IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 003468

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Ozlem Karakoc
Date of birth:	06 October 1982
Date of death:	14 July 2017
Cause of death:	1(a) UNDETERMINED
Place of death:	362 Edgars Road, Lalor, Victoria, 3075
Keywords:	Family violence; intimate partner homicide

INTRODUCTION

1. On 14 July 2017, Ozlem Karakoc was murdered by her former intimate partner, Murat Davsanoglou. At the time of her death, Ms Karakoc lived at a public housing residence in Lalor with her eight-year-old child. Ms Karakoc was 34 years old at the time of her death.

2. Ms Karakoc was born in Australia on 6 October 1982 and was of Turkish descent. She had one brother.

3. Ms Karakoc had a mild intellectual disability. During her primary school education, it was identified that she had learning difficulties. In year nine she transferred to Berendale Secondary Special School where she completed her high school education.

4. Ms Karakoc's mother suffered from mental illness, and it was alleged that Ms Karakoc's father perpetrated family violence against both Ms Karakoc and her mother. As a result of this, Ms Karakoc and her family had engagement with Child Protection during her childhood.

5. Ms Karakoc also suffered from mental ill health, and across the course of her life was diagnosed with major depressive disorder with associated psychotic episodes, bi-polar disorder, schizoaffective disorder and Post Traumatic Stress Disorder (PTSD).

6. Ms Karakoc commenced a relationship with Mr Davsanoglu in approximately 1999 when she was in her late teens. Mr Davsanoglu was seven years older than Ms Karakoc. This relationship continued on and off for the following 18 years.

7. In approximately 2002 Ms Karakoc married Mr Mehmet Pekel. Mrs Karakoc fell pregnant during this relationship and gave birth to a daughter on 15 April 2009. Ms Karakoc and Mr Pekel separated whilst Ms Karakoc was pregnant.

8. Ms Karakoc was uncertain whether Mr Pekel or Mr Davsanoglu was the biological father of her daughter and referred to them both as her father at various times over the following years.

9. Ms Karakoc commenced a relationship with Ozden Gonullu in February 2017. In approximately late May 2017 Ms Karakoc and Mr Gonullu separated for a brief period, before resuming their relationship in June.

10. In June 2017 Ms Karakoc advised Mr Davsanoglu that she was resuming her relationship with Mr Gonullu. Around this time, Ms Karakoc and Mr Gonullu became engaged. Mr Davsanoglu was unhappy with this decision and continued to contact Ms Karakoc and visit Ms Karakoc from this time until the fatal incident.

THE CORONIAL INVESTIGATION

11. Ms Karakoc's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

12. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

13. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Karakoc's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into the death of Ms Karakoc including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. On 13 July 2017 Mr Davsanoglu attended Ms Karakoc's residence, where both Ms Karakoc and her daughter were present. At approximately midnight, Ms Karakoc's daughter fell asleep in Ms Karakoc's bedroom.

17. In the early hours of the morning on 14 July 2017, Mr Davsanoglu and Ms Karakoc reportedly engaged in a sexual encounter before entering the bathroom at the residence and filling the bathtub. Both Ms Karakoc and Mr Davsanoglu entered the bath and Mr Davsanoglu used force to hold Ms Karakoc underwater until he was satisfied that she had died by drowning.

18. Mr Davsanoglu then removed Ms Karakoc's body from the bathtub and partially dressed her before placing her in the boot of his Ford Falcon sedan. Mr Davsanoglu then drove to South Australia in his vehicle, with the intent of going to the Nullarbor Plain, before he changed his mind and retuned to Melbourne on 17 July 2017.

19. That same day, Mr Davsanoglu placed Ms Karakoc's body in the garage of an unoccupied property before confessing to an associate, family, and friends that he had killed Ms Karakoc. He then handed himself in to police at the Fawkner Police Station.

20. On 7 December 2018, Mr Davsanoglu pleaded guilty to the murder of Ms Karakoc in the Supreme Court of Victoria. On 24 May 2019 he was sentenced to a term of imprisonment of 23 years.[2]

Identity of the deceased

21. On 21 July 2017 Ozlem Karakoc, born 06 October 1982, was visually identified by her uncle, Samim Ozerkan.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 18 July 2017 and provided a written report of his findings dated 27 November 2017.

