IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0126

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:	Richard Powell
Date of birth:	8 June 1984
Date of death:	8 January 2017
Cause of death:	1(a) Head injuries sustained in a motor vehicle incident (pedestrian)
Place of death:	Stewarts Lane, Sunbury, Victoria
Catchwords:	family violence; homicide

INTRODUCTION

1. Mr Richard Powell was 32 years old and living a transient lifestyle with his partner, Ms Jessie Donker at the time of his death. Mr Powell and Ms Donker had two children together, a daughter born in 2008 and a son born in 2016.

2. Mr Powell was born in Melbourne and was raised by his parents along with his two older siblings and a younger brother. He attended Sunbury Secondary College until Year 11 and left to commence work as a tradesperson doing concreting.

3. Mr Powell and Ms Donker started an intimate relationship in approximately 2006. At the commencement of their relationship, Ms Donker already had a son from a previous relationship. Mr Powell and Ms Donker initially lived with his parents before moving into a rental property owned by Mr Powell's parents when Ms Donker fell pregnant with their first child Dakoda.

4. In 2009, when Dakoda was about one, Ms Donker and Mr Powell began abusing drugs. They smoked cannabis regularly and used amphetamines, and later began using methylamphetamines. This continued for the next five years or so. During that period, Mr Powell abused Ms Donker not only physically but also psychologically and emotionally. During this period child protection received numerous reports and the couple's children were placed in the care of others at times when child protection intervened.

5. In 2013, police raided the couple's home and arrested Mr Powell for trafficking methylamphetamine and weapons offences. He was released on bail initially but then went into custody following his plea hearing in August 2014. He was ultimately sentenced to a term of imprisonment and was released on parole in around November 2015.

6. During Mr Powell's term of imprisonment, Ms Donker stopped using illicit substances and was able to get gainful employment. Ms Donker was able to secure a rental accommodation and her children were returned to her care during this period.

7. After Mr Powell's release from prison in November 2015, Ms Donker fell pregnant again with the couple's second child. The initial few months after Mr Powell's release were stable but shortly thereafter, Mr Powell started using methylamphetamines and the relationship became violent again.

8. Ms Donker eventually lost her job in May 2016 and without her income, the couple lost the rental accommodation in November 2016. They applied for emergency housing but were forced to live in their car in the meantime. Child Protection intervened and the couple's children were placed in the care of Mr Powell's parents. Ms Donker's first child from another relationship was placed in the care of his maternal grandmother.

9. In the lead up to the fatal incident, Ms Donker was allowed to have regular visits with her children and chose to park her car in Sunbury near the home of Mr Powell's parents. Mr Powell was only allowed supervised access and lived with friends, stayed with his parents from time to time and on occasions slept with Ms Donker in her car.

THE CORONIAL INVESTIGATION

10. Mr Powell'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.

11. 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.

12. 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.

13. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Powell'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.

14. This finding draws on the totality of the coronial investigation into the death of Mr Powell, including evidence contained in the coronial brief and further evidence obtained under my direction. 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]

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

Circumstances in which the death occurred

15. On 7 January 2017, Mr Powell and Ms Donker were observed arguing outside of Mr Powell's parent's home with their youngest child located in the back seat of the car.[2] During this argument, Mr Powell reportedly jolted their car backwards with the intention of frightening Ms Donker.[3] Mr Powell then proceeded to punch Ms Donker in the chest and choke her. Ms Donker '*responded by hitting him with something…he then punched her in the face, and just kept punching'*.[4]

16. Residents in several of the surrounding properties contacted the police, however, upon their arrival Mr Powell had left the scene. Police observed Ms Donker to be wounded above her right eye and questioned both Mr Powell's parents and Ms Donker as to the events that took place.[5] During questioning, Ms Donker advised that she and Mr Powell had had an argument but that she did not wish to make a statement or allow her injuries to be photographed. Police then attempted to locate Mr Powell but were unsuccessful.[6] Following information provided by a witness that Ms Donker had instigated the assault, police issued a VP Form L17 identifying Ms Donker as the respondent and Mr Powell as the affected family member in this matter.[7]

17. Following this incident, Ms Donker parked in a kindergarten carpark to sleep for the night in her car.[8] Between 5:20am and 6:00am on 8 January 2017, Mr Powell arrived at the carpark and began to physically assault Ms Donker while she slept.[9] During the assault, Mr Powell

---

[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.

