveillance of a person;*
> *i. unlawfully stalking a person….*

"coerce" , a person, means compel or force a person to do, or refrain from doing, something.

579. According to the DFVPA this definition is applicable in a range of relationships including former defacto relationships (ie. such as that between Langham and Mr Hely) (see DVFPA, s15) and is relevant in determining whether to make a protection order (Part 3, DFVPA) or a police protection notice (part 4, DFVPA) in Queensland.

580. Professor Douglas commented that there has recently been a focus in academic research and public debate on the concept of coercive control. This research encourages supporters of family violence victims and intervenors to see the patterns of behaviours rather than focusing on a single behaviour which might by itself appear trivial.

581. The Queensland Women's Safety and Justice Taskforce (2021) observed there is no single recognised definition of coercive control but suggested that it is generally understood:

… to describe a pattern of behaviour designed to control another person who is, or has been in a domestic relationship with the person using the behaviour. It is most often perpetrated against women and children and, while each individual case will be different, it can include:

the gradual isolation of a women from her friends, family and other supports; degrading put downs; humiliation and threats; 'gaslighting'; monitoring her movements—including through electronic devices; use of technology and/or social media to control and manipulate; financial control; removing reproductive control; micro-managing every aspect of her life—what she wears, when and what she can cook, eat, sleep, leave the house…(2021a:11)

582. Professor Douglas noted the following DV conduct present for Ms Langham in the inquest brief of evidence:

Domestic and Family Violence (based on s8 DVPA)	*GH reported behaviours*
Physical violence	GH bit Ms Langham: Punched and kicked Ms Langham in April 2020: Damage to Ms Langham property, smashing walls
Sexual violence	GH took photos of Ms Langham semi naked while she slept, some witnesses had seen the photos: 'Guilted her into having sex'
Emotionally and psychologically abusive (see also s11 DVPA)	GH 'putting down' Ms Langham Called Ms Langham names GH did not like Ms Langham to be alone with friends Recalls Ms Langham would get the 'silent treatment' after an argument with GH
Economically abusive (see also s12 DFVPA)	GH 'drained her account'
Threatening	GH threatened her 'it could be a T-bone, a fire, or accident' 'If you don't get taken out by a sniper, I will run you off the road' Ms Langham said that GH mentioned that one of ex's houses burned down but they could never pin it on him. He was investigated Aware of GH death threats

	Mentioned someone in the drugs business who could ‘sort out’ his wife.
Controlling	GH intercepted/checked Ms Langham’s text messages, going through her phone – ‘thought he was controlling’ Not allowed to talk unless GH present on face time calls (with Ms Langham’s mother) Ms Langham described GH as ‘controlling’ – would go through her phone, knew who her friends were and monitored her social media Ms Langham believed GH installed tracking app on her phone
Threatening to commit suicide/self-harm so as to torment/intimidate or frighten	November 2019- GH threatened self-harm and was missing for 24 hours GH made threats to kill himself 7 February 2021 GH message: ‘I have three weeks to enjoy my life’ ‘I would rather be dead than live without you’ GH said he had messaged Ms Langham ‘understanding why people used guns’ He said ‘the only way they are going to get me is in a box.’ ‘Why am I still here?’
Unauthorised surveillance of a person/ Unlawfully stalking a person	GH followed Ms Langham to work Delivering flowers to unit GH taking things from Ms Langham’s unit/hanging around the unit after he had moved out GH delivered gifts to Ms Langham unit after he had moved out GH pulled up beside Ms Langham on the road

GH attended Ms Langham's unit went through drawers (found Ms Langham new number?): B5
GH broke into Ms Langham's unit, wrote in her diary
GH hanging around Ms Langham's unit
Stalking

Relevant Risk Factors for Homicide in DV Cases

583. In 2018 ANROWS released National Risk Assessment principles based on findings from empirical studies, literature and reports from international and Australian DV death review committees and Coroners' Courts. Professor Douglas identified the risk factors which were present for Ms Langham as set out in the table above.

1. Separation

   Separation is recognised as an extremely dangerous time for women leaving a coercive and controlling relationship. In a 2019 report the Qld Domestic and Family Violence Death Review and Advisory Board (DFVDRB) found a strong correlation between separation and homicide. Between 2006 and 2019 46.7% of Qld victims of intimate partner homicide were known to have separated or intending to separate from the perpetrator.

2. Stalking

   Stalking in the context of DV more than doubles the risk of being killed or nearly killed. A US study of the deaths or near deaths of 437 women found that being followed or spied on by the abuser in the 12 months before the lethal incident resulted in a nearly 2.5 fold risk of death. In 2019 the DFVDDRB reported evidence of stalking by 12.8% of DV homicide offenders between 2006 and 2018.

3. Threats to Kill

   American studies have found that women whose abusers threatened to kill them were 15 times more likely to be killed.

4. Coercive Control

A detailed analysis of intimate partner homicides in NSW between 2008 and 2016 demonstrated that 99% of the homicides were preceded by non-physical forms of coercive control.

5. Suicide Threats and Attempts

   The National Risk Assessment Principles note that threats of suicide are a strategy used by perpetrators to exert control. They are a risk factor for femicide-suicide cases. Twenty-three percent of men who killed a partner in NSW between 2017 and 2019 suicided following the murder.

6. History of DV

   A UK study of 25 cases of intimate partner homicide identified that the perpetrator exhibited behavioural risk markers in previous relationships, specifically coercive control, intimate partner violence and/or stalking.

7. Pathway to Homicide

   Monckton-Smith's[7] eight-stage pathway to homicide – pre-relationship (previous DV), early relationship, relationship, trigger event, escalation, change in thinking, planning and homicide. The escalation stage was defined as an increase in frequency, severity or variety or abuse, control or stalking and was preceded by a trigger event such as the relationship ending. The escalation stage may include begging, crying, threats of violence, suicide threats and stalking.

   Mr Hely's behaviour, as reported to police by Ms Langham, was consistent with the escalation stage.

   In 2022, Boxall et al[8] reviewed 199 incidents of IPH of a female between 2007 and 2018 and identified three pathways to homicide – fixated threat, persistent orderly and deterioration/acute stressor.

[7] Monckton Smith J. (2020). "Intimate partner femicide: Using Foucauldian analysis to track an eight stage progression to homicide." *Violence Against Women* 26(11): 1267-85

[8] Boxall, H., Doherty, L., Lawler, S., Franks, C., and Bricknesll, S. 2022. The "Pathways to intimate partner homicide" project: Key stages and events in male-perpetrated intimate partner homicide in Australia. Sydney: ANROWS.

> Professor Douglas noted that Mr Hely fit into the "fixated threat" group as did one third of all IPH offenders. Despite being jealous, controlling and abusive in their relationships these offenders were relatively functional in other aspects of their lives. They were often typically middle-class men who had low levels of contact with the criminal justice system. Their abusive behaviour often took the form of controlling, stalking and monitoring behaviours which escalated during separation. IPH was used by the offender to re-establish control over the victim.

584. Professor Douglas identified numerous missed opportunities to identified and respond to Mr Hely's escalation and risk to Ms Langham

Missed Opportunities

Police Response

585. The suicide threat of 6 September 2020 should have raised numerous flags for homicide/serious harm. Mr Hely's NSW history showed he had used similar controlling tactics previously. If those records had been considered it would have likely changed the approach of the police at that time and in the future.

586. On 7 February 2021 the police could have taken out a Police Protection Notice and a DVO. They should have had talked to Ms Langham about DV and her options.

587. There was sufficient evidence to investigate Mr Hely for stalking which would have raised a question of bail and presumably his NSW history (I'm not sure an investigation would automatically lead to bail considerations – maybe his history would become relevant during the investigation?).

588. Forrest and Cacace were aware that Mr Hely had previously threatened suicide, had made a death threat, they had separated, she had changed her phone, he had previous DV history interstate.

589. Forrest, Cacace and Pearce were focussed on her lack of fear but Ms Langham hadn't been asked whether she was fearful.

590. Forrest incorrectly stated the burden of proof required for a DVO and said she needed evidence of physical assault or property damage. Sgt Pearce appeared to also give that weight.

591. Professor Douglas referred to studies indicating that police retained a "physical violence mindset" which may have contributed to the lack of action taken on 7 February.

592. If police believed Ms Langham could get a DVO then they should have applied on her behalf – research shows much more successful outcomes when police apply for DVOs.

593. Police should have checked interstate records and asked Ms Langham further questions.

594. Senior Constable Forrest said that she had no training (for DV?) since she began policing 12 years ago.

595. Constable Cacace found his training at the academy some three months prior to be rushed with insufficient opportunity to answer questions.

596. UK research indicates that force-wide in-person training relating to coercive control led to an increase in arrests but the effect of that training had an impact for only about 8 months post training.

597. Sergeant Peace was overworked and had no framework on which to assess matters.

598. The police should have considered accompanying Mr Hely to the unit to retrieve the rest of his belongings.

599. There was an insufficient assessment of risk by all police involved.

600. Police took no action in relation to the numerous breaches of the TPO committed by Mr Hely. He could have been charged with those and with a stalking offence.

