INDEPENDENT COMMISSION OF INQUIRY INTO QUEENSLAND POLICE SERVICE RESPONSES TO DOMESTIC AND FAMILY VIOLENCE

SUBMISSION BY TOWNSVILLE COMMUNITY LAW

INTRODUCTION & BACKGROUND

1. Townsville Community Law is a non-profit, community based legal centre providing services to an area including North Queensland.

2. The contact for this submission is:

Bill Mitchell OAM HonLLD
Principal Solicitor
Townsville Community Law
[redacted]

3. We consent to publication of this submission in its entirety.

4. We note the terms of reference as follows:

> *a) whether there is, and if so, the extent and nature of, any cultural issues within the Queensland Police Service (QPS) relating to the investigation of domestic and family violence identified in the Report;*
>
> *b) how any cultural issues identified within the QPS relating to the investigation of domestic and family violence have contributed to the overrepresentation of First Nations people in the criminal justice system;*
>
> *c) the capability, capacity and structure of the QPS to respond to domestic and family violence, having regard to initiatives undertaken by the QPS in responses to previous reports and events;*
>
> *d) the adequacy of the current conduct and complaints handling processes against officers to ensure community confidence in the QPS;*
>
> *e) AND any other matter the Commission considers relevant for consideration to deliver its Report.*

5. Our submission is broadly based on our clients' experience of their interactions with the Queensland Police Service (QPS). We have chosen to focus our submission on the understanding gained from our representation of the family of Doreen Langham in ***An Inquest into the House Fire at Browns Plains and the Death of Gary Matthew Hely and Doreen Langham***.[1]

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[1] Doreen Langham's family have consented to this submission being made.

6. The Findings in the Langham Inquest are due to be delivered on Monday 27 June 2022.

7. The Inquest into Doreen's death provides an exceptional lens through which to reflect on QPS culture and the deficiencies and failings that lead to her death.

8. It is our view that the circumstances of Doreen's death will be determined with clarity because her interactions with police, the court, with other agencies and Gary Hely are well-documented and reported within Queensland's media.

DOREEN'S DEATH WAS PREDICTABLE AND PREVENTABLE

9. From the outset, it is critical to note that Doreen's death was both **predictable** and **preventable**.

10. It was **predictable** on any proper risk assessment brought to the unfolding circumstances, given Mr Hely's prior violent history towards former spouses, his past psychologically controlling, abusive and on at least one occasion, his violent behaviour towards Doreen, his stalking behaviour involving continual breaches of the temporary protection order (**TPO**) by attending at and around her house without her consent, and his 'pure venom' death threat made directly to her.

11. It was **preventable** in that QPS could, and should, have taken steps to apprehend Mr Hely and intervene as the breaches mounted; QPS could, and should, have responded to Doreen's 000 call on 21 February more quickly; and QPS could, and should, have taken steps to ensure Doreen's safety when they did finally attend in the early hours of 22 February 2021.

12. The QPS response to Doreen's complaints about the threat Mr Hely posed was woefully inadequate. Doreen's complaints were generally dismissed by attending officers, her allegations were not taken seriously nor investigated thoroughly. She took several steps for her own protection; and she contacted QPS where she thought it appropriate; but through a series of oversights, omissions, and errors, QPS did not adequately respond to protect her.

13. The failures and inadequacy of the QPS can be summarised as including:

- A failure to take Doreen's complaints seriously;
- A failure to engage in a trauma-informed, victim centric protective response;
- An assumption about how domestic violence victim/survivors should present;
- A failure to make routine inquiries of Doreen herself and/or others;
- A failure to access easily accessible interstate records of Mr Hely;
- A failure to properly identify patterns of domestic violence and assess Doreen's safety risk in the requisite contextual, fully informed way;
- Inadequacies and inaccuracies in the Occurrence sheets;

- A failure to charge; Mr Hely was not charged with offences in relation to his escalating behaviour, including his threat and stalking conduct;

- A failure to attempt to locate, monitor or engage with/intervene with Mr Hely; and

- A failure to properly review the escalating nature of the breaches and invoke further managerial action.