[2] Coronial Brief, Exhibit 36- 000 Call – Loraine Owens, 715-722; Coronial Brief, Exhibit 38- 000 Call – Kim Stephens-Cain, 722-732; Coronial Brief, Victoria Police Incident and Case Progress, 733-735

[3] *Coronial Brief*, Exhibit 116- Transcript Recorded Interview, 835

[4] Ibid

[5] Coronial Brief, Statement of A Powell, 126; Coronial Brief, Statement of C Donker, 169; Coronial Brief, Statement of Senior Constable R Mitchell, 535-6

[6] Coronial Brief, Statement of Senior Constable R Mitchell, 537; Coronial Brief, Victoria Police Incident and Case Progress, 733-735

[7] Coronial Brief, Victoria Police Incident and Case Progress, 734

[8] Coronial Brief, Exhibit 116- Transcript Recorded Interview, 848

[9] Ibid, 849-850

pulled Ms Donker from the car by her hair and struck Ms Donker multiple times to the face.[10] Ms Donker then returned to the car and began repeatedly driving it towards Mr Powell before braking or swerving in order to miss Mr Powell. During her interview with police, Ms Donker reported that she had done this in order to frighten Mr Powell.[11] On the final drive forward, Ms Donker struck a pole that Mr Powell was hiding behind.[12] This impact caused the pole to bend and strike Mr Powell directly to the head, killing him instantly.[13]

18. Ms Donker contacted emergency services requesting assistance and then drove to Mr Powell's parents' home at approximately 6.08am, informing them of what happened.[14] Police arrived soon after and arrested Ms Donker.

19. Upon arrest, Ms Donker was observed to have several injuries and markings to her body and face, believed to have been a result of violence perpetrated towards her by Mr Powell on 7 and 8 January 2017.[15]

20. On 11 May 2018, in the Supreme Court of Victoria, Ms Donker was found guilty of the manslaughter of Mr Powell by unlawful and dangerous act. Ms Donker was sentenced to five years imprisonment with a non-parole period of two years.[16]

Identity of the deceased

21. Upon reviewing the available evidence, Coroner Rosemary Carlin completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 11 January 2017, concluding that the identity of the deceased was Richard Alfred Powell born 8 June 1984.

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

Medical cause of death

23. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 9 January 2017 and provided a written report of her findings dated 6 April 2017.

[10] Ibid
[11] Sentencing Remarks, *R v Donker* [2018] VSC 210, 8.
[12] Ibid.
[13] Ibid. .
[14] *Coronial Brief*, Statement of Peter Powell dated 8 January 2017, 152
[15] *Coronial Brief*, Statement of Detective Leading Senior Constable Cameron Merrett dated 2 February 2017, 66-67
[16] *R v Donker* [2018] VSC 210, 36

24. Dr Iles noted the following:

(a) The post mortem examination revealed evidence of mixed blunt and sharp force injuries to the face and skull that has resulted in extensive skull fractures. These injuries would be immediately incapacitating and fatal;

(b) The nature of the deceased's injuries suggests a focal impact to the head by an edged object. This edged object was likely to be the sign on the end of the pole located in proximity to the deceased at the scene of the fatal incident; and

(c) There was evidence of a fracture to the right mid radial shaft associated with an overlying skin laceration.

25. Toxicological analysis of post-mortem blood samples identified the presence of amphetamines, methylamphetamine and cannabis metabolite. None of these detected substances were at levels that suggest a connection to the mechanism of death in this case.

26. Dr Iles provided an opinion that the medical cause of death was '1(a) Head injuries sustained in a motor vehicle incident (pedestrian)'.

27. I accept Dr Iles' opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

Family violence investigation

28. As Mr Powell's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**)[17] examine the circumstances of Mr Powell's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[18]

29. Mr Powell's relationship with Ms Donker met the definition of '*domestic partner'* under the *Family Violence Protection Act 2008* (Vic) (**the FVPA**).[19] The assaults perpetrated by Mr

[17] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[18] The VSRFVD provides assistance to Victorian 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-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

[19] Section 9(1)(b) of the *Family Violence Protection Act 2008*

Powell towards Ms Donker in the lead up to the fatal incident met the definition of '*family violence'* in the FVPA.

30. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr Powell and Ms Donker prior to Mr Powell's death.

31. The available evidence suggests that Mr Powell and Ms Donker's relationship was tumultuous and characterised by numerous family violence incidents primarily perpetrated by Mr Powell.

History of Victoria Police contact with Mr Powell and Ms Donker

32. On 3 November 2009, Victoria Police were contacted by Ms Donker who alleged that Mr Powell had perpetrated family violence towards her.[20] During this incident, Mr Powell made threats to Ms Donker's life, damaged several pieces of property and threatened to suicide by pouring petroleum on himself and throughout the residence.[21] Following his arrest, Ms Donker reportedly took an overdose of medication prescribed for treatment of her bi-polar and was admitted to Sunshine Hospital.[22] Mr Powell was sentenced to a 12 month Community Based Order (CBO)[23] as a result of this incident, and a Family Violence Intervention Order (FVIO) was granted against Mr Powell preventing him from perpetrating family violence towards Ms Donker.[24]

33. Whilst Mr Powell and Ms Donker's children were not present during this incident, a notification was made to the Department of Health and Human Services, Child Protection (Child Protection) by Victoria Police and an investigation was commenced.[25]

34. Between 3 November 2009 and 10 November 2011, Victoria Police attended three further incidents of violence between Ms Donker and Mr Powell but did not undertake any civil or criminal proceedings on any of these occasions due to a lack of information provided by either party.[26]

---

[20] Coronial Brief, Statement of Leading Senior Constable J Newman, 495; Coronial Brief, Appendix B- Incident Report 100020693.
[21] Magistrate's Court of Victoria, Application and Summons for an Intervention Order Case Nr: Y03243175; Coronial Brief, Victoria Police Incident and Case Progress, 657.
[22] The Department of Health and Human Services, Case Records of Deklan Donker, Dekoda Powell and Brenton Powell, 2686, 2639-2647.
[23] Victoria Police, Criminal Record of Richard Powell, 4-5.
[24] Magistrate's Court of Victoria, Intervention Order Case Nr: Y03243175;
[25] The Department of Health and Human Services, Case Records of Deklan Donker, Dekoda Powell and Brenton Powell, 2685-2686, 2664-2676.
[26] Coronial Brief, Victoria Police Incident and Case Progress, 658-662.

35. On 18 May 2014, Victoria Police responded to a further family violence incident between Ms Donker and Mr Powell.[27] Upon arrival, Ms Donker was located sitting outside of the residence with another man[28] and was observed to be crying, to have scratches on her forearm and to have dust covering her legs.[29] Ms Donker advised police that she had fought with Mr Powel and that he had physically assaulted her, causing the injuries to her arm before fleeing the scene.[30] Ms Donker informed police that she felt helpless, intimated and sacred throughout the incident.[31] A FVIO was sought by police and later issued at the Broadmeadows Magistrates' Court identifying Ms Donker as the Affected Family Member and Mr Powell as the Respondent.[32] The FVIO stipulated that Mr Powell must not commit family violence, but did not restrict his contact with Ms Donker.[33]

36. On 2 July 2014, police received a report from a bystander regarding a verbal argument between Mr Powell and Ms Donker.[34] Upon arrival, police questioned Ms Donker and Mr Powell however, no violence was identified by either party or witnesses and no further action was taken.[35]

37. On 22 August 2014, Mr Powell was incarcerated for possession of prohibited weapons, possession of illicit substances, the trafficking of illicit substances, theft and criminal damage.[36]

38. Following his release from prison on 12 November 2015, Mr Powell recommenced the use of methamphetamines and was reported to have become 'more jealous and controlling, and would even stop Ms Donker from going to work…he was still abusive, violent and suspicious, often accusing her [Ms Donker] of having affairs'.[37] During this period, Ms Donker lost her accommodation and employment and in 2016, Child Protection placed all three children back into the care of their paternal and maternal grandparents.[38]

---

[27] Coronial Brief, Victoria Police Incident and Case Progress, 665-669; Coronial Brief, Statement of Constable D Tunbridge, 504.
[28] Ibid.
[29] Ibid.
[30] Ibid, 505.
[31] Ibid.
[32] Magistrates Court of Victoria, Intervention Order Case Nr: E11626180.
[33] Ibid.
[34] Coronial Brief, Victoria Police Incident and Case Progress, 670-672.
[35] Ibid, 671-672.
[36] Victoria Police, Criminal Record of Richard Powell, 2-3.
[37] Ibid.
[38] Ibid.