601. If the matter had been properly assessed, it could have been referred to a HRT.

Court Response

602. Professor Douglas concluded that the court could not have done any more.

Centre for Women & Co

603. Professor Douglas commented that given the high risk context the centre could have attempted to contact Ms Langham again after she failed to engage on 11 and 15 September 2020. They could also have alerted police.

604. However, from 9 February 2020 there was nothing more that the Centre could have done. It was supporting Ms Langham and she wished to stay at home. There was a plan to consider referral to a high work team after her next court date on 23 February.

Mental Health Support

605. Mr Hely had counselling four times from 19 August to 4 September 2020. He told his counsellor that he was verbally abusive to his partner and appeared insecure and vulnerable with a blaming/justifying mindset. He was booked for 8 and 18 September but did not attend.

606. On 29 August 2020 he told his GP he had anger control issues. He did not mention DV. After a consultation with a GP on 9 November 2020 the GP prepared a mental health care plan. He phoned Mr Hely to collect it and make an appointment with the psychologist but Mr Hely did neither.

Professor Carrington's Report

607. Professor Douglas agrees with Professor Carrington's considerations and recommendations as to improvements to the policing response.

608. She concludes that it may be worth piloting the Women's Police Station model i.e. a specialist victim-centred police station specifically designed to deliver an integrated response for victims of DV staffed by suitably qualified multi-disciplinary teams of police, DV workers, social workers and legal advisors.

609. She states:

> *The Brief demonstrates a lack of awareness of risk by successive police officers involved in this case, a failure to take non-physical forms of violence/coercive control seriously, a failure to focus on safety (reverting to an adversarial approach of competing … stories) and a failure to ask about and hear [Ms Langham's] views about her own safety. We know the victim's self-perception of risk is one of the top five performing risk factors ... These issues that have been identified time and again (Douglas, 2019). The Brief also shows a lack of communication and information sharing between services. Given the repetitive nature of these issues it seems worthwhile to trial a new approach and pilot the proposed Women's Police Stations in Queensland given their apparent success overseas. Having said this, I think many aspects of women's police stations should be integrated as a key part of current police practice within the QPS.*

Conclusion

610. Professor Douglas concluded that there was a lack of connection between systems and significant concerns with the police response. Systemic issues include lack of training which translates to problematic responses including a lack

of understanding of risk, a failure to take non-physical forms of DV seriously and a lack of communication within the QPS and with other agencies.

DFVDRU Review

611. The Domestic and Family Violence Death Review Unit is established within the Coroners Court of Qld to provide assistance to coroners in their investigation of DV and child protection related deaths to support the identification of any missed opportunities for intervention and the consideration of whether there are opportunities to prevent future deaths from occurring in similar circumstances. The Unit also provides support to the State Coroner in his position as Chair of the independent, multidisciplinary Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) established to enhance the systemic review of DV related homicides and suicides in Qld.

612. The DFVDRU reviewed the circumstances surrounding the deaths of Ms Langham and Mr Hely. Once again I am grateful for the invaluable assistance of the staff of the DFVDRU.

613. The DFVDRU noted that the relationship was characterised by coercive control by Mr Hely including him:
    - Going through her phone;
    - Being present when she was Facetiming friends and family;
    - Isolating her from friends and family;
    - Refusing to speak to her to control her behaviour.
    - Sending multiple texts and becoming increasingly abusive if she didn't respond;
    - Coming into her room and taking photos of her without her consent;
    - Threatening to release intimate photos of her on the internet if she left him;
    - Threats of suicide when she wanted to end the relationship;
    - Coerced sex;
    - Destroying property and personal items;

- Physical assaults – punching her in the head and biting her;
- Threats to kill;
- Breaking into her house.

614. He demonstrated a similar pattern of coercive control in previous relationships:
    - Threats to kill
    - Threats to rape
    - Threats to suicide
    - Assault and threats to harm
    - Coerced sex
    - Verbal abuse
    - Non-lethal strangulation
    - Stalking, harassment and intimidation
    - Isolating from family and friends
    - Breaking into homes
    - Leaving flowers
    - Pet abuse
    - Taking intimate photos without consent
    - Love-bombing e.g. engaged to both previous partners within six months
    - Setting fire to a house.

615. The DFVDRU utilises the coding system developed by the Ontario DV Death Review Committee to explore lethality risk indicators associated with intimate partner homicides as they view it as the most comprehensive available and there are demographic similarities between Canada and Queensland.

616. There are 39 DV lethality indicators in total. There are an average of 12 lethality indicators present for intimate partner homicide cases in Queensland.[9] In this case the DFVDRU identified that 20 of the 39 lethality indicators were present:

[9] The Ontario Domestic Violence Death Review Committee lethality coding system was applied to 92 intimate partner homicides that occurred in Queensland between 2011 and 2019 where a prior history of violence was able to be established. Of these cases, the largest number of lethality risk indicators present was 28, and the lowest number identified was one. Only 3 (3.3% of 92) cases recorded 27-39 lethality risk indicators.

1. history of domestic and family violence in the relationship
2. prior threats to kill the victim
3. prior suicide threats by perpetrator
4. prior attempts to isolate the victim
5. controlled most or all of the victim's daily activities
6. prior forced sexual acts/or assaults during sex
7. prior destruction or deprivation of the victim's property
8. choked/strangled victim in the past
9. perpetrator was abused and/or exposed to domestic and family violence as a child
10. escalation of violence
11. obsessive behaviour displayed by perpetrator
12. extreme minimisation and/denial of spousal assault history
13. actual or pending separation
14. depression – in the opinion of family/friends/acquaintances – perpetrator
15. depression – professionally diagnosed
16. failure to comply with authority – perpetrator
17. after risk assessment, perpetrator had access to victim
18. sexual jealousy - perpetrator
19. misogynistic attitudes – perpetrator
20. victim's intuitive sense of fear of perpetrator

617. The DFVDRU found that there were multiple potential points of intervention in which the service response could have been strengthened, prior to Ms Langham's death, as set out in the table in Annexure B to these findings.

618. The DFVDRU recognised that this homicide-suicide occurred within a region where an integrated service response, high-risk team and specialist domestic and family violence court were operating, all of which are intended to enhance the way services collaborate to keep victims safe and hold perpetrators to account. Despite this there was minimal evidence of services working together, recognising the swift escalation in risk or responding effectively to Ms Langham's multiple attempts at seeking help. The Magistrate identified the high risk of harm

but that failed to prompt any further consideration by agencies of the need for a better response.

619. An evaluation of the Integrated Service Response and High-Risk Teams Trial in 2019 found that while the trial has produced evidence of improvements in service integration it also experienced a range of challenges which included:
    - participating agencies assessed risk differently, with the common approach to assessing risk not being incorporated as intended;
    - there was confusion about the roles and responsibilities of high-risk teams and the broader integrated service response;
    - agencies that form part of the integrated service response were confused about their capacity to share information outside of high-risk teams (and despite the introduction of clear information sharing provisions within the *Domestic and Family Violence Protection Act 2012* as part of the Not Now, Not Ever (2015) reforms); and,
    - there was a need to improve focus on perpetrators and holding them to account, alongside the continued focus on victim safety.

Clement O'Regan

620. Mr O'Regan was an Assistant Commissioner of the QPS until his retirement in 2020. His policing career spanned some 40 years and included responsibility for police training. He was the Assistant Commissioner in charge of the ESC. He has numerous academic qualifications including a Masters Degree in Education.

621. Mr O'Regan reviewed the QPS response to Ms Langham with regard to the following issues:
    - the adequacy of the response to Ms Langham's contact and complaints;
    - systemic failures in regard to that response;
    - cultural issues and the reasons for the failure to investigate the complaints and address criminal offending;
    - the changes stated to have been made by the QPS since February 2021.

622. Mr O'Regan found the ESC investigation to be thorough and objective.

623. In relation to the response to Ms Langham's complaints Mr O'Regan found that the police had a process driven approach to the extraordinarily complex issue of DV which resulted in them failing to identify the risk. He said, "These officers ticked the box that minimised the amount of paperwork they would be required to fulfil and get them to their next job …. They were complying with a process but not professionally assessing risk and real or potential harm."

624. In relation to QPS reforms Mr O'Regan noted that one of the major elements of the organisational reform was actually renaming the existing State Domestic and Family Violence and Vulnerable Persons Unit to the Domestic, Family Violence and Vulnerable Persons Command with the replacement of the Inspector in charge to an Assistant Commissioner. He said there was no indication that extra resources had been allocated to the new Command other than a change of badging and a new command structure.

625. Mr O'Regan said that High Risk Teams have been in place since 2018 and the VPU has been growing over the past four years but most of the positions are still temporary and staffing them properly results in taking officers from front line positions.

