INQUIRY INTO SUPPORT PROVIDED TO VICTIMS OF CRIME

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Lili Greer
[redacted]

SUBMISSION: SUPPORT FOR VICTIMS OF CRIME

I lost my mum Tina Louise Greer to domestic violence at age thirteen. My mum was classified as a missing person for ten years, as her body has never been found. The main suspect Les Sharman was never formally interviewed by Queensland police. In 2022 the Coroner's Court accepted that Les Sharman (now deceased) murdered my mum in 2012 and deemed that an inquest would not be necessary, as it was not in the public interest.

Below is a summary of my experience as a related victim of crime over the past eleven years. My experience highlights the improvements that need to be made to how victims and related victims of crime are treated. Firstly, I will briefly outline my experiences with the Queensland Police, Coroners Court and Victims' Services, followed by recommendations that will help improve the services for future victims.

Queensland Police Service

Support

In the initial years following my mum's disappearance, I was updated on the case via the news and radio. I was not made aware of the support services available as a 13-year-old, which was critical as I had no coping skills to deal with the unfolding events. My mother's [redacted] Les Sharman, also visited where I was staying on several occasions. I felt unsafe, experienced nightmares, and engaged in risk-taking behaviours during this time. The lack of aftercare and support from QPS had a significantly detrimental impact on my mental health to the point where I contemplated suicide often.

I was unaware of any support services until 2020, eight years after my mum's disappearance and murder. Until the support of Queensland Victims' Homicide Support, the entire process was painstakingly isolating and traumatic to deal with alone.

Recommendation 1

To prevent further traumatization, services for children must be made available such as a child support officer. This is critical as "youth who have experienced trauma are even more acutely affected" than adults (Adams 2010). A child support officer will be able to talk through the case appropriately and delicately, answer any questions they may have and provide necessary counselling and updates.

Advice from Victims of Crime South Australia's states that children at eleven years of age understand death similarly to adults (VOCSA 2023). Thus, it is paramount that their questions are answered honestly, and their feelings acknowledged. By explaining the situation at a level, they can understand, children can appropriately cope with the situation. Rather than finding out later in life, which can cause further emotional disruption and hurt

(VOCSA 2023).

Investigation

Les Sharman was a known criminal to the police and a Finks motorcycle gang member with violent tendencies. Although QPS had six years to interview the main suspect, this did not occur. I was only interviewed once in 2012, despite having the most contact with Sharman and mum. No further interviews took place until after Sharman died in 2018. Moreover, I was not notified that the main suspect never gave a formal interview until after his death, nor was I provided with an explanation as to why he was never interviewed.

It has since been revealed by the DFVDRU Review of my mum's case that:

- The police contact in this matter represents a significant missed opportunity for intervention.
- Failure to thoroughly investigate matters and pursue criminal charges where appropriate. No evidence of any additional steps being taken to protect Tina from further harm despite the officer's assessment that it was likely she had and would experience violence in the relationship.
- Evidence of poor policing attitudes towards victims of domestic and family violence which may have influenced their response.

Recommendation 2

QPS is to adopt a person-centred approach towards victims and related victims. In cases where a full investigation could not be conducted, a person-centred approach would see QPS provide an explanation with legal backing (if requested) as to why the investigation has been unsuccessful (NDP 2016). Adopting a person-centred approach will decrease victims' risk of retraumatization and help them move forward (NSW Health 2022). As opposed to simply saying "nothing can be done".

Recommendation 3

To prevent significant missed opportunities and failures to pursue criminal charges, QPS and victims would benefit from an external body to review homicide & missing persons-related cases. I recommend that review's take place every twelve to twenty-four months until the investigation is closed. This is because "there are many historical examples in Australia where significant elements of various police forces have been found to be demonstrably corrupt and where widespread misconduct was a day-to-day reality" (IBAC 2023). Moreover, review from an independent body will prevent missed opportunities and maintain police accountability instead of relying on the potential of an inquest years after the crime.

The Queensland Coroners Court

Despite the concerns mentioned above and missed opportunities, in 2022 the Coroner's

Court ruled that it was not in the public interest to hold an inquest into my mum's murder. I received this news via email without warning or support to go through the document.