39. On 11 October 2016, a neighbour called Victoria Police and requested their attendance in response to an incident of family violence between Ms Donker and Mr Powell. Upon arrival, police could not locate anyone at the residence.[39]

40. On 24 October 2016, police responded to a report of physical violence by an anonymous caller.[40] Police spoke to Mr Powell and Ms Donker separately[41] and Ms Donker informed police that no violence had taken place and that the bruise on her arm was the result of playing with her children.[42] On this occasion, police did not take any civil or criminal action and submitted formal referrals to support services for both parties.[43]

41. On 27 October 2016, police responded to another incident of family violence between Mr Powell and Ms Donker. On this occasion, Mr Powell told police that Ms Donker had locked him out of the house and that he wanted to retrieve some possessions before leaving.[44] Police questioned Ms Donker who advised that no violence had taken place and Mr Powell was escorted from the address.[45]

42. On 29 October 2016, police respond to a family violence incident between Ms Donker and Mr Powell in similar circumstances to the incident which took place on 27 October 2019.[46] On this occasion, police noted 'that neither party at the time divulged any threats, damage or assaults by either party'[47] and formal referrals were submitted for both parties.[48]

43. On 29 December 2016, a neighbour of Mr Powell's parents called emergency services in relation to a verbal dispute between Ms Donker and Mr Powell.[49] When police attended the property, no one was present and no further action was taken.[50]

44. On 1 January 2017, neighbours again reported a verbal argument between Mr Powell and Ms Donker.[51] Upon arrival, police questioned Mr Powell and identified him as the Affected Family

[39] Coronial Brief, Appendix R- Transcript of 000 Call – Loraine Owens, 716.
[40] Coronial Brief, Victoria Police Incident and Case Progress, 687-689; Coronial Brief, Statement of Senior Constable K Moore, 507-509; Coronial Brief, Statement of Constable H Perkins, 520-522.
[41] Coronial Brief, Statement of Senior Constable K Moore, 508.
[42] Coronial Brief, Victoria Police Incident and Case Progress, 687-689; Coronial Brief, Statement of Senior Constable K Moore, 507-509; Coronial Brief, Statement of Constable H Perkins, 520-522.
[43] Ibid.
[44] Coronial Brief, Statement of Constable S Manniche, 513.
[45] Coronial Brief, Statement of Constable S Manniche, 513-4.
[46] Coronial Brief, Statement of Senior Constable R Brown, 517; Coronial Brief, Victoria Police Incident and Case Progress, 690-692.
[47] Ibid, 718.
[48] Coronial Brief, Victoria Police Incident and Case Progress, 692
[49] Coronial Brief, Exhibit 24- Transcript of 000 Call – Kate Sharp, 693-696; Coronial Brief, Statement of K Sharp, 298.
[50] Coronial Brief, Statement of K Sharp, 298-299.
[51] Coronial Brief Statement of M Prentice, 317; Coronial Brief, Exhibit 29- Transcript of 000 Call- Andrew Orr, 697-702; Coronial Brief, Exhibit 29- Transcript of 000 Call- Meredith Prentice, 703-708.

Member on the family violence report (**VP Form L17**).[52] Ms Donker was not present during police attendance, and police provided informal referrals to support services for both parties.[53]

45. On 2 January 2017, Victoria Police responded to a verbal dispute between Mr Powell and Ms Donker.[54] On this occasion, police identified that Ms Donker was homeless and had requested to reside with Mr Powell's parents with whom she was not welcome. During police attendance, Ms Donker noted that she had a flat car battery and was unable to leave the address. Mr Powell provided his battery to Ms Donker with the agreement that she would reside with a friend that evening. Police identified that the '*dispute was verbal only'* and formal referrals were submitted for both parties.[55] No civil or criminal action was taken on this occasion.