626. Mr O'Regan noted the workload in the Logan District and that, at midnight on 22 February 2021 the log showed 44 jobs unresourced of which nine were code 3 priority, 34 on delay (code 4), one BOLO (Be On the Look Out) and eight jobs were resourced with units at the incidents.

627. Mr O'Regan also noted that recent data indicates that DV made up 30% of the total hours of calls for service in Logan and accounted for 52% of actual police time. There has been a 28% increase in calls for service.

628. Mr O'Regan said that any real change to police behaviour will require significant and ongoing education and training. The last whole of service training for DV

took place in 2017. He said that OLPs have little educational or cultural change value. Operational police treat them as another compliance process to be completed with minimal effort and little real learning. He noted that Covid impacted training programs. He said that an evidence based training program needs to be developed.

629. Mr O'Regan stated:

Responding to DV is one of the core tasks of policing. It is a constant and individually exhausting task for police officers on the road. Organisational systems renewal and reform cannot continue to be crisis driven. A performance driven leadership culture of constant improvement and organisational learning is critical to preventing normalisation of poor performance or just process compliance.

630. Mr O'Regan noted that little was proposed in the QPS response around effective perpetrator prevention programs and that area needs greater emphasis and accessibility.

631. In relation to Acting Superintendent Martain's statement, Mr O'Regan stated that he checked the QPS website for the new QPS Domestic and Family Violence Strategy as outlined in the statement but could only find that the currently available publication is the expired 2016-2019 strategy (but it had been uploaded to the website by the time he gave evidence at inquest).

The Inquest

632. The inquest was held in Southport from 7 to 11 March 2022. The brief of evidence comprised over 300 exhibits and 24 witnesses were called to give oral evidence.

633. The issues explored at the inquest were:

1. The findings required by s45(2) of the Coroners Act 2003; namely the identity of the deceased persons, when, where and how they died and the cause of their deaths;
2. The adequacy of the Queensland Police Service response to Ms Langham;

3. The extent and adequacy of responses to Ms Langham by domestic violence services;
4. The extent and adequacy of responses to Mr Hely by domestic violence services and the QPS; and,
5. Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice

Witnesses

634. The oral evidence of most of the witnesses accorded with their ESC interviews and statements and I do not propose to repeat it in these findings but instead concentrate on relevant matters which have not been set out above.

The Resident of Unit 105

635. The resident of unit 105 said that she awoke at about 3.30am on 22 February 2021. At about 3.40am she heard muffled yelling and screaming. She only heard one voice. Someone knocked on her door and told her to get out of the unit. She went outside and saw that unit 107 was on fire.

636. She had previously heard Mr Hely yelling on occasion.

Doctor Christopher Day

637. Dr Day is the Forensic Pathologist who conducted the autopsies. He said there was an injury to Ms Langham's spleen which happened at or around the time of her death but before she died. It could have been caused by blunt force trauma or a sharp instrument but he could not ascertain any further details because of the damage caused by the fire.

638. Dr Day was unable to determine the cause of Ms Langham's death. She inhaled soot deep into her lungs but there was little carbon monoxide in her blood indicating that she was breathing at the time the fire started but she died very

soon after. He considered that the combination of the spleen injury and the fire was the cause of her death.

639. Mr Hely had a significant amount of carbon monoxide in his blood indicating that he was alive for a longer, but indeterminate, period of time after the fire started. He had wounds on his neck and left chest which caused bleeding. Dr Day opined the level of carbon monoxide in Mr Hely's blood, whilst high, was insufficient to independently cause death. Dr Day concluded Mr Hely died from a combination of his wounds and the effects of fire.

Senior Constable Kaye Forrest

640. Senior Constable Forrest has been in General Duties at Broadbeach and Crestmead police stations for the vast majority of her 13 year police career. She is obviously an experienced officer. She is a Field Training Officer for First Year Constables.

641. She has attended numerous DV incidents – in fact, on some days she can attend up to four on one shift. She has been the investigating officer for numerous criminal offences. She has issued Police Protection Notices and obtained DVOs under the DFPV Act. She was trained in DV at the Police Academy. Since then she has completed online training programs (OLP) approximately every two years.

642. Despite her years of policing experience, Senior Constable Forrest gave evidence that she did not understand the basics of applying for a DVO on behalf of a victim of DV. She said that the incorrect information that she gave Ms Langham on 7 February 2021 i.e. that police required proof beyond reasonable doubt of contemporaneous physical injuries to proceed whereas private applications could include the complete history of DV including non-physical DV, was her genuine belief at that time.

643. Senior Constable Forrest gave evidence that it was her understanding that the only condition police could include on a PPN was that the respondent be of good behaviour and only a DVO brought by private application could include further conditions.

644. She also gave evidence that at that time she didn't understand that DV could include coercive control. That evidence was obviously inconsistent with the information she provided to Ms Langham as recorded on Constable Cacace's BWC.

645. She stated that she believed Mr Hely was moving to New South Wales.

646. She could give no reasonable explanation for her failure to take into account or investigate further Ms Langham's disclosures of Mr Hely's history of DV with previous partners. She said that she knew how to look at CrimTrac on her QLiTE. Senior Constable Forrest stated that it was not common practice to look up the criminal history of a respondent to a DV as it is a "civil matter", however she said that had she looked at Mr Hely's interstate criminal history she would have issued a PPN. She agreed, after reconsidering the conversation she had with Ms Langham that she had sufficient information to issue a PPN.

647. Senior Constable Forrest said that completion of the DV-PAF was not part of her decision-making at that time although it is now. She said that it was completed when the job was finished and the decisions had already been made to take further action.

648. Senior Constable Forrest said that she now knows that her beliefs about DV were incorrect. Since February 2021 she has undertaken a half-day course on DV and she may have completed an OLP. Concerningly, however, Senior Constable Forrest said that she had been giving the same advice as she gave to Ms Langham for her whole policing career and no other police officer had ever told her that the information was incorrect.

649. This indicates either that a significant number of frontline police officers do not understand even the basics of the law and OPMs relating to DV or they are not doing their job in accordance with their lawful duties and obligations.

650. Senior Constable Forrest stated that she was aware that she could have offered Ms Langham and Mr Hely a referral to a DV support service but she did not do so with Mr Hely and she could not recall whether they had offered it to Ms Langham.

651. Senior Constable Forrest said she was served with a notice of disciplinary proceedings on 2 February 2021 and a couple of weeks later she was advised that the proceedings were discontinued. She has no idea why that occurred. She said that at no time since Ms Langham's death has she been spoken to about her conduct on 7 February 2021 or received any advice or mentoring from a senior officer.

First Year Constable Michael Cacace

652. Constable Cacace was sworn in on 18 November 2020. He said he had been trained in DV at the Academy and on 7 February 2021 did some training with a VPU officer in which he was told about the purpose of the VPU and HRRs. He was trained in PPNs at the Academy.

653. He considered that Ms Langham was at risk but he was guided by officers Forrest and Pearce as his senior officers. He said that Senior Constable Forrest was incorrect when she told Ms Langham that police needed proof beyond a reasonable doubt but he couldn't recall hearing her say that. He also knew it was incorrect that there was a different standard required for a PPN as compared to a private application.

654. He can't recall being trained in CrimTrac but now knows how to use it. He only received his QLiTE device a couple of days prior to 7 February 2021 and didn't know how to use it. He had no specific training on the use of the device at the Academy.

655. In regard to the disciplinary process he was told to undertake two OLPs on DV and received “managerial guidance”. The ESC report had been sent to him but he had not read all of it.

Senior Constable Matthew Down

656. Senior Constable Down has been a police officer since 2014, predominantly in general duties at Browns Plains station. He said 75% of his work is related to DV. He was trained in DV at the Academy before he was sworn in. Senior Constable Down is an FTO but he received no training to undertake that role.

657. He was trained in the DV-PAF via an OLP in September 2021. He believed it was a tool to assess whether a DVO was required. He completes it at the end of the job when back at the station. He said that his understanding is that the only factors that should be recorded on the DV-PAF are those that you actually see when you attend that job and the form is used for statistics.

658. He said it is standard practice to look at a criminal history before attending a job but he would not usually look at interstate criminal histories.

659. Senior Constable Down said that he didn’t have his QLiTE with him on the night he saw Ms Langham so he didn’t look at any previous incidents or the incident log.

660. Senior Constable Down said that when Ms Langham told him that Mr Hely had come into her residence and stolen the rose he didn’t consider whether he had committed a criminal offence.

661. He said he didn’t know that Ms Langham had told police that Mr Hely was staying at his workplace. When he left her unit he looked around but didn’t see Mr Hely’s car.

662. Senior Constable Down made no further inquiries after he took Ms Langham's statement. He didn't think the breaches were serious enough to do anything further. He couldn't explain why he didn't make any effort to find Mr Hely and arrest him. He said that in hindsight he believes he could have done more but from his experience he did not believe it was an urgent matter.