During the appeal process, a number of coronial employees demonstrated little to no understanding of the nature and dynamics of domestic and family violence. Furthermore, in a subsequent letter from the coroner denying an inquest, the coroner stated that my mum's death was not preventable. However, numerous studies have affirmed that women who have separated from their partners are at higher risk of homicide victimisation by intimate partners than women in current relationships (Hotton 2001; Wilson & Daly 1993; Johnson & Hotton 2003; Wallace 1986; Barnard et al. 1982).

I took advocating for seven months, attaining 22,789 petition signatures (Change.Org 2022) and personally meeting with the Attorney General to prove that my mum's case was in the public interest. My experiences with the Coroners' Court are best summarised by the words of Freckelton, "coronial matters if managed poorly, not only can generate secondary trauma but can be pathogenic" (2016, p.6).

I have attached the letter from the coroner, which demonstrates a lack of trauma-informed care and understanding of domestic and family violence.

Recommendation 4

Mandatory training and education of all Coroner's Court employees in areas of domestic and family violence. Education and training will improve the services ability to make educated coronial decisions and provide trauma informed approach to dealing with victims (ANROWS 2022). Without coronial support, the State sets a poor precedent for past, present, and future victims of domestic violence.

Recommendation 5

To ensure the Coroners Court aligns with trauma-informed practices before releasing sensitive information such as coronial reports, victims are to be contacted. During this call, victims/ related victims will be briefed about the nature of the information they will receive, their rights moving forward, supports available like counselling and be given the opportunity to ask any questions they may have (Freckelton 2016). Through this process the Coroners Court will demonstrate its ability to "adhere to sensitive communications" which is necessary when dealing with families (Johnstone 2007).

Victims of Crime Assistance

Although the Coroner confirmed that my mum was murdered in 2012, this ruling did not happen until 2022. As my mum's body has never been found, she was technically a missing person for ten years. Due to this, I was ruled out of any victims of crime assistance on a technical basis. It is worth mentioning that during this time, she was a suspected victim of

homicide, and had it not been for the significant missed opportunities in the investigation, it is likely this case would have been solved.

Recommendation 6

To prevent eligible victims from being technically ruled out of financial assistance, Victim Services is to create a special consideration category for victims and related victims who may be eligible under exceptional circumstances.

Summary

The current process and services set up to support victims is designed for individuals to fail. Throughout my mum's homicide investigation, it has been a continuous battle between traumatization and fighting for justice, where I have been met with little to no empathy. It has been my responsibility to highlight the many injustices in my mum's case and advocate for its reopening rather than the QPS or the Corners Court.

In conclusion, to prevent further trauma and adverse impacts to victims and related victims of crime, I put forward the following recommendations to be considered.

1. Speciality services for children to discuss the case, answer any questions they may have, provide updates and counselling.
2. In circumstances where an investigation or prosecution cannot be carried out by police victims are to be given a explanation with legal backing as to why an investigation or prosecution was not possible.
3. External board to review homicide & missing persons related cases every between twelve to twenty-four months until the investigation is closed to prevent missed opportunities and maintain accountability.
4. Mandatory training and education of all Coroner's Court employees in areas of domestic and family violence.
5. Prior to the release of sensitive information such as coronial reports victims are to be contacted. During this call, victims will be briefed about the nature of the information they will receive, their rights moving forward, supports available, and be given the opportunity to ask any questions they may have.
6. Victim services to create a special consideration category for victims and related victims who may be eligible under special circumstances.

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QUEENSLAND COURTS

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26/05/2022

Ms Lili Greer
[redacted]

By email: [redacted]

Dear Ms Greer,

Thank you for talking to me on the phone last week about your concerns about Coroner Roney's findings into the circumstances of your mother's disappearance.

I have discussed your concerns with the Coroner, and she agreed to amend the findings at paragraphs 10, 20, 21 and 41, as per our discussion. I **attach** a copy of those amended findings for you.

In respect of your concerns about the conclusions reached by the Coroner in paragraphs 53 (no public interest in proceeding to inquest) and 56 (insufficient evidence that Tina's death could not have been prevented), the Coroner will write to you separately about your concerns.

I also discussed your request for investigation material with Coroner Roney. Coroner Roney has advised that, although it is not usual for the court to release investigation material, she has authorised release of some material to you. Accordingly, I attach copies of the following material:

1. Queensland Police Service (QPS) Missing Person (MP) Report;
2. QPS Addendum MP Report;
3. QPS Supplementary Form 1 (Report to Coroner); and
4. QPS email giving investigation update.