46. On 7 January 2017, Mr Powell and Ms Donker were observed arguing outside of Mr Powell's parent's home.[56] During this argument, Mr Powell reportedly jolted their car backwards with the intention of frightening Ms Donker and unsettling their child who was also in the car.[57] Mr Powell then proceeded to punch Ms Donker in the chest and choke her. Ms Donker '*responded by hitting him with something…he then punched her in the face, and just kept punching'*.[58]

47. Residents in several of the surrounding properties contacted the police, however, upon their arrival Mr Powell had left the scene. Police observed Ms Donker to be wounded above her right eye and questioned both Mr Powell's parents and Ms Donker as to the events that took place.[59] During questioning, Ms Donker advised that she and Mr Powell had had an argument but that she did not wish to make a statement or allow her injuries to be photographed. Police then attempted to locate Mr Powell but were unsuccessful.[60]

48. Following information provided by a witness that Ms Donker had instigated the assault, police issued a VP Form L17 identifying Ms Donker as the respondent and Mr Powell as the affected family member in this matter.[61] Despite a long history of family violence between Ms Donker

---

[52] Family violence referrals from Victoria Police are made through the Victorian Police Risk Assessment and Risk Management Report 'L17' and are the mechanism by which Police who attend family violence incidents can make referrals to community agencies and/or reports to Child Protection.
[53] Coronial Brief, Victoria Police Incident and Case Progress, 709-711.
[54] Coronial Brief, Victoria Police Incident and Case Progress, 712-714.
[55] Ibid, 713.
[56] Coronial Brief, Exhibit 36- 000 Call – Loraine Owens, 715-722; Coronial Brief, Exhibit 38- 000 Call – Kim Stephens-Cain, 722-732; Coronial Brief, Victoria Police Incident and Case Progress, 733-735
[57] *Coronial Brief*, Exhibit 116- Transcript Recorded Interview, 835
[58] Ibid
[59] Coronial Brief, Statement of A Powell, 126; Coronial Brief, Statement of C Donker, 169; Coronial Brief, Statement of Senior Constable R Mitchell, 535-6
[60] Coronial Brief, Statement of Senior Constable R Mitchell, 537; Coronial Brief, Victoria Police Incident and Case Progress, 733-735
[61] Coronial Brief, Victoria Police Incident and Case Progress, 734

and Mr Powell, police do not appear to have considered this in their completion of the VP Form L17 and contradict themselves several times in the risk assessment section of the referral form. For example, whilst noting that seven incidents of family violence have occurred in the past, police also note that the risk of future violence is 'unlikely'.[62] In addition, the risk factors pertaining to historic incidents of family violence were not completed meaning that a significant amount of detail regarding the violence was absent from the referral.[63]

Child protection service contact with Mr Powell and Ms Donker

49. Ms Donker and Mr Powell's children were the subjects of 10 separate Child Protection reports made between 2007 and 2016. Eight of these reports were made whilst Ms Donker and Mr Powell were in a relationship, with the majority of the concerns held by Child Protection being related to the family violence perpetrated by Mr Powell towards Ms Donker.[64]

50. Without detailing all ten occasions in which Child Protection received a report, I note that at the time of the fatal incident, the available evidence indicates that Child Protection had been made aware of multiple incidents of family violence perpetrated by Mr Powell against Ms Donker. Family members and friends had also made reports to Child Protection regarding the violence between Ms Donker and Mr Powell and noted concerns as to the escalation of this violence.[65] Ms Donker had also self-reported violence to Child Protection and at one stage, had agreed to the issuance of an FVIO in protection of her.[66] Child Protection had also repeatedly cited family violence as the main reason for their involvement and removal of the children from the family home.

51. I confirm that despite the above information available to Child Protection workers, they do not appear to have provided any support to either party to obtain assistance in relation to family violence and did not take steps to assess Ms Donker's safety or provide her with assistance. I however note that various referrals were made for Ms Donker to receive additional assistance but that she either refused this support or was unavailable to accept the support.