663. Senior Constable Down said that he could have put out a BOLO alert for Mr Hely, asked the DDO to locate him using his phone and looked at previous addresses on the system. He said that had he looked at CrimTrac and been aware of Mr Hely's interstate history he would have taken urgent action to locate him that night.

664. He admitted that if he had read Ms Langham's DV application which was on the police database he would have seen that she provided the address of Mr Hely's workplace and two phone numbers for him.

665. At the time Senior Constable Down considered that it was a case of Mr Hely's "advances of love" being rejected and that his behaviour was normal in those circumstances.

666. Senior Constable Down said that he has not been subject to disciplinary proceedings arising from this matter but received mentoring in relation to the ESC findings.

Senior Constable Lachlan Jones

667. Senior Constable Jones said that he had received no formal notice of any disciplinary proceedings against him. The matter had not been discussed with him by any senior officer.

668. Senior Constable Jones said he had received no training about coercive control.

669. He said it remains his practice not to look at criminal history or CrimTrac before attending an incident.

Constable Mitchell Langford

670. Constable Langford said that his training at the Academy was fast tracked due to COVID and he was told to read the relevant legislation. He did undertake the DV training at the academy and since then he has completed two OLPs on DV. They were undertaken as a result of the ESC review into Ms Langham's death. He also had to speak to a senior officer.

671. Constable Langford could offer no explanation as to why he didn't check the side gate or take further steps to contact Ms Langham. He said he'd had minimal training on QLiTE at the time but he probably could have looked up previous breaches. He knew how to look up a criminal history but not CrimTrac.

672. Constable Langford said he routinely looks at CrimTrac and criminal histories now as well as checking other available information on the database.

673. Constable Langford said that at the time he considered the job of going to Ms Langham's residence minor and unimportant.

Ben Hamilton (Queensland Fire and Rescue Service)

674. Officer Hamilton believes that the garage door was open at the time the fire started. He said the front glass sliding door was in the shut position and the laundry door was locked.

Sergeant Steven Torrisi

675. Sergeant Torrisi concluded that the fire started in the living room. The exact source of ignition could not be determined but the fire was ignited as a result of intentional human involvement i.e. provision of an ignition source.

676. He said the fire burnt at greater than 600 degrees Celsius and could have been greater than 1000 degrees.

677. Sergeant Torrisi believes that the garage door was open at the time of the fire. He could not determine whether the front door was open or closed. The front sliding door was shut.

Detective Sergeant Darren Reilly

678. Detective Sergeant Reilly said that Mr Hely was last seen on CCTV just before midnight at the grassed area behind unit 107. At that time he was heading towards the unit.

679. Detective Sergeant Reilly stated that it was likely that Mr Hely entered the back yard of the unit around midnight. He gained access to the unit sometime after that. He could have gained access if Ms Langham went outside to have a cigarette.

Detective Inspector Paul Fletcher

680. Detective Inspector Fletcher is the OIC of the Logan DFV and VPU. He said he has received no training for that position.

681. There are ten to eleven thousand DV calls per year at Logan. They account for 52% of all calls for service in the district. DV assaults account for 48% of all assault matters. There are 450 matters classified as HRR per year and 250 at any one time. Detective Inspector Fletcher said that the workload is overwhelming and Logan district was understaffed by 60 police officers at the end of 2021. It takes an officer about four hours to complete one PPN.

682. He said that there have been significant changes in the way DV matters are reviewed since Ms Langham's death. Staffing was increased so that two full time officers review matters seven days per week. They consider about 250 matters per week. There has been a DV checklist developed to assist them. Detective

Inspector Fletcher said that Mr Hely would still not be classified as an HRR as, because of the need to prioritise matters due to the level of staffing, only matters involving actual assaults can be dealt with as HRRs.

683. No officers of the unit have received any further training in DV and there is no formal training available for VPU officers. There is also no external training offered to police. He agreed that a lack of external training can lead to confirmation of incorrect practices, beliefs and cultural issues. Detectives from the VPU attend police stations to educate general duties officers about DV and 30 of those officers have done a three day training course run by the VPU. Detective Inspector Fletcher said that more training is needed across the board. Detective Inspector Fletcher said that most general duties officers are not sufficiently trained in the use of the DV-PAF.

684. Detective Inspector Fletcher said that the trial of the embedded social worker was very successful and the VPU saw that handling of DV matters by that station improved. He believes that it should be implemented in every police station.

Senior Sergeant Wayne Smith

685. Senior Sergeant Smith said that DV matters cannot now be given a priority 4 unless the aggrieved requests it. All DV calls must otherwise be given at least a priority 3. There are now DFVC sergeants embedded in police communication centres to provide advice to Comcos.

Detective Sergeant Anthony Bradbury

686. Detective Sergeant Bradbury was the officer in charge of the ESC investigation. He explained the disciplinary process within the QPS. Disciplinary proceedings are decided by senior management who receive a copy of the ESC report. He said that Senior Constable Forrest was still being investigated but her OIC had been advised of her complete misunderstanding of DV matters within days of Ms

Langham's death. Proceedings were also continuing in relation to Senior Constable Jones.

Superintendent Ben Martain

687. Superintendent Martain explained that the QPS intend to trial a mobile DV police station. He said that it will be a large police van fitted out with police equipment and it will be placed in areas with high DV numbers in visible places such as shopping centres. The locations and days will be randomly allocated but the presence of the van will be advertised on social media platforms. The trial will assess whether the van is more effective when it is staffed with female officers only. The trial is to commence in the next couple of months and will run for three months with the results available in about nine months.

688. Superintendent Martain said that the last whole of service face to face DV training was conducted in 2017 and since then there have been some OLPs delivered. He said there are about 12,000 police officers across the state. Seventy-one of those officers have undertaken a five day DV course. It is intended to deliver annual face to face training to all officers. The current chapter 9 of the OPMs will be replaced by a DV manual which should be completed this year. The QPS is exploring the streamlining of the PPN process.

689. Superintendent Martain said that the QPS supports the funding of The Centre for Women & Co to continue the co-responder model and believes it should be rolled out more broadly over the state.

Mr O'Regan

690. Mr O'Regan said that he believes that many general duties officers called to DV matters are "ticking boxes" and doing the least they can do so they can get to the next job. He said that had Senior Constable Forrest taken out a PPN she would have had to spend hours doing the paperwork and she had taken another job whilst they were still with Ms Langham on 7 February. He said the process needs to be streamlined. He believes that Senior Constable Forrest knew the law

relating to DVOs but chose to misrepresent it to Ms Langham (None of us can remember Mr O'Regan specifically alleging that although it may have been implied).

691. He said that an accurate identification of risk for DV matters is critical but in this case officers Forrest and Cacace did not even hear Ms Langham when she gave them information about Mr Hely's past DV history. Had they listened to her and done an interstate criminal history check the matter would have been dealt with entirely differently.

692. He believes that police officers do consider DV important but they are overwhelmed. He said the essence of training has to be the identification of patterns of behaviour and assessment of risk. The last whole of service training on DV was in 2017 and there has been no real training since then. He said that OLPs were not sufficient to change the culture of the QPS. He said that DV training should be added to the annual core skills training that all officers have to undertake. He believes there is some regional acceptance and normalisation of certain behaviour.

693. Mr O'Regan believes that DV requires a multi-disciplinary approach rather than only a policing approach. He said that there has to be greater focus on perpetrator accountability and there is a real paucity of programs available in the regional districts.

694. He said that officers Jones and Langford should have gained access to Ms Langham's unit when they went there on 22 February 2021.

Ms I

695. Ms I, as a social worker employed by The Centre for Women and Co, has extensive experience in the DV area as well as academic qualifications. She was an impressive and helpful witness.

696. Her role at the Centre is to respond to incoming referrals from women who require support. The response is underpinned by assessing risk, safety planning, monitoring and referral to other agencies. She speaks to up to ten women per day. The Centre had over 400 referrals (and more self-referrals) in the last year. Logan district has the most DV calls in the entire state.

697. Ms I spoke of the difficulties of assisting women to obtain financial support and assistance when they are trying to escape DV. The Centre is funded by the State Government and has very limited funding – only $20,000 per annum is available for security upgrades (including changing locks etc) for clients of the service. This means they can rarely fund other security measures such as phone and house sweeps for surveillance devices. They can refer women for the Escaping Violence Payment which can be up to $1800 but due to the huge demand it can take months to be paid. Centrelink crisis payments of about $200 can be applied for but there are very strict criteria (eg the woman has to have been on Centrelink and left their residence within the last seven days). Victims of DV can apply to Victims Assist Qld but those payments can take up to two years. There are a maximum of fifteen placements in women's shelters in Qld and often there are no vacancies and if there are, the women have to move a long way away to get them.

698. Ms I said that the inability to obtain financial assistance often results in women being unable to leave a DV relationship as they cannot afford to do so.

699. Ms I said that Ms Langham did everything she could to ensure her own safety and the Centre did everything possible to assist her. Ms I said perpetrators of DV should be held accountable for their actions instead of the victim having to take responsibility for their safety.