Release of material to family members is at the absolute discretion of the Coroner, and any material released must not be used for any purpose other than that for which is was released. The material is released for your information, and must not be circulated or shared further. The material has also been redacted to protect the privacy of witnesses referred to in the reports.

You will hear from Coroner Roney shortly, but if you have any questions about this letter or the attach material please contact me on [redacted].

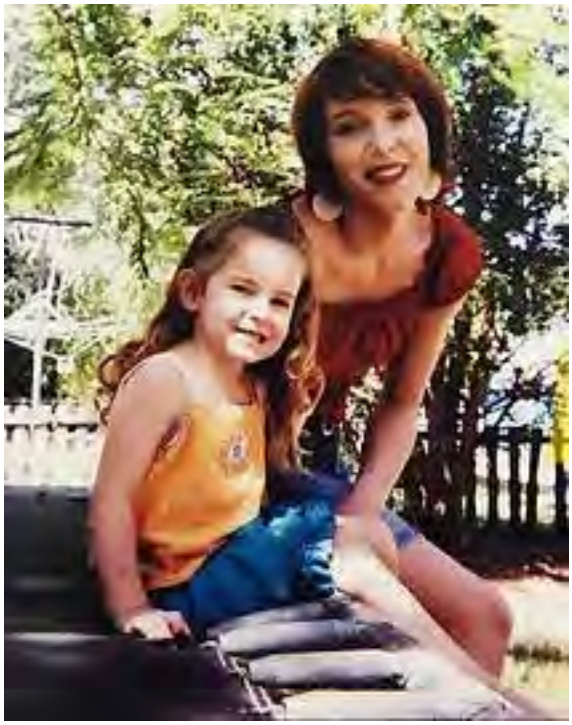
Yours sincerely

[redacted]

Sarah Lane
Counsel Assisting

A Reply to the Coroner - Part 1

For a state to be so out of touch with the realities of domestic violence is beyond concerning. The case of Tina Greer's death is just one example of how the state of Queensland refuses to take accountability or interest in protecting victims of intimate partner violence. Tina Greer, 32, went missing in 2012. In May 2022, the coroner accepted the police theory that Tina was, in fact, a victim of domestic violence and consequently, murdered by her partner.



Even though her body is missing, no one has been convicted, and the main suspect was never interviewed, the Coroner has denied my request for an inquest. Perhaps I wouldn't be writing this if the Corner's Court of Queensland understood and acknowledged the nature of domestic violence. However, as I will reveal, the sheer level of ignorance displayed is truly shocking. Below are my arguments as to why Tina Greer deserves an inquest and to draw attention to the inadequacy and oversight of the Corner's Court of Queensland.

Domestic Violence & Public Interest

Reasons for a coroner to hold an inquest in the public interest.
1. An inquest is likely to help explain the cause of death.
2. There are unresolved suspicious circumstances.
3. Publicity through inquest may help to prevent future deaths in similar circumstances.

I am obliged to consider the public benefit of an inquest proceeding. I am unable to see one [public benefit] here based upon the current state of the evidence. - *QlD Coroner*

Statistically and academically, there is no doubt that domestic violence, specifically intimate partner homicide, is cause for public interest. In Australia, intimate partner homicide is the most common form of homicide. In 2018-19 these offences accounted for **21 per cent of all homicides and 62 per cent of all domestic homicides** (ANROWS 2022). Notably, in Queensland, from 2006-2018, **265** women, men and children were killed by a family member or as a result of an intimate partner relationship (DFVDRU 2018).

Domestic violence has affected over **5.8 Million** Australians, with 2.2 million having experienced physical and/or sexual violence from a partner and 3.6 million have experienced emotional abuse from a partner (ABS 2020). In December 2021 alone, 1800RESPECT (domestic support line) received over 27,200 calls (SBS 2021).

Despite all of the evidence, the coroner refuses to see how publicity through an inquest would generate awareness and help prevent future deaths in similar circumstances. Tina's case is a play-for-play example of how physical, emotional and financial abusive play out.

Victim blaming

Overwhelming, the tone of the refusal for an inquest letter I received was unsympathetic and blamed Tina for her circumstances. In light of receiving such a response lacking in awareness, the concept of victim blaming seems fitting.