52. In the various child protection applications against Mr Powell and Ms Donker, Child Protection also sought family violence specific conditions but did not appear to take any identifiable steps

[62] DHHS L17 portal records provided to the Court, 4-5
[63] Ibid
[64] Example: ibid, 26642676, 2484-2497, 1694.
[65] Ibid, 1544, 1586.
[66] Ibid, 1487.

to support Ms Donker or Mr Powell to achieve them. On several occasions, Child Protection also recommended that a condition be placed on the protective orders, requiring Ms Donker to undertake an anger management course. Whilst this condition may have been sought as a result of Ms Donker's aggressive behaviour towards Child Protection or her erratic behaviour towards Mr Powell's family, practitioners should have considered that Ms Donker was not being treated for bi-polar at the time of this engagement and that Child Protection practice guidelines on responding to parents who have been effected by family violence indicate that aggressive behaviour is commonplace and should be managed with empathy and consideration of the circumstances and trauma of the parent.

53. I note that Child Protection did not appear to consider Ms Donker's placement as a victim in any meaningful way and Ms Donker was not provided with any additional support to distance herself from Mr Powell and assume the care of her children. In failing to provide this support, Child Protection appear to have overlooked that the best interests of the child are often met by assisting the affected parent to secure their own safety and wellbeing.

54. At the time of the fatal incident, Ms Donker and Mr Powell had limited finances, were homeless, were experiencing mental health issues and had a history of significant service involvement. Mr Powell also had a history of violent offending and evidence suggests that both Ms Donker and Mr Powell were using illicit substances. In addition, there was a long history family violence including threats to kill and the use of strangulation. According to the existing risk assessment framework in place at the time of this incident, Ms Donker was at a high risk of experiencing ongoing family violence and/or being killed by Mr Powell. This information was available to Child Protection at the time of their engagement and should have been employed by practitioners to develop a more family violence, victim focused response.

55. The available evidence suggests that Child Protection were the only consistent service involved with Mr Powell and Ms Donker at the time of the fatal incident. Had either Ms Donker or Mr Powell been engaged with family violence support in the lead up to the fatal incident, assistance may have been provided to Ms Donker to obtain a FVIO against Mr Powell or to secure safe housing so that he was unable to locate her. Intervening earlier to provide family violence specific support may have also resulted in either party making attempts to address their relationship or may have enabled Ms Donker to identify the risk that she and her children were being exposed to by Mr Powell's escalating use of violence.

Men's Referral Service

56. Family violence referrals from Victoria Police are made through the Victorian Police Risk Assessment and Risk Management Report 'L17' and are the mechanism by which Police who attend family violence incidents can make referrals to community agencies and/or reports to Child Protection. No To Violence (NTV) receive police referrals for perpetrators of family violence through this process.

57. On 2 January 2017, NTV received a referral for Mr Powell following the incident of violence involving Ms Donker on the same day.[67] Records provided by NTV indicate that there was '*no call attempt*'[68] made in relation to this referral '*due to time constraints*'.[69] As noted above, this referral was inaccurately completed by police to suggest that Ms Donker was at low risk of family violence. The limited information contained in the referral may have resulted in the matter being triaged below other, more high-risk matters.

58. I note that it is important that all family violence perpetrators receive a response from support agencies when it is appropriate to do so and doesn't place the victim at risk. Family violence is rarely an isolated event and whilst one matter may appear to be low risk, risk should be viewed in conjunction with the history of the victim and perpetrator. Furthermore, intervening with a perpetrator when the perpetration of family violence is considered 'low risk' could take steps to preventing future incidents form occurring.

59. NTV provided further information to the Court to confirm the number of unactioned L17 referrals between 1 January 2017 and 30 June 2020. NTV confirmed that all after hours referrals between midday Friday to 4 pm Sunday are handled by the men's referral service, any referrals which are not actioned are returned to an Orange Door or other local intake provider for follow up. NTV also confirmed that 62% of their referrals were unactioned.

60. NTV further confirmed that of the unactioned referrals, 61% of them were due to the respondent having not been contacted by Victoria Police, this is policy to protect victims in case the respondent becomes aware of actions against them without an interim FVIO in effect. It is unclear from the response provided by NTV whether referrals which are unactioned and referred on to Orange Door/local intake providers are then left unactioned indefinitely.