14. Further, the failure of attending QPS officers included:

- They made no attempt to raise Doreen, apart from a single knock on the door;

- They did not utilise basic policing skills to further investigate the property, including entering the property or backyard pursuant to powers afforded to officers under the *PPRA*;

- They did not attempt to contact Doreen or Mr Hely by phone;

- They did not conduct appropriate patrols to search for Mr Hely; and

- They did not appreciate the seriousness of Doreen's call for assistance from QPS, which is particularly concerning given the previous complaints, DVOs or criminal history was readily available to officers via their QLITE devices.

15. This is despite the plethora of prior recommendations, particularly those from the *Not Now, Not Ever* Report[2] and initiatives of the QPS in response to that report. The fact that such initiatives, whilst commendable, did not have their desired effect suggests that further steps are required.

THE OBLIGATION TO INVESTIGATE

16. The obligation to 'investigate' credible domestic violence is enshrined in s 100 of the *Domestic and Family Violence Protection Act 2012* (**the DFVP Act**), which requires an officer who 'reasonably suspects' that domestic violence has been committed, to investigate it or cause it to be investigated.

17. The OPM also has clear directives to properly listen and investigate complaints of domestic violence. At 9.2, the OPM states that officers *"should actively enforce legislation and make use of investigative skills and evidence gathering procedures to identify and support the person most in need of protection."* The OPM at 9.3.3 states that for domestic violence complaints, *"the incident is to be fully investigated."* And at 9.4: the officer *"should, where necessary, make use of investigative powers provided by the PPRA".*

18. In Doren's case, the QPS had everything they needed to make an appropriate risk assessment, issue a PPN, and take steps to protect her. They minimised Doreen's experience and gave the appearance of rejecting it as true. Such conduct could well have deterred a victim-survivor of

[2] *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland,* Special Taskforce on Domestic and Family Violence in Queensland, 28 February 2015, Brisbane, at: https://www.publications.qld.gov.au/dataset/not-now-not-ever/resource/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7.

domestic violence (albeit that it did not do so here) and meant that the QPS missed a critical opportunity to fulfil its function as a protector of the most vulnerable in our community. QPS determined, based on Doreen's demeanor and the nature of the complaint (without corroborating evidence), that there was insufficient evidence to do anything, and nothing diverted them from that course. QPS took a 'tick-the-box' approach, or compliance approach, rather than actively listening and investigating the matter.

19. The fact that Doreen was required to obtain a private TPO rather than be issued a PPN or a police application for a DVO meant that the High-Risk Team from the District Domestic and Family Violence and Vulnerable Persons Unit did not review the application or the making of the order itself in fulfilling its important check for potentially high-risk scenarios.

THESE ISSUES ARE NOT NEW OR NOVEL

20. Many of the law and policy issues raised from the events surrounding Doreen's death are not new. In November 2014, Coroner Hutton, in the *Inquest into the death of Noelene Marie Buetel*[3] made several recommendations to the QPS and to the State Government which were then endorsed and enlarged upon by the Special Taskforce on Domestic and Family Violence in Queensland in its *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* Report[4] produced in February 2015.

21. QPS has noted the scale of their response to that report, including wholescale review of police training around domestic violence, the establishment of specialised units at the State and district levels, as well as the specific changes to procedure. While commendable, the failings seen in the police interaction with Doreen in the lead up to her death show structural and cultural change is clearly needed.

22. It is accepted that there is a significant degree of good intentions and commitment at the highest levels of the QPS hierarchy to bettering the service around domestic and family violence. The more recent recommendations of the Women's Safety and Justice Taskforce in its first report, *Hear Her Voice,* in November 2021 and the annual reports of the *Domestic and Family Violence Death Review and Advisory Board* have been considered and incorporated. QPS has noted that the process of examination and improvement on such issues under his command is continuous.