700. Ms I said that there was a three month trial of a co-responder program with the QPS which involved a social worker embedded in a police station for a few days per week who would visit the RCFS victims with police officers. The pilot occurred at Logan and the Centre staff saw a definite improvement in the

referrals from police after the trial. The Centre also received very positive feedback from the women who were involved in the trial.

701. Ms I said that she often sees women make private applications for DVs because police officers have refused them. This happens particularly where there is no physical evidence of assault. She said the policing response is always dependent on the individual police officer. She said it is a widespread issue that women get a poor response from police officers – they are commonly not believed, treated as the perpetrator or dismissed. She often sees that police dismiss breaches of DVOs and do not take them seriously unless there has been a physical assault.

702. Ms I has observed that police officers do not perceive DV to be a criminal matter and do not charge perpetrators with criminal offences. She said that she believes that breaches of DV orders are not taken seriously by the courts and those who breach orders are rarely sentenced to imprisonment.

703. Ms I noted that perpetrators need diversion and rehabilitation and there is a severe lack of men's behaviour change programs. There are only three programs available in the Logan area and all of those have long waiting periods. When a perpetrator has to leave their residence due to an ouster order there is no accommodation available to them which makes this a high risk time for victims.

704. Ms I said that coercive control underpins every aspect of DV and separation is the highest risk factor of lethality which is why it is crucial for women to be somewhere safe when they leave a relationship. A PPN is the most timely protection available and the issue of a PPN can remove the fear of retaliation and escalation of anger. She believes that a law enforcement response to DV can be a real deterrent to a perpetrator. Another high risk period for victims is when the perpetrator is served with a DVO but Ms I said that in her experience it was common for victims not to be advised when this occurred.

Mr C

705. Mr C saw Mr Hely for four counselling sessions. He has fifteen years' experience as a counsellor. Mr Hely was referred by The Centre for Women & Co.

706. Mr C utilised Cognitive Behaviour Therapy to focus on Mr Hely's accountability in his relationship. Mr Hely told him he was verbally abusive to Ms Langham and wanted to address his past behaviours. Mr C recognised that Mr Hely was using emotional abuse, denial and blaming. Mr Hely did not disclose his past DV relationships to Mr C.

707. Mr C said there are waiting lists for both men's behaviour programs which operate in the Logan area.

Professor Kerry Carrington

708. Professor Carrington said that Ms Langham had a minimum of sixteen contacts with three police stations and the response she received illustrated a systemic failure of the QPS in its handling of DV matters. At the core of the failures was a lack of training which resulted in an incident-based approach which was not effective and culminated in a catastrophic failure.

709. There was no case management of Ms Langham's complaints, no single officer or station handling her case, no auditing of errors and no holistic overview.

710. The Professor is of the view that police officers need specialist external trainers and embedded DV social workers to change the culture. Frontline police need to be trained in risk assessment. She said that a trial of an embedded social worker in a Toowoomba police station changed the whole culture of that station. It involved five social workers who were available 24 hours per day seven days per week in a station of 195 police officers. The police officers could obtain advice from the social workers or ask them to speak to the aggrieved when it was safe to do so i.e. when the perpetrator had been removed.

711. Professor Carrington said that there have been an enormous number of evaluations done on specialist police stations which have proven that they are effective in providing a better service to victims.

Professor Heather Douglas

712. Professor Douglas said that police need better training in DV. There are deep cultural issues that require new strategies to address DV. She said that perpetrator programs are crucial and they need to be available. Police need to support victims and hold perpetrators to account but perpetrators also need support to change their behaviour.

713. Professor Douglas said that mandatory referrals for perpetrators is required. There is insufficient funding available for programs and even those perpetrators who want help cannot obtain it.

714. Professor Douglas said that police are still using a "separate incident" approach rather than a holistic view which means that numerous risk factors are missed.

715. Officers Forrest and Cacace treated the matters as low risk and that assessment carried through Ms Langham's subsequent contacts with police.

716. Professor Douglas said that an offence of coercive control would not have assisted Ms Langham as the police did not charge Mr Hely with the criminal offences that were available to them. Had they charged him they would have interviewed him and may have seen that he was struggling with numerous issues including homelessness. She observed that he seemed to be open to counselling at the early stage but he was not offered a perpetrator program.

Conclusions and Findings

The Causes of the Deaths

717. I find that Mr Hely intended to kill Ms Langham, kill himself and set her residence on fire.

718. He went to her residence complex at about 2.30pm on 21 February 2021. He was at the front of the residence when Ms Langham called police at 9.21pm. He was at the rear of the unit when police attended some four hours later. He waited at the rear for police to attend and leave, then waited for two more hours before he gained entry to Ms Langham's unit. Detective Reilly concluded that it was likely that Mr Hely entered the back yard of Ms Langham's unit around midnight. I am unable to determine how he gained access to the unit, however I am satisfied that Ms Langham did not consent to him entering her unit.

719. Once inside Mr Hely struggled with Ms Langham during which time she sustained an injury to her spleen. Mr Hely sustained injuries to his neck and chest. It is possible that he inflicted those injuries himself. He doused Ms Langham with petrol and possibly himself. He may have poured petrol around the unit. He then ignited the fire in the loungeroom.

720. The fire commenced between 3.30 and 3.45 am. Ms Langham and Mr Hely were alive and conscious when the fire started although Ms Langham died very soon after the fire began.

The Adequacy of the Queensland Police Service Response to Ms Langham's Complaints

721. There were numerous missed opportunities for police officers to respond to Mr Hely's escalating behaviour.

<u>6 September 2020</u>

722. Although Mr Hely's threat to commit suicide was recognised as a DV and coercive control matter, no officers considered his CrimTrac history which may have prompted flags to be entered on the system and altered the manner in which future complaints were treated.

7 February 2021

723. Senior Constable Forrest and Constable Cacace did not take Ms Langham's complaint seriously. They did not listen to or act on the information she gave them. They did not record that information correctly in the database. They did not put flags on Mr Hely's or Ms Langham's names on the database. Their inadequate response impacted on decisions made in relation to Ms Langham's later contacts with police.

724. I find it very difficult to accept the evidence of Senior Constable Forrest, an experienced officer and a Field Training Officer, that her understanding of the DV law was so flawed. It was incumbent on Constable Cacace, who knew that she was giving Ms Langham incorrect information, to correct or raise it with a senior officer but he failed to do so.

725. It is greatly concerning that Senior Constable Forrest said that she would not look at a DVO respondent's criminal history as it is a "civil matter".

726. Senior Constable Forrest acted inappropriately in accepting Mr Hely's statement that he was in NSW and taking no further action after they had spoken to him on the phone. It was their duty to take out a PPN and a DVO and to take further action to ensure Ms Langham's safety.

727. They should have referred Mr Hely for counselling and support.

728. Senior Constable Forrest and Constable Cacace failed to comply with their duties and obligations as police officers.

11 February 2021

729. Constable Langford served the TPO on Mr Hely without offering him referral to a support service.

14 February 2021

730. Constables Crews, Barry and Lawrance failed to treat Ms Langham's complaints seriously. They did not identify that she was at high risk of death or serious harm. They failed to identify Mr Hely's serious interstate criminal history. They failed to carry out any basic investigations or attempt to locate him.

15 February 2021

731. Senior Constable Jolly took two statements from Ms Langham. Although he recorded Ms Langham as fearful and her risk as "high" and recorded threats to kill, controlling behaviour, ongoing conflict and stalking he did not consider that those factors required him to carry out any investigations or make any real attempt to locate Mr Hely and charge him with criminal offences. He did not check CrimTrac and failed to recognise the significance of the previous breaches and the escalation of Mr Hely's behaviour. He asked other officers to patrol for Mr Hely but failed to follow up with them or handover the matter to any other officer when he went on leave for seven days.

732. Senior Constable Jolly gave evidence that he thought Mr Hely was trying to "woo her back" on Valentine's Day.

16 February 2021

733. Senior Constable Down and Constable McGregor attended Ms Langham's unit. She gave them a comprehensive history of Mr Hely's behaviour and Senior Constable Down rated her as fearful and the risk level high but despite this said that he considered the matter "innocent and minor" and not sufficiently serious to take any action.

17 February 2021

734. Senior Constable Down continued to fail to recognise the serious nature of Ms Langham's complaints. He gave evidence that when she told him that Mr Hely

had entered her unit and taken the rose he did not consider whether that was a criminal offence. He failed to check previous occurrences and CrimTrac. He considered the breaches were not serious enough for him to take any action other than obtaining a statement from Ms Langham.

735. Concerningly, Senior Constable Down gave evidence that on 17 February he believed that Mr Hely's behaviour was normal for a man whose "advances of love" were being rejected.

736. He treated Ms Langham's fears as trivial by telling her to report the breaches once per week so that she didn't have to come to the police station every day.