[67] No to Violence, Case Records of Richard Powell, 1
[68] Ibid, 7.
[69] Ibid.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Child protection services

61. The main concerns relating to Child Protection engagement are that despite a long history of family violence and protective actions taken on behalf of their children, Ms Donker as a victim of Mr Powell's violence was never provided with referrals for appropriate support despite her being homeless, abusing substances and being in an abusive relationship. Child Protection's response to the Court acknowledges that at times, their service was bias in favour of the children and there were periods where they could have provided more support to Ms Donker as a primary caregiver and biological parent.

62. However, Child Protection confirm that in the 12-month period leading up to the fatal incident, Ms Donker was subject to various referrals to family violence supports through the Multi Agency Triage (MAT) process which she declined or for which she was unavailable.

63. Child Protection did further acknowledge that they did not adequately connect Mr Powell's violence with his poor parenting and placed almost all responsibility on Ms Donker to meet the day to day care needs of the children including ensuring they attended medical appointments. Mr Powell became easily invisible in the planned interventions and when he was included, he declined referrals to parenting support programs to address his parenting deficits.

64. Since the fatal incident, Child Protection have adopted new procedures that include identifying the tasks required to address the risks posed by a family violence perpetrator and the support required to the affected parent to provide for the ongoing needs of the child. Both the procedure and the advice include information to assist child protection practitioners to develop strong safety plans for the affected parent and the children as part of statutory case planning, and to create appropriate linkages for children and their families.[70]

65. Child Protection also point to developments[71] around the Orange Door network which is a collective of safety hubs designed to make it easier for those experiencing or at risk of family violence to get help, and assist families requiring support to care for their children. The Orange Door provides an integrated intake pathway to women's and children's family violence services, services for men who use violence, and family services. Referrals to the Orange Door

[70] Child Protection response dated 30 September 2020, 19-22
[71] Ibid

would have been made by Child Protection practitioners if the case was being managed in present times.

66. I note that the Child Protection response to concerns raised by my investigation correctly state that:

> *"Ms Donker was at risk of injury or death from Mr Powell throughout their relationship; this chronic experience of trauma strongly and adversely influenced Ms Donker's own behaviour…she also appeared to live in a constant state of fear and threat from Mr Powell.* ***Victim survivors who use violence are more likely to have experienced long-term violence by their intimate partners, as was the case for Ms Donker****."*[72] [emphasis added]

67. I confirm that several recommendations regarding Child Protection services were made by the Royal Commission into Family Violence[73] (**Royal Commission**) seeking to improve Child Protection's response to family violence, including; the introduction of family violence training for all Child Protection staff, the further development of existing family violence guidelines and policies and continued support for the co-location of family violence specialist workers across all Child Protection offices. The Victorian Government has since identified all these recommendations as being implemented.[74]

68. I note that since the fatal incident, Child Protection have updated guidelines to strongly encourage service collaboration and advise that '*collaboration with other service providers supporting the affected parent may assist in identifying realistic goals and actions, and contribute to the affected parent feeling supported by the system*.'[75]

69. In addition, Child Protection staff are now required to undertake family violence training, including a two-day in-person training session and the completion of a suite of e-learning modules.[76] The introduction of family violence specialist workers in Child Protection offices is also of noted importance to improving Child Protection practice in relation to family violence. This co-location provides Child Protection workers with easy access to advice on how to respond to instances where an adult parent may be experiencing family violence and practice advice strongly encourages the use of these consultations in all instances of family violence.

---

[72] Child Protection response dated 30 September 2020, 17
[73] State of Victoria, Royal Commission into Family Violence *Final Report* (2016).
[74] Family Safety Victoria, *The 227 recommendations,* < https://www.vic.gov.au/family-violence-recommendations?q=child+protection>.
[75] Department of Health and Human Services, *Advice and Protocols- Planning for children's safety where there is family violence,* < https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/case-planning/planning-childrens-safety-where-there-family-violence>..
[76] Victorian Government (Department of Premier and Cabinet), *Three Years On From The Royal Commission into Family Violence* (2019).