23. Only 12 months ago and long into the period of response to the *Not Now, Not Ever* Report, significant gaps in the QPS service delivery were still apparent. Some gaps e.g., in the extent of materials accessed by, and the regularity of review by, the DFVVPU, has been improved. But there is a level of intransigence that has not yet been disturbed. Without a greater investment in the recruitment, training, quality assurance, disciplinary attention and general cultural and operational realities attending the role of general duties officers – who are primarily responsible for the first response to critical domestic violence incidence – and to the command structures applicable to them, such measures will fall flat.

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[3] *Findings of Inquest into the death of Noelene Marie Beutel,* Coroner John Hutton, 17 November 2014.

[4] *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland,* Special Taskforce on Domestic and Family Violence in Queensland, 28 February 2015, Brisbane, at:
https://www.publications.qld.gov.au/dataset/not-now-not-ever/resource/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7

24. Several operational psychological pressures and trends have been identified as causative of an inadequate response:

- A compliance or process driven approach rather than professionally assessing risk / real or potential harm – a 'check the box' approach rather than individualised care and attention;
- The downward pressure of bureaucratic or administrative responsibilities required in relation to issuing PPNs, applying for domestic orders etc;
- De-sensitisation to domestic violence, given the extent to which it features in policing;
- A failure to recognise non-physical violence aspects of domestic violence;
- An acceptance of the respondent's version or at least an equal acceptance of that; and
- A stereotype view of what a domestic violence victim/survivor looks and acts like.

25. It is of course the case that 'cultural change' forms part of QPS training initiatives. However, when looked at in detail, the 'cultural change' program (which is yet to be delivered, due to COVID-19 related limitations), it is intended to be a once-off one-day program (albeit that its content would, inform annual training), the intended delivery is via 'domestic violence champions' (QPS) who will attend in stations after having obtained the training themselves. The content of that training (and indeed the other aspects of the DV training) is yet to be determined.

KEY POINT 1: THE NEED FOR QPS REFRESHER TRAINING

26. Training of frontline officers is wholly insufficient, either due to the lack of scenario-based training, or in its recency and frequency. Expert commentary has underscored the importance of in-person, reflective, peer located training modules.

27. Annual refresher training in domestic violence for all police officers should to be a compulsory measure. Annual 1-day in-person refresher training in DV, with a significant component comprising scenario-based training, and peer review and discussion is sought. Such training should cover the less obvious and more complex components of domestic violence policing, to develop a protective, respectful, and informed response to survivor-victims.

KEY POINT 2: THE NEED FOR EXTERNAL INPUT IN TRAINING

28. External input into training must occur, through experts and even, to a lesser degree, to exposing police officers to the stories of domestic violence victim-survivors. Clearly such input in the content and delivery of training is extremely beneficial. It is critical to ensure the quality of its delivery, that service-wide training models incorporate a component of DV experts both internal and external to the QPS, as well as community sector and lived experience of domestic violence victim-survivors.

29. It is also noted that at this stage, tertiary qualifications (Certificate level) exist and have been attained on a voluntary basis to date. It is submitted that greater incorporation by way of

requirements for positions within specialised units, by officers who take special responsibility for domestic violence in the stations, and, by way of incentives to general duties officers more generally, should be better incorporated in the police service.

KEY POINT 3: THE EFFECTIVENESS OF THE DISTRICT DFVVPU

30. Quality assurance and or external review is necessary to ensure the effectiveness of District Unit functions with respect to checking the domestic violence response of the stations in the district and ensuring that high risk cases were properly identified and managed. It is critical that the State DFVVPU command ensure that District units are regularly reviewed in a qualitative, evidence-based sense.

KEY POINT 4: NECESSARY STATION LEVEL CHANGES

31. Whilst the development of specialist units was necessary, there is the risk that general duties police do not attain a greater level of proficiency in their responses to domestic violence.