Victim blaming is a degrading act that occurs when the victim(s) of a crime is held responsible (partially or fully) for the crimes that have been committed against them (Andrew et al. 2003). Victim blaming emerges as a negative social response in legal, medical, health and social settings (CRCVC 2009).

Despite the DFVDRU Review of Tina's case, which highlights that the police contact in this matter represents a significant missed opportunity for intervention.

1. **Failure to thoroughly investigate matters and pursue criminal charges where appropriate.**
2. **No evidence of any additional steps being taken to protect Tina from further harm despite the officer's assessment that it was likely she had and would experience violence in the relationship.**
3. **Evidence of poor policing attitudes towards victims of domestic and family violence which may have influenced their response.**

The Coroner refuses to consider a that Tina's death could have been prevented.

A different outcome for your mother would not have been achieved if she had had more information or support about Domestic and Family Violence. - *QlD Coroner*
Although she had left Mr Sharman, Tina continued to feel the need to associate or have contact with Mr Sharman. Whatever the reason her continued contact put her at risk, even when she had managed to move away from him. -*QlD Coroner*

As seen above, the coroner not only refuses to acknowledge the importance of intimate partner violence prevention but also proceeds to blame Tina for her death. Attitudes towards domestic violence are important to understand how people react or behave towards victims and perpetrators of these aggressions (Graciá et al. 2009). As Dr Boxall states, although the "pathways leading to homicide are complex and vary, there were several points at which it is possible to intervene and stop these trajectories" (2022). Alarmingly, you would think awareness and reflection would be a priority in a state with one of the highest prevalence's of IPV and homicide (ABS 2020). BUT no, let's continue to shift blame and perpetuate toxic views from one of the most influential positions in the state. We wonder why 60-70% per cent of domestic and family violence is never reported to police (Scott 2021; Bgurm & Barchbank 2021).

The reality

In actuality the reasons Tina and many others continue to have contact with their abusers is complex and deserves attention, rather than blame.

Why people don't leave

1. Fear of repercussions; stalking,
increased physical violence, and homicide
2. Homeless
3. Financial insecurity
4. Social and cultural expectations
5. Believing that the abuse is their fault
6. Lack of emotional support
7. Embarrassment
8. Denial

(Eckstein 2011)

A week after she and I moved into separate accommodation, our house was stalked. Pot plants smashed on the veranda, doors and windows shaken. I vividly remember crawling down the halfway about to wet myself because I could hear someone outside the bathroom. He damaged our front door because we didn't hear him knocking. When he came next, he tried dragging her down the hallway, yelling, "get in the room, Tina". I held her free hand and didn't let go, "get the [redacted] off her", he said bluntly, grabbing me by the arm. A couple of weeks later, her car was vandalised during the night. He would call continuously, threatening to kill her if she didn't answer him, and the list goes on. So why did Tina maintain contact with him? To put it simply, out of protection for herself and her family. To argue otherwise is simply incorrect.

Furthermore, numerous studies have affirmed that **women who have separated** from their partners **are at higher risk of homicide** victimisation by intimate partners than women in current relationships (Hotton 2001; Wilson & Daly 1993; Johnson & Hotton 2003; Wallace 1986; Barnard et al. 1982).

Moving Forward

As a nation, Australia is currently drafting the National Plan to End Violence against Women and Children 2022-2032.
Some key points include;

- Long-term bipartisan investment by all governments across prevention, intervention, response and recovery.
- Listening, engaging and being informed by diverse lived experiences, particularly those of victim-survivors.
- Training and workforce development across support across sectors such as the police, justice systems and frontline services.
- Improving the justice system to ensure people impacted by family, domestic and sexual violence can achieve justice, and people using violence and abuse are held to account.

With these points in mind, it is clear that Tina's case is in the public interest as well as in the best interest of the Coroners Court. Not only would holding an inquest for Tina help prevent future deaths from occurring, but it would also raise awareness and educate the public and the coroner's Court about the complexities of Domestic Violence. Without Coronial support, the State sets a poor precedent for past, present and future victims of domestic violence.
It's time to stop promoting a culture of ignorance, gaslighting and victim-blaming. It is time to listen to the experts and accept the realities of domestic violence.

SIGN PETITION - Inquest for Tina

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