[2] *R v Davsanoglu* [2019] VSC 332.

24. The post-mortem examination revealed:

    a) moderate post-mortem change;

    b) a number of injuries to Ms Karakoc's body comprising bruises to the right temporal and left frontal regions, the right submandibular region, scapular regions, right upper arm, and right hand;

    c) pulmonary oedema with slightly hyperexpanded lungs;

    d) red discolouration parietal pleura on right; and

    e) no natural disease.

25. Dr Lynch noted that autopsy findings in cases where a person has died as a result of suspected drowning *'are nonspecific and diagnostic signs of drowning per se do not exist. Investigation of deaths occurring in the setting of immersion requires considerable weight to be given to the circumstances surrounding the death'*.

26. Dr Lynch also noted that the findings of the autopsy were consistent with, but not specific for, death as a consequence of drowning.

27. Toxicological analysis of post-mortem samples identified the presence of gamma-hydroxybutyrate (GHB), cannabinoids, antidepressant medications venlaxafine (and its metabolite desmethylvenlafaxine) and sertraline, and antipsychotic medication aripiprazole. It was noted that given the post-mortem interval, some or all of the GHB may represent endogenous production.

28. Dr Lynch provided an opinion that the medical cause of death was 1(a) UNDETERMINED.

FURTHER INVESTIGATIONS AND CORONERS PREVENTION UNIT REVIEW

29. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in intimate relationships.

30. The relationship between Ms Karakoc and Mr Davsanoglu met the definition of *'family member'* as defined by the *Family Violence Protection Act 2008* (Vic) (FVPA).[3] Moreover,

[3] *Family Violence Protection Act 2008* (Vic), s 8.

Mr Davsanoglu's actions towards Ms Karakoc during their relationship, including his fatal assault of Ms Karakoc, constituted *'family violence'*.[4]

31. In light of Ms Karakoc's death occurring in circumstances of family violence, I requested that the Coroners Prevention Unit (CPU)[5] examine the circumstances of her death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[6]

Family violence in the relationship between Ms Karakoc and Mr Davsanoglu

32. Ms Karakoc reported that Mr Davsanoglu perpetrated family violence against her during their 18-year relationship, primarily in the form of controlling behaviour, emotional and psychological abuse, and financial abuse. She described that he was emotionally abusive and '*puts her down a lot'*.[7]

33. Ms Karakoc reported to her psychologist, friends and family that Mr Davsanoglu constantly asked her for money, and that she had leant him $7,000 which he had not repaid.

34. Ms Karakoc commenced a relationship with Mr Gonullu in February 2017. On 27 February 2017 she sent a text message to Mr Davsanoglu advising him that she wanted to end their relationship and began to distance herself from him. Despite this, Mr Davsanoglu continued to contact Ms Karakoc over the following months.

35. On 3 June 2017 Ms Karakoc told Mr Davsanoglu via text message that she had resumed her relationship with Mr Gonullu after a brief period of separation. In response, Mr Davsanoglu told her that he would only leave her alone and allow her to be with Mr Gonullu if she gave him $10,000 for his car.

36. In the following weeks Mr Davsanoglu engaged in controlling and emotionally abusive behaviour towards Ms Karakoc. He repeatedly contacted her, asking her to contact him and telling her not to ignore him when she did not respond.

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[4] *Family Violence Protection Act 2008* (Vic), s 5.

[5] The CPU is a specialist service for Coroners, established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[6] The VSRFVD provides assistance to Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

[7] Monash Health, medical records relating to Ozlem Karakoc.

COMMENTS

37. Pursuant to section 67(3) of the Act, I make the following comments connected with Ms Karakoc's death.

Reports of family violence to services

38. Ms Karakoc had contact with a range of mainstream, government and family violence specific services in the months leading up to her death. This service contact related predominantly to her mental health, the parenting of her daughter, and to family violence perpetrated against her by persons other than Mr Davsanoglu.

39. Ms Karakoc's relationship with Mr Davsanoglu and his perpetration of family violence towards her was not disclosed to, or known by, most of these services. However, during Ms Karakoc's engagement with Monash Health, the City of Greater Dandenong - Family Support Services (City of Greater Dandenong FSS) and Uniting Vic.Tas - Child First services (Child First), there were references to Ms Karakoc's relationship with Mr Davsanoglu which indicated that family violence had occurred within the relationship.