32. The role of the Domestic and Family Violence Liaison Officer is at times split between non-DV duties and DV duties and which can lead to significant lag time in the follow up by liaison officers in respect of the repeat calls for service. Arrangements and resources must ensure that suitably timely interventions are taken. Even at a large police stations arrangements do not ensure 24/7 coverage of DV matters. The effectiveness of this position – in terms of protection of domestic violence victim/survivors and in terms of informing policing approaches within the police stations in which they are based, are extremely limited.

33. Officers-in-Charge of the stations themselves have significant responsibilities for cultural change. OICs now have responsibilities to review, or delegate the review, of all BWC footage of first response officers to DV callouts. The BWC review initiative must be put in place in all districts. This is important, and time-consuming, but it must be backed up with the capacity for reflection and redirection where systemic issues are identified through this process.

34. Arrangements include where detectives from a DFVVPU circulate through police stations within a district monthly to review breach files and give insight, going out on jobs and providing education. Again, this is a commendable initiative, but it does not leave the stations with personnel who are trained, and sufficiently senior, to maintain that focus on quality and appropriate domestic violence policing.

35. All OICs, or a suitably senior delegate of an OIC, should take on full-time responsibility for domestic violence matters, reviews, education, and cultural issues at the station level throughout the State and be appropriately trained to do so.

KEY POINT 5: REVIEW OF STATION-BASED DOMESTIC VIOLENCE RESPONSES

36. It is imperative that sufficient data is generated to ensure that the QPS can regularly and systematically qualitatively assess its responses to domestic violence outside of the crisis-driven responses.

37. The role suggested in KP4 could be relied upon to compile and provide data to the State DFVVP Units for such assessment to occur which would provide meaningful feedback on the success of the state-wide initiatives that are being rolled out.

KEY POINT 6: NECESSARY SYSTEMS CHANGES

38. The Inquest into Doreen's revealed that:

- Despite OPMs recommending reference to interstate histories, and this being available to all officers, this critical information source was not accessed by anyone;

- Despite the OPMs intending that the DV-PAF be used by first response officers to inform their responses at incidents, it appears to be seen by them (and their supervisors) as a compliance measure to be completed afterwards. It was almost invariably not well understood and not adequately or accurately completed;

- The information recorded by first response officers in their occurrences were often not adequate to permit any real risk assessment nor was it always accurate (this may be contrasted with the records made by communications staff); and

- The paperwork associated with PPNs is an unduly heavy administrative burden on police officers which has the real capacity to deter resort to such actions.

39. As to interstate histories, the OPM at 9.3.1 makes clear that where the identity or location is known, checks *"should"* be made on QPRIME, QCAD and CRIMTRAC/NPRS. This is a standard response, and this direction should be strengthened and incorporated in further police training.

40. As to the DV-PAF, the OPM at 9.2.4 states that it *"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."*

41. Whilst the QPS is trialling alternative methods of risk assessment and the result of those efforts are yet to hand, it is unclear when that will be the case. It is submitted that the that this direction is strengthened so that it is to be used as an operational tool at the scene.

42. As to what should be recorded in occurrences, we recommend that further training, and processes for streamlining and assessing the quality of the reporting/record of domestic occurrences be implemented to ensure that these vital records are adequately and accurately kept.

43. Finally, as to the administrative burdens regarding PPNs, and seeking TPOs, we note that several initiatives have been presented to government for legislative change in that regard although there is no detail on what those changes might be.

KEY POINT 7: CO-RESPONDER/CO-LOCATION/GENDERED SERVICE-DELIVERY MODELS

44. We support approaches that engage a multi-disciplinary response to domestic violence. Each of the currently trialled models has different components that will be reviewed and should be considered together to inform permanent strategies.

45. We note the importance of flexibility in terms of the availability of DV workers/social workers for domestic violence victims/survivors alongside police, and the connection of vulnerable individuals to the broad range of practical and psychological support services they may require.