21 and 22 February 2021

737. Ms Langham's 000 call should have received higher priority which would have resulted in police attending earlier. Whilst it may not have warranted higher than a code 3 it should have been monitored by the dispatchers and the Comcos. It seems that the importance of the call got lost in the handovers of those positions.

738. Senior Constable Jones and Constable Langford attended four hours after she called but had not looked at the previous history of the matter or Mr Hely's CrimTrac history. They failed to fulfil their duties and obligations to investigate the matter and ensure Ms Langham's safety. They were at her door for 40 seconds during which they knocked on the door once and then quickly left when there was no answer.

739. If officers had attended earlier that evening they may have seen Mr Hely walking around the complex. If officers Jones and Langford had walked around Ms Langham's unit they may have seen Mr Hely in the back yard. There were therefore missed opportunities to disrupt his plans or provide Ms Langham with assistance, for example, to leave the residence.

Conclusions

740. I find that, overall, the response of the QPS to Ms Langham's complaints and contacts regarding Mr Hely was inadequate and police officers failed to protect her and prevent her death. It is possible that, had every complaint been dealt with in accordance with relevant duties and obligations, Mr Hely would not have killed Ms Langham or himself.

741. Ms Langham deserved, and the community should expect, the kind of policing response to DV that is outlined by Professor Carrington. The response she received fell far short of basic expectations.

742. The poor response by numerous officers indicates a serious lack of training and consequently, understanding, of the complex nature of DV by police officers generally but particularly frontline officers. This is concerning as reviews of DV matters by specialist DV police can only be based on the records made by frontline officers. If those records are deficient reviews are ineffective. Further, there is a lack of any specialist training for those police officers that the QPS considers specialist DV officers such as those who work in the VPU who are given responsibility for training and mentoring frontline officers.

743. The seriousness of Ms Langham's complaints and her risk of lethality were not recognised by the DV specialist police who reviewed her complaints. Some reviews which should have been undertaken were not due to a lack of police staffing.

744. By the time of Ms Langham's death Mr Hely had continually breached the DVO and committed other serious criminal offences but no police officer considered his offending was significant enough for them to make any real attempt to locate him so that he could be questioned and charged.

745. Police officers failed to take even the most basic steps to investigate Ms Langham's complaints or ascertain the risk Mr Hely posed to her. Had one of the numerous officers with whom she had contact looked at CrimTrac on their

QLiTE device they would have realised that Ms Langham was at great risk. Unfortunately this information was not available to Ms Langham so she was unable to assess that risk for herself. It was the duty of the police officers to make themselves aware of Hely's past serious history of DV, particularly since Ms Langham alerted police officers to that history.

746. Every officer involved in this case failed to comply with OPM 9.3.1 which stated that they should review interstate records. Further, a number of officers (including a sergeant) said that they did not know how to find that information on the police database. None of the officers understood the purpose of the DV-PAF

747. The greatest systemic failure is that every police officer dealt with each complaint in isolation and without checking the police database for relevant information. A holistic investigative approach would have revealed that Mr Hely had concerning DV history interstate and that the frequency and severity of his behaviour was escalating.

748. I accept that none of those officers acted out of malice and their inadequate response was the result of inadequate training and acute understaffing in the Logan District coupled with an ever increasing demand for services. I accept that the pandemic greatly affected training and staffing within the QPS at that time. I accept that each of the police officers involved with Ms Langham and Mr Hely have been impacted by their deaths and regret any failings and that this inquest views their conduct in hindsight and in light of the tragic outcome. In particular, I note that Senior Constable Jones is described in his performance reviews as a keen, motivated, hardworking officer who has previously received an award for bravery. I accept that he has taken steps to increase his knowledge in relation to DV since Ms Langham's death.

749. I accept that the QPS has made and continues to make efforts to address the lack of training that has been delivered in recent years and the increasing demand for services in relation to DV.

750. However, I agree with Professor Carrington's assessment of the police response:

> *No one officer or team took responsibility for Ms Langham's case. Vital information was not passed on, diluted, misunderstood, went missing, not followed up or fell through the cracks of so many different QPS officers and communication systems. There were so many errors, mistakes and lost opportunities in this case to respond effectively to potentially lethal DV that leads me to conclude these short-comings are systemic, structural and institutional, and not attributable to the failings of any single individual police officer. In fact, some QPS police were set up to fail being given no or insufficient background of the history of the matter.*

751. As already stated, I accept that the QPS has made efforts to address procedures and training since February 2021 but, practically, police alone are not able to deal with the scourge of DV. They are not social workers or psychologists or lawyers and cannot be expected to be trained in all of those disciplines. The duty of police officers is primarily to address criminal offending, however, at this time, they continue to struggle to recognise DV breaches as criminal offences. The huge problem of DV offending needs to be addressed by multi-disciplinary teams which include but are not restricted to police officers.

752. Although it was not explored at this inquest, I note that it was not only QPS officers that failed to hold Mr Hely accountable as a perpetrator of DV. His NSW criminal history indicates that he was never held sufficiently accountable in that state for his persistent and serious conduct against his previous partners.

The Adequacy of Responses to Ms Langham by Domestic Violence Services

753. I find that Ms I of The Centre for Women & Co did everything she could to assist and support Ms Langham, considering the very limited funding available to that service.

Recommendations

754. I have been much assisted by the comprehensive and helpful submissions of the parties in this case.

755. I take into account that the Commissioner of Police has undertaken, in submissions to the inquest, that the QPS will shortly commence a twelve month pilot program to embed QPS domestic and family violence specialist officers into the Brisbane Domestic Violence Service at South Brisbane and the Domestic Violence Action Centre at Ipswich.

756. The *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* report released in 2015 included several recommendations directed at the QPS about improving police officers' understanding of the dynamics of DV and to strengthen options for perpetrator accountability. Specifically:

- improve the criminal investigation and prosecution of perpetrators of DV;
- achieve a more pro-active investigation and protection policy;
- ensure that arrest is prioritised where a risk assessment indicates the action is appropriate; and
- improve governance, supervision, and training of police officers in relation to DV.

757. The circumstances of Ms Langham's death indicate that the QPS has been unable to date, to implement those recommendations.

758. The Women's Safety and Justice Taskforce report which was released this year contained 89 recommendations. The Queensland government has recently agreed to implement all recommendations and has commenced an inquiry to examine the widespread cultural issues within the Queensland Police Service. Under these circumstances I find it unnecessary to address those recommendations further, however, this inquest has revealed the need for urgent reforms to address the inadequate response of the QPS to victims of DV and I therefore recommend that, as a matter of urgency:

1. The Queensland Government provide funding for the QPS to trial a specialist victim-centred police station specifically designed to deliver an integrated response for victims of DV staffed by suitably qualified multi-disciplinary teams which include police officers with specialist DV training, DV workers, social workers and legal advisors in the Logan District;

2. The Queensland Government provide funding for an appropriately qualified and experienced DV specialist social worker to be embedded at the front counter of every police station in Logan District for a trial period of 12 months

3. OPM 9.3.1 be amended to state that officers "must" view a person's interstate record for every DV matter.

759. The Commissioner of Police supports the above recommendations and submits that the three-month trial of the embedded social worker model at Toowoomba was supported by 100% of Toowoomba police officers and resulted in significant benefits to front line officers. Further the Commissioner acknowledges that:

Our organisation does not have all the answers. We need to work together, with all levels of government, non-government organisations, businesses and the community to identify and deliver sustainable, long term and culturally appropriate solutions.

760. In relation to support for perpetrators I agree with Ms Reece's submission that the QPS should consider requiring officers serving TPOs and DVOs to provide perpetrators with information about counselling and support, parenting and mediation, housing and legal assistance by way of a document such as the "Information for Respondents" document provided to respondents to DVOs by the Caxton Legal Centre.

Findings required by s. 45

Ms Langham

Identity of the deceased –	Doreen Gail Langham
How she died –	Ms Langham was killed by Gary Hely in a context of intimate partner homicide.
Place of death –	Unit 107, 4 Myola Street BROWNS PLAINS QLD 4118 AUSTRALIA
Date of death–	22 February 2021
Cause of death –	a combination of spleen injury and the effects of fire

Mr Hely

Identity of the deceased –	Gary Matthew Hely
How he died –	Mr Hely died from the effects of a fire he intentionally lit in order to kill Ms Langham. It is likely that his death was intentional.
Place of death –	Unit 107, 4 Myola Street BROWNS PLAINS QLD 4118 AUSTRALIA
Date of death–	22 February 2021
Cause of death –	the effects of fire

I close the inquest.

Jane Bentley
Deputy State Coroner
SOUTHPORT

ANNEXURE A

Domestic Violence Protective Assessment Framework (DV-PAF)

Category 1 Risk Factors

Frequency: are DV incidents happening more often and between shorter time periods? This may include incidents not reported to police.

Pregnancy: is the aggrieved (if female) pregnant? This may create considerable stress on the relationship.

Previous incident(s)/contraventions(s): are there previous DV incidents/contraventions recorded between the aggrieved and respondent?