Victoria Police

70. Victoria Police acknowledges that the L17 completed on 2 January 2017 was deficient. L17s are used to inform support agencies of the of the risk posed to the affected family member and to guide the level of response that the agency will then provide to a victim or perpetrator of family violence.[77] Due to restraints on the resources of specialist family violence agencies, services may be unable to respond to all instances of violence reported to them and may triage low risk matters as not requiring a response. It is integral that agencies are provided with all the information relevant to the nature of the family violence in order to determine the appropriate level of response required to minimize the risk of ongoing or future violence. I further note that it is important that L17s are accurately completed as future risk assessments are affected in further family violence events which are attended by police. In this case, the attending members on 7 January 2017 did not place weight on the family violence history when considering who to identify as the primary aggressor.

71. Victoria Police suggest that the assessment of Ms Donker as the primary aggressor was correct. However, the attending members on 7 January 2017 placed too much emphasis on the information provided by the reporting member of the public who called 000, even though the evidence from the family was inconclusive, Mr Powell was missing and Ms Donker had facial injuries and declined to provide evidence. Had a stronger emphasis on the objective evidence of past family violence reported in the LEAP history been assessed properly, police members may have given stronger weight to a decision to make Mr Powell the primary aggressor and not Ms Donker. These considerations are affirmed in the attached January 2019 Responding to Family Violence (Primary Aggressor) internal Victoria Police policy which states that the assessment should be based on controlling behaviours, any history of family violence, threats to kill and the relative fearfulness of each party.[78]

72. The Royal Commission examined evidence that a primary aggressor is able to use the '*incident-based'* police response to conceal the extent of their offending and to cast doubt on the information provided by a victim.[79] At a family violence incident attended by police, some perpetrators can appear calm and reasonable, whereas victims can be agitated, or potentially even violent. The complexities and challenges arising from a family violence incident can sometimes lead police to misidentify the primary aggressor at an incident, which can result in

[77] Ibid, 5.
[78] Victoria Police, *Responding to Family Violence (Primary Aggressor) policy* – January 2019, 2
[79] Royal Commission into Family Violence *Final Report* (2016), Volume 3, Chapter 14, 1

a delay in providing the parties with access to the correct support services.[80] Personal bias and myths about family violence have influenced the police workforce in the same ways they have influenced the wider community.[81]

73. I note that misidentification of the primary aggressor at the time of the incident, can result in adverse consequences for victims in their lives and through the justice system including ongoing victimisation; risks to safety; barriers to engagement with support services; loss of contact with children and children being left with an unsafe carer (with resulting impacts on children); misapplied intervention orders or other civil actions; and potential criminal sanctions.[82]

74. I consider that on the balance of available evidence, that Ms Donker should have been identified as an affected family member and not the primary aggressor, especially considering the history of reported family violence between the two parties.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Richard Powell, born 8 June 1984;

    (b) the death occurred on 8 January 2017 on Stewarts Lane, Sunbury, Victoria from 1(a) Head injuries sustained in a motor vehicle incident (pedestrian); and

    (c) the death occurred in the circumstances described above.

76. Having considered all the available evidence, I am satisfied that no further investigation is required in this case.

77. I convey my sincere condolences to Mr Powell's family for their loss.

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

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

[80] Victoria Police, *Responding to Family Violence (Primary Aggressor) policy* – January 2019, 3
[81] Ibid
[82] Royal Commission into Family Violence *Final Report* (2016), Volume 3, Chapter 14, 1

Mr Peter Powell and Mrs Antonia Powell, Senior Next of Kin

Ms Lauren Callaway, Assistant Commissioner, Family Violence Command, Victoria Police

Ms Lindsey Walker, Victorian Government Solicitor's Office

Ms Leng Phang, Department of Fairness, Families and Housing

Ms Jacqui Watt, CEO, No To Violence

Ms Eleri Butler, Chief Executive Officer, Family Safety Victoria

Ms Sandy Pitcher, Secretary, Department of Fairness, Families and Housing

Detective Senior Constable Hannah Thompson, Coroner's Investigator

Signature:

JUDGE JOHN CAIN

STATE CORONER

Date: 13 July 2021

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.