46. We support a well-resourced co-responder model, that embeds a social worker within police stations to attend scenes after safety concerns are met, to take evidence and to inform police officer responses to domestic violence incidents. The model in the Logan District should be further funded and extended. Akin to PLOs, domestic violence workers could be employed by an external agency, or the QPS, and enlisted to work in stations state-wide.

47. Further, the ability for women to attend a specialist DV police unit (knowing their location, having a centralised point of contact, where police work alongside other specialist social workers (at least), and preferably with access to other agency and professional supports able to be accessed) is also a valuable consideration.

48. This is more in line with the Argentinian model espoused by Professor Carrington than that which is currently proposed by the mobile gendered service delivery model. It is unclear whether a temporary, mobile model containing only police officers (albeit female police officers) will be accessed by victim/survivors. The trial should also incorporate and investigate measures to adapt these models in a culturally appropriate way for communities (e.g., remote Indigenous communities, or cultural groups or regional locations). Further, it is noted, that sufficient senior responsibility (Assist. Cmr level) for specialised units is best practice.

49. It is submitted that the QPS could well benefit from continued funding for, and greater incorporation of both:

- Domestic violence/social workers embedded in police stations; and

- Specialist domestic violence police units available to domestic violence victims/survivors which proactively employ women (but not exclusively) where those officers are well trained in appropriate domestic violence responses, where there is infrastructure and furnishings that are welcoming and facilitate the attendance of women and children, and which are co-located with at least domestic violence/social workers if not easy access to other professional and practical support agencies where necessary.

KEY POINT 8: COURT REFERRALS

50. It is noted that private applications are not necessarily going to come to the attention of the QPS with any urgency. There is limited consideration about the processes of referral between courts and the QPS High risk team.

51. It is submitted that this referral process should be reviewed and formalised to ensure that cases do not get missed.

KEY POINT 9: FUNDING FOR DOMESTIC VIOLENCE SERVICES

52. The limits of the services that can be provided by domestic violence services depend on funding arrangements for the co-respondent model. The funding of such agencies was the subject of recommendation in the *Not Now, Not Ever* Report and to enable a trauma-informed, more appropriate, multi-disciplinary response to domestic violence, such agencies are key.

53. In those circumstances, funding for domestic violence agencies should be a priority response by the State Government, to ensure that the QPS responses to domestic violence are supported more broadly.

KEY POINT 10: STANDALONE OFFENCE FOR THREATS TO KILL IN A DOMESTIC SETTING

54. No officer saw fit to consider criminal charges against Mr Hely. Whilst the offence of 'threats' (s 359 of the *Code*) exists, it is rarely prosecuted.

55. It is submitted that a recommendation ought to be made to assist in putting the issue of threats of death in a domestic setting before the State Government to consider criminalising that act as a standalone offence, to strengthen policing response much in the way that non-fatal strangulation and the new offence of coercive control might be seen to assist in policing responses to domestic violence.

KEY POINT 11: INCREASED FUNDING FOR QLD CORONIAL LEGAL SERVICE

56. The Queensland Coronial Legal Service is funded by a modest grant[5] from the State Government to Caxton Legal Centre and Townsville Community Law. It has represented family members in many DFV related investigations and inquests conducted in Queensland in the last 7 years.

57. This state-wide service provides legal advice about any aspect of the coronial process and associated issues can provide representation for bereaved family members appearing in some inquests. It also helps families connect with social work, counselling, and other support services.

58. Representation of family members in inquests such as Doreen Langham's are complex, resource intensive endeavours, but are a critical part of our systems review and are fundamental to access to justice and ultimately the proper rule of law.

59. Increased funding is needed to ensure proper capacity to represent the interests of families in coronial and death review processes.

*** END ***

[5] Caxton Legal Centre and Townsville Community Law each receive approximately $150,000 per annum to provide a state-wide service.