Separation: have the aggrieved and respondent recently separated or are they separating? Is the aggrieved wanting or attempting to leave the relationship?

Severity: is the violence escalating/becoming more serious? For example, moving from verbal to physical, pushing to slapping, slapping to beating or serious/life threatening injuries.

Sexual violence: has the respondent committed sexual violence against the aggrieved? For example, using sex or sexual acts as a form of control, punishment or violence.

Significant change in circumstances: is there now or recently been a significant change in circumstances? For example, unemployment, financial hardship, child custody/access disputes, interfamily conflict.

Strangulation/suffocation: is there evidence the respondent has attempted to strangle/suffocate the aggrieved now or in the past?

Threats to kill: has the respondent threatened to kill the aggrieved/family members?

Use of weapons: has the respondent used or threatened to use a weapon to commit DV against the aggrieved/family in current or previous incidents?

Not present – no category 1 risk factors present.

Category 2 Risk Factors

Alcohol/drug misuse: is there a history of alcohol/drug misuse by aggrieved/respondent and does this occur concurrently with DV?

Animal cruelty: has the respondent harmed or threatened to harm family pets?

Child abuse: is there a history of abuse or neglect of a child by the respondent, irrespective of the relationship between the child and respondent?

Controlling behaviour: does the respondent try to control the aggrieved, for example, where he/she goes, what they do, who they spend time with, controlling finances, isolating the aggrieved from friends, family and/or support?

Cultural considerations: are there cultural considerations preventing the aggrieved from reporting DV in the future? For example, aggrieved may not be aware of rights in Queensland, aggrieved is isolated, cultural customs prevent aggrieved from speaking out.

Mental health issues: is there history of mental health issues for respondent? Is there evidence of a diagnosed or undiagnosed disorder which might increase risk of DV to the aggrieved?

Respondent history of violence: does the respondent have a violent history towards the aggrieved, family or others? Are there incidents of domestic violence with a previous partner?

Ongoing conflict: is there an issue creating conflict in the relationship or family unlikely to subside in the near future?

Significant damage/destruction of property: has the respondent significantly damaged property as a means of intimidating or victimising the aggrieved?

Stalking: does the respondent follow, contact, intimidate, place under surveillance, manipulate or harass the aggrieved?

Suicidal: has the respondent or aggrieved threatened or attempted suicide?

Violent threats: has the respondent threatened an act(s) of violence against the aggrieved/children/family?

Not present – no category 2 risk factors present.

Fear Level

Not fearful: aggrieved does not appear fearful of DV occurring in the future.

Fearful: aggrieved appears fearful of DV occurring in the future

Very fearful: aggrieved appears very fearful of DV occurring in the future

Unable to be assessed

Level of Risk

Unknown: level of risk unable to be determined.

Medium: no significant/current indicators of risk of harm to the aggrieved. Changes in circumstance or DV may create risk for the aggrieved and any future incidents should be carefully assessed.

High: proactive police response to risk is recommended. Indicators of risk of harm to the aggrieved have been identified. The respondent has the potential to cause harm. They may also have the potential to cause serious harm if there is future violence and/or risk and/or a change in circumstance.

Extreme: proactive police response to risk is highly recommended. There are identifiable indicators of risk of serious harm to the aggrieved. An incident could happen at any time and the impact could be serious

ANNEXURE B

Point of Intervention	Event	What happened?	What else could have happened?
1.	**19 August to 18 September 2020.** Gary attended four of six sessions with a psychologist (Mr C).	• Gary was referred to a psychologist by the Hart Centre[10] and contacted Mr C on 19 August 2020. • Gary stated that he "*was worried that his partner would leave him as a result of recently being verbally abusive towards her*" • He further stated "*this was not the first time he has been verbally abusive with her and that in other relationships he has been verbally and physically violent*"[11]. • Gary had six sessions[12] booked with the psychologist and attended four; cancelling two appointments prior to his threat to suicide in September 2020. • Mr C had experience with men's behaviour change programs and the focus of their sessions was Cognitive behavioural therapy. • On **4 September 2020** (the day prior to his threats of suicide below) Mr C (Psychologist) questioned Gary about '*what he needed to ensure he could remain a safe and responsible man*' and Gary replied that he was not '*going to do anything'* but felt the (undisclosed) 'incident'[13] was a setback to '*some of the progress he had been making'*. This was	• While it is positive that Mr C challenged Gary's disclosures, no structured risk assessment was undertaken by this psychologist in his sessions and nor were comprehensive notes taken by him. • Indeed, Mr C stated that it is not his usual practice to take comprehensive notes, specifically: "*I did not recall exactly what the verbally abusive things were that Mr Mr Hely relayed to me. I would not ordinarily record the details of those things. I can remember now that he said he had called her a variety of derogatory things including bitch, slut and cunt*[14]". • There does not appear to have been any follow up with Gary for further appointments by the psychologist when he cancelled the last two sessions. • A more structured risk assessment or exploration of Gary's disclosures of past abuse may have prompted further action (noting that the threshold for referral to police for a psychologist is generally when someone is assessed as posing a

[10] According to Mr C, The Hart Centre provides telephone counselling for people experiencing relationship issues. See more here
[11] Client notes provided by Mr C from initial discussion dated 19 August 2020.
[12] 19 August 2020, 24 August 2020, 31 August 2020, 4 September 2020, 8 September 2020 and 18 September 2020.
[13] In his statement after the homicide-suicide Mr C stated that it wasn't his place to ask details about what incident Gary was referring to or any prior history (despite Gary self-disclosing a prior history of abuse to both Doreen and other parties)
[14] Police Statement of Mr C para. 12

Point of Intervention	Event	What happened?	What else could have happened?
		Gary's last session with his psychologist prior the apparent homicide-suicide in **February 2021**.	significant/imminent risk or harm to themselves or others).
2.	**Father's Day 5- 6 September 2021** Threats of suicide by Gary reported to police by Doreen (Gary had left the unit they shared at 9.30pm threatening to drive into a truck and then jump off a cliff. He continued to send texts messages until 1.14 am on 6 September). He then turned his phone off and Doreen was unable to locate him.	• Doreen notified Browns Plains Police Station that Gary had made threats to suicide (within the context of a relationship separation). • Notes indicate officers engaged a Police negotiator to contact Gary and a mental health clinician to undertake a mental health/suicidality assessment. • The mental health clinician[15] confirmed Gary's controlling behaviour appeared to be the sole purpose of the suicide note. • Police recorded the incident as DV – Other as Doreen stated she was not fearful of Gary, there was no physical violence and no property damage. • Police undertook checks of QPrime however there was no prior occurrences involving the couple. Searches do not appear to have been conducted of any interstate history[16] through CrimTrac. • A referral to The Centre for Women & Co was made for Doreen by officers at this time. The Centre for Women & Co	• Police could have searched interstate history for Gary, which would have identified him as a persistent and recidivist perpetrator. The negotiator had a very focussed interaction with Gary which sought to deescalate any immediate risk of harm. He denied any specific intent to take his own life. • A referral at this point to a men's behaviour change program for Gary to address his use of coercive control may have provided an earlier intervention point. • Despite the referral for Doreen to a domestic and family violence support service no discussion appears to have been held with Doreen by police regarding domestic and family violence and the options available to her (such as a private protection order). • Sending a hard copy information package to Doreen may have placed her at greater risk, given Gary was continuing to reside with her. The service only attempted to call Doreen on two occasions prior to closing the referral.

[15] Q-Health Mental Health Liaison Service situated in the Brisbane Police Communications Centre and operates within a consultation-liaison framework and links with other agencies or mental health services as required.
[16] Information known to police at the time included Gary having associations with OMCG activity, convictions for negligent driving, road rage, common assault, threats of violence and rape towards former partners, abusive interactions with neighbours, AVOs with former partners, stalking and intimidating behaviour towards former partners, damage to property, threats to kill former partners, theft, non-lethal strangulation and suspicion of arson.

Point of Intervention	Event	What happened?	What else could have happened?
		attempted to call her but did not make contact and did not leave a message. They instead sent her an information package about their service.	
3.	**29 August 2020 – November 2020** Gary visits the GP on six occasions	• Gary was prescribed Fluoxetine[17] in August 2020. • During a GP consultation with Dr A on 29 August 2020, Gary and Dr A spoke about his "self-diagnosed anger issues" when Gary disclosed that he had "difficulty controlling his emotions and anger and this was affecting his relationship". • Dr A states in his police statement that "he (Gary) did not mention violence toward his spouse". • A recommendation was made at this time by the GP for a Mental Health Care Plan and Gary agreed to a referral to be made to a Psychologist Mr Baxter in Stones Corner, however Mr Baxter had relocated to Melbourne and this referral was never re-referred to another provider. • Even though Gary had commenced counselling with a Psychologist on 19 August 2019, there is no mention of this earlier referral in the statement provided by Dr A.	• GP's have access to resources to guide and support them in working with patients affected by domestic and family violence.[18] • Noting that the GP didn't identify domestic and family violence as a presenting issue (despite Gary's disclosure), the White Book presents comprehensive guidance on domestic and family violence, outlining the signs for GP's to be aware of. • Had Dr A sought guidance from this resource he may have better understood the underlying context of Gary's disclosures and given greater priority to the psychologist referral or considered referring Gary to a men's behaviour change program.