40. The Family Violence Risk Assessment and Risk Management Framework in place at this time in Victoria was the Common Risk Assessment Framework (CRAF). Under the CRAF, best practice for mainstream services who identified indicators of family violence included asking questions about family violence and taking appropriate action, for example, by making referrals to specialist family violence services for assessment.

41. Ms Karakoc was referred to Child First on 17 March 2017 for parenting support. During her intake assessment and a subsequent consultation on 22 March 2017 it was noted that Ms Karakoc had been in a relationship with Mr Davsanoglu and he had perpetrated family violence against her. However, these notes also indicated that the couple were no longer in a relationship. No other information was provided to Child First to suggest that Ms Karakoc was having contact with Mr Davsonoglu or experiencing family violence from him. At this time, Ms Karakoc was also engaged with family violence support services in relation to her experiences of family violence from other family members. As such, further risk assessment or family violence referrals in relation to Mr Davsanoglu were not required.

42. Ms Karakoc was engaged with the City of Greater Dandenong FSS from 18 May 2017 onwards. On several occasions during this engagement, Ms Karakoc indicated that her daughter's father had perpetrated family violence towards her. It is not clear whether Ms

Karakoc was referring to Mr Pekel or Mr Davsanoglu when she made these comments. However, on 12 July 2017 she referred to him as *'Mirat'*. This suggests she was referring to Mr Davsanoglu.

43. The City of Greater Dandenong FSS did not assess Ms Karakoc's family violence risk in relation to Mr Davsanoglu. However, this appears reasonable given that up until 12 July 2017 Ms Karakoc indicated that she was no longer in contact with him. Two days prior to the fatal incident Ms Karakoc stated that she was having regular contact with Mr Davsanoglu but made no disclosures of family violence or safety concerns during this conversation. As the information provided at this time was not indicative of a high-risk situation requiring an urgent response, the City of Dandenong FSS appropriately planned to discuss this with Ms Karakoc in more detail at a later date.

44. On 2 February 2017 Ms Karakoc told staff from Monash Health that her partner was emotionally abusive. No further risk assessment or referrals were made in relation to this disclosure.

45. Monash Health noted that the CRAF was not a mandated training requirement at this time, therefore knowledge and use of the CRAF was varied across clinicians and allied health staff interfacing with patients.

46. In 2016, the Victorian Royal Commission into Family Violence detailed a range of issues with respect to the contents of the CRAF and its uptake by services. The Royal Commission recommended that the CRAF be reviewed and that the new Family Violence Risk Assessment and Risk Management Framework be legislated within the *Family Violence Protection Act 2008* (Vic), so that prescribed organisations would be required to align their policies, procedures and tools with it.

47. Since that time, all of the services who were engaged with Ms Karakoc are now prescribed agencies under a new Family Violence Risk Assessment and Risk Management Framework, known as the MARAM, with legislated responsibilities relating to knowledge and identification of family violence, and the assessment and management of family violence risk. This has led to significant transformation of the service sector response to family violence risk assessment.

48. Since their engagement with Ms Karakoc, Monash Health has undertaken significant work to review their family violence response and align their practices with the MARAM.

FINDINGS AND CONCLUSION

49. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Ozlem Karakoc, born 06 October 1982;

    b) the death occurred on 14 July 2017 at 362 Edgars Road, Lalor, Victoria, the cause of death was UNDETERMINED; and

    c) the death occurred in the circumstances described above.

50. I convey my sincere condolences to Ms Karakoc's family for their loss.

51. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

52. I direct that a copy of this finding be provided to the following:

    Samim Ozerkan, Senior Next of Kin

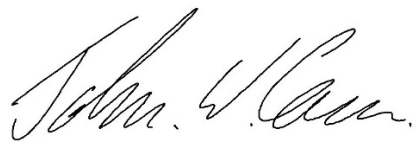
    Dora Cosentino, Minter Ellison

    Laura Colavizza, Monash Health

    John Bennie PSM, City of Greater Dandenong

    Sergeant Simon Quinnell, Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date: 14 September 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.