[17] Fluoxetine is used to treat depression, obsessive-compulsive disorder, and panic attacks.
[18] https://www1.racgp.org.au/newsgp/racgp/recognise-and-respond-white-book-update-guides-gps

Point of Intervention	Event	What happened?	What else could have happened?
		• On 9 November 2020 Gary saw his GP again to discuss "multiple issues including his mental health".	
4.	**8 February 2021** Doreen's (private) application for a protection order is heard at the Beenleigh Specialist Domestic and Family Violence Court	• Doreen is supported by a Duty Lawyer in court and her application for a temporary protection order includes a total of 8 conditions including no contact and ouster provisions[19]. • The Magistrate hearing the application for the Private Domestic Violence Order recognised the risk posed by Gary, identifying him as "***extremely unstable***" and questioned Doreen's Solicitor whether "***the* (High) *Risk team needs to be looking at this".*** • No action appears to have been taken by court staff in response to the suggestion made by the Magistrate following the proceeding. • The Domestic Violence Assistance Program present at the court refers Doreen to The Centre for Women & Co, after a discussion with Doreen.	• Beenleigh is a Specialist DFV Courthouse which has a focus on providing high level and improved services to victims of domestic and family violence. • The protection order was served on Gary on 11 February 2021, with no referrals offered to him. He reportedly appeared compliant with police and there (again) does not appear to have been any checks taken by police of his interstate history. • The referral by the Domestic Violence Assistance Program does not include a copy of Doreen's private application[20] and there is no mention of the Magistrate's comments regarding a possible referral to a high risk team; which may have prompted a more informed assessment of her risk.
5.	**10 February 2021** Intake process undertaken by The Centre for Women & Co	• Telephone conversation with Doreen and the Intake Worker. Doreen disclosed to the intake worker that Gary took photos of her while she slept	• The Private Application and supporting statement from Doreen outlines **12 of 39 lethality risk indicators**[21] which would

[19] The full conditions included: requiring Gary to be of good behaviour and not commit domestic violence against Doreen, prohibiting Gary from remaining at Doreen's address, prohibiting Gary from: coming within 100m of Doreen at any time; locating or contacting Doreen by any means; possessing guns; ammunition and weapons; and items prohibited under the *Drugs Misuse Act*.
[20] Doreen's application outlined a range of abusive behaviours perpetrated against her by Gary including: not allowing her to have any friends, not speaking to her for days, going through her phone and messages, constantly accusing her of being unfaithful, deliberately damaging her property, physically attacked her in a drunken rage, threatened to physically attack her, threaten to come to her workplace, stalked her during periods of separation, verbally abusing her, threatening suicide, not allowing her to speak to other people and sending multiple text messages in an attempt to harass her.
[21] Review of the Private Application and supporting statement from Doreen using the Intimate Partner Homicide Lethality Risk Coding Form.

Point of Intervention	Event	What happened?	What else could have happened?
		in her underwear; threatened to kill her; that she was terrified and left the unit to stay with friends; that she had changed her phone number so she would not receive any further messages from him; that he had searched her property to locate her new number (and sent her further abusive messages). • Doreen also disclosed a severe assault while Gary was intoxicated including Doreen being punched repeatedly in the face, and kicked in the back on April 2020 (that was not reported to police). • An initial Intake form and a brief risk assessment was completed based on the information Doreen disclosed at the time. Doreen was placed on a waitlist for service and was not considered high risk. Factors noted by the Intake Worker at the time were: separation of less than 6 months, threats to kill, coercive control and threats of suicide by Gary. • Additional factors disclosed by Doreen during this conversation included: jealousy; Gary constantly checking her phone; stalking; verbal abuse; (his) threats to suicide; problematic	have identified an escalating pattern of behaviour. • The worker did not attempt to obtain a copy of the protection order to better inform their understanding of the relationship/any risk indicators disclosed. • Irrespective, the risk assessment undertaken by the worker showed a limited exploration of the abuse that Doreen disclosed which may have informed a better assessment of the risk Gary posed (i.e. sexual violence not being identified as a risk factor). • While they offered a referral to a women's shelter she did not accept because she was worried about the impact on her lease, (noting they offered to also negotiate with the real estate on her behalf). • Additional strategies could have included a safety alarm, increased surveillance, priority appointment with a case worker or referral to a high-risk team.

Point of Intervention	Event	What happened?	What else could have happened?
		substance use (perpetrator); and coerced sex.	
6.	**11 February 2021** Temporary Protection Order (TPO) served on Gary Mr Hely	• Gary attended the Police Station and was served with the order. • He reportedly engaged well with officers and stated he understood the conditions including the ouster and no contact conditions. • No referral appears to have been offered to Gary at the time.	• Additional checks do not appear to have been undertaken by officers at this time with respect to Gary's interstate history through CRIMTRAC. • A referral for Gary to a perpetrator behaviour change program may have acted as another point of early intervention (noting of course that there are challenges with the availability and accessibility of these programs). • At least some of the previous domestic and family violence orders with Gary Mr Hely as the perpetrator from NSW should have been registered on the National Domestic Violence Order Scheme.
7.	**11 – 21 February 2021** Multiple breaches of the TPO reported to Police which did not prompt further investigation or action[22]	• As outlined within the QPS Ethical Standards Investigation Report no further action was taken by officers in response to these reports. • Doreen's presentation was described as not being fearful and that she was "joking with officers" which is cited as a contributing factor as to why officers did not treat her concerns and the breaches seriously.	• Undertaking steps to investigate the reports may have supported the pursuit of criminal charges against Gary for the breaches of the order/acted as an additional point of referral to relevant service providers for him. • QPS appears to have taken statements from Doreen, and offered victim support, which Doreen declined. • Police could have also referred Doreen to a high-risk team given she was reporting an escalating pattern of abuse which included a persistent disregard for the

[22] (Statement made by Doreen on 15/2/2021 and 17/2/2021

Point of Intervention	Event	What happened?	What else could have happened?
			order, leaving flowers at her address, entering her home to retrieve the flowers, stalking, driving past her address whilst throwing threatening gestures and leaving a sign on a public lamp post outside her house, declaring his love for her, (particularly Gary taking into account his previous behaviours with former intimate partners).
8.	**14 – 16 February 2021** Doreen contacted The Centre for Women & Co to discuss recent breaches by Gary to the TPO and requests the locks on her unit be changed.	• Doreen called the agency on multiple occasions disclosing she was terrified and that there had been further breaches (the flowers being placed in the property, him breaking into her house to remove the flowers and ejaculating on her sheets). • The Centre for Women & Co arranged a locksmith to attend on 16 February and replace the locks on the doors to the unit. • The locksmith identified an extra door and requested permission to change this one also. This was done on the same day and his was the last contact with the agency.	• There does not appear to have been any additional steps taken by the worker to reassess any potential risks faced by Doreen (in response to the multiple apparent breaches by Gary). • Locks do not appear to have been changed on the internal door to the garage which may have been how Gary entered the unit. • Doreen confirmed she didn't want to relocate for now but wouldn't be returning to the address until the locks had been done and could have a friend stay with her 'here and there' when they had been done. • The worker did not re-assess Doreen's risk, although internal case planning notes on 15 February 2021 indicate that should Doreen continue to report breaches the service would consider a referral to a HRT.
9.	**21 February 2021** Doreen sought help from police as she had seen Gary at her house.	1. The triple zero call at **9.20pm** was triaged by the Communications Coordinator as a 'partial' job for	5. Doreen clearly states to the triple zero call receiver that there was a protection order involving her ex-partner and he is currently outside the front of her address. She also

Point of Intervention	Event	What happened?	What else could have happened?
		immediate action and was recorded as a domestic and family violence related. 2. The job was coded as a prowler disturbance and allocated to a patrol car. Due to the (assessed) non-urgent nature of the call was responded to some three hours later. 3. Upon attendance at **1.07am**, officers undertook initial checks but did not attempt to enter the premises or call Doreen because of the possibility that she was asleep. 4. At 3.55am on 22 February 2021 a Triple Zero call was logged claiming a fire at the Unit occupied by Doreen Langham. At this stage it was unknown that the body of Gary Mr Hely was also in the unit.	discloses having sighted him earlier in the day. 6. Clear breaches of the TPO were reported and should have instigated an immediate response and attendance. 7. No checks appear to have been undertaken of Gary's previous interstate history and the protection order in place at the time does not appear to have been identified by the call taker. 8. Doreen was still alive when officers attended at 1.07am, given the autopsy report notes that damage to her lungs and that she inhaled soot. 9. The inadequacies of the police response on this occasion was discussed at length in the QPS Ethical Standards report so will not be explored here.