IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 0855

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Yucel ARSLAN
Delivered on:	14 December 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	Inquest on 4, 5, 6 and 7 December 2017
Findings of:	Coroner Audrey JAMIESON
Counsel assisting the Coroner:	Ms Katherine Fitzgerald instructed by the Coroners Court In-House Legal Service
Representation:	Mr Tim Fitzpatrick on behalf of the family Mr Paul Lawrie instructed by Minter Ellison appeared on behalf of Chief Commissioner of Police
Catchwords:	Use of force, police response to suspected ingestion of drugs

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I, AUDREY JAMIESON, Coroner,
having investigated the death of YUCEL ARSLAN

and having held an inquest in relation to this death at Melbourne on 4, 5, 6 and 7 December 2017[1]:

find that the identity of the deceased was YUCEL ARSLAN

born on 4 July 1976[2], aged 40

and that the death occurred on 24 February 2016

in the Royal Melbourne Hospital, Parkville, Victoria
from:
I (a) Methamphetamine Toxicity
in the following circumstances:

INTRODUCTION[3]

1. Yucel Arslan[4] (also known as Seymen Aga) was aged 40 years and lived with his parents, Cengiz and Fatma Arslan, in Roxburgh Park. He was the oldest of five children to this marriage (his father also had four other children).

2. Yucel was born in Australia but was of Turkish descent. He had two children, Haci and Aydin, with Emel Aydin from whom he was separated.

3. His father said '*Yucel was a good and respectful son. He was a very good boy. He was very respectful to his elders and was very generous.*'[5]

4. Yucel was involved in two serious car accidents about five years before his death and did not work after that time.

5. His GP, Dr Suleyman Saban, who treated Yucel between 2000 and 2015, said that Yucel had a history of heroin and benzodiazepine abuse, anxiety and depression. He

[1] The inquest was scheduled for 7-10 August 2017 but was delayed due to the discovery at the commencement of the inquest of a recording of a conversation with Murat Toygar which occurred shortly after the death. The existence of the recording was not known to the Court or the parties and required translation. I was assisted by Professional Standards Command with this matter.
[2] He was also recorded as having a birth date of 7 April 1976
[3] This section is a summary of facts that were uncontentious and provide a context for those circumstances that were contentious and will be discussed in some detail below.
[4] With the consent of the family, Yucel Arslan was referred to as Yucel during the course of the Inquest. Save where I have determined formality requires the use of his full name, I have endeavoured to refer to him only as Yucel throughout the Finding.
[5] CB at p. 23

was also treated by Dr Mustafa Erciyas for mixed anxiety and depressive illness. Dr Erciyas last saw Yucel on 15 February 2016 when he was prescribed anxiolytic medication, Diazepam and Stilnox. According to his father, Yucel spent approximately one week in the Epping Hospital in 2015 for depression.

6. Yucel had an extensive criminal history dating back to 1991 and was, at the time of his death, on a 15 month Community Corrections Order **(CCO)** dated 17 February 2015. The CCO included 90 hours of unpaid community work as well as treatment and rehabilitation conditions. The relevant offences included driving while suspended, use of an unregistered vehicle and contravening a CCO. In addition, on 20 January 2016, he was sentenced to a further 24 month CCO for obtaining financial advantage with the condition that he undertake offending behaviour programs.

7. At about 1.50pm on 24 February 2016, Yucel and his friend, Murat Toygar, were pulled over by two plain clothed police members (driving an unmarked blue Ford Territory) in Flemington due to the manner in which the vehicle was being driven. Yucel was driving his orange Holden (registration 1AS1FW). During this contact with police, Yucel swallowed a small plastic bag containing a quantity of white powder.

8. The police used some force to try and prevent Yucel from swallowing the substance. Ambulance Victoria **(AV)** paramedics attended at the request of police and said that they tried to persuade Yucel to attend a hospital, but he declined to do so. The police were unable to hold him and both the paramedics and police left the scene.

9. Yucel later attended the Royal Melbourne Hospital **(RMH)** in a distressed state, where he went into cardiac arrest and, despite resuscitation attempts, died at approximately 4.40pm that day.

INVESTIGATION AND SOURCES OF EVIDENCE

10. This finding is based on the totality of the material and the product of the coronial investigation of Yucel's death. That is, the brief of evidence compiled by my Coroner's Investigator, Detective Sergeant Chris Spillane, Yarra Criminal Investigation Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel.

11. All this material, together with the inquest transcript, will remain on the coronial file.[6] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

12. The purpose of a coronial investigation of a *reportable death*[7] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[8] It is self-evident that Yucel's death fell within the definition of a reportable death.

13. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[9]

14. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[10] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[11] These are effectively the vehicles by which the coroner's prevention role can be advanced.[12]

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[6] Access to documents held by the Coroners Court of Victoria is governed by section 115 of the ***Coroners Act 2008***. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[7] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria (see section 4(1)), reportable death includes *"a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury"* (see section 4(2)(a)).

[8] Section 67(1).

[9] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[10] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act.

[11] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[12] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

15. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[13]

FINDINGS AS TO UNCONTENTIOUS MATTERS

Identity of the Deceased Person

16. On 24 February 2016, Cengiz Arslan visually identified the deceased's body as being that of his son, Yucel Arslan, who was born on 4 July 1976.

17. Identity is therefore not in dispute and requires no further investigation.

18. I find, as a matter of formality, that Yucel Arslan, born on born 4 July 1976, died in the Royal Melbourne Hospital, Parkville, on 24 February 2016.

Medical Cause of Death

19. A post mortem examination was conducted by Dr Sarah Parsons, forensic pathologist of the Victorian Institute of Forensic Medicine **(VIFM)**, on 25 February 2016. She determined the cause of death to be 'methamphetamine toxicity'.

20. Dr Parsons also noted haemorrhage within the muscles of the neck and fractured ribs but considered these observations to be secondary to cardio-pulmonary resuscitation which occurred at the RMH, but she could not rule out an assault. She said that '*the bruising in the neck is widespread and non-specific. Given the distribution of the bruising and rib fractures they are in keeping with CPR, but assault cannot be entirely excluded but is considered less likely*'.[14]

21. Apart from therapeutic drugs, the toxicological report found the presence of methamphetamine (~7.3 mg/L); amphetamine (~0.3 mg/L); 7-aminoclonazepam (~0.1 mg/L) and delta-9-tetrahydocannabinol (~8 ng/mL).

22. Peak concentrations of methamphetamine following 30 mg oral doses are known to peak at about 0.1 mg/L, with a possible range of 0.05 to 0.3 mg/L. Based on this, the

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[13] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[14] Email to the Court dated 16 November 2016. She later confirmed this view during her evidence at the inquest (T. 343, T. 27)

amount of methamphetamine found in Yucel body was significantly higher than what would be considered a *normal* dose.

23. I accept Dr Parsons' advice regarding the cause of Yucel's death.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

24. The focus of the investigation and inquest was on the circumstances leading to Yucel's death, with particular focus on the contact between Yucel and the police. That is, whether the 'use of force' applied by the police was reasonable and appropriate and whether the actions of police contributed to Yucel's death.

Victoria Police Policy

25. Central to the investigation and inquest was consideration of the Victoria Police Manual – Procedures and Guidelines – Searches of Persons (Search of Person VPM) which provides in relation to concealed or ingested drugs that:

> '*Where there are reasonable grounds to believe that a person is concealing drugs or related evidentiary items:*
>
> a. *in their mouth*
> b. *assess the person against the Medical Checklist and take action as required. Where necessary, seek advice from the Custodial Medicine Unit, VIFM or local FMO*
> c. *take reasonable steps to ensure the person does not ingest anything further*
> d. *verbally encourage the person to surrender the item/s.* ***Do not use force*** *to prevent the person from swallowing.*' [Emphasis added]

Family Concerns

26. Yucel's family raised concerns[15] regarding the circumstances of Yucel's death, which I note was largely informed by Mr Toygar's account of what happened: '*We believe police brutality and delay of treatment enforced by the police officers acted as chains of causation in Yucel's death.*'

27. In summary the family said that, Yucel was handcuffed immediately upon intercept; Yucel was in fear and as a result swallowed drugs; the police were aggressive and forcibly tried to get Yucel to regurgitate by shoving their hands down his throat while punching him into submission; that an onlooker called an ambulance rather than police;

[15] By letter to the Court dated 7 March 2016.

that an onlooker tried to stop police because they were concerned they would kill him; the police prohibited ambulance personnel from assisting; and that a delay and the injuries caused by the police accelerated Yucel's demise.

Chief Commissioner of Police Submissions

28. Prior to the inquest, counsel for the Chief Commissioner of Police **(CCP)**[16] conceded that the actions of police (or use of force) were contrary to the direction in the Search of Person VPM but noted that *Policy and Guidelines* are for guidance only, whereas, VPM *Rules* are mandatory.

29. Further, that it was unusual to have a mandatory direction in a *Policy and Guideline* and this was *unsatisfactory* and that the rationale for the direction '*is not obvious and cannot be described to the court with certainty.*'

30. However, the CCP submitted that the use of force against Yucel was consistent with the overarching duties of police to *protect life* and *help those in need of assistance.*

31. I was advised that a review was to be undertaken of the direction to examine legal justification for use of force and the statutory basis for use of force.

Relevant Background Circumstances

Office of Correctional Services Review

32. The Office of Correctional Services Review[17] provided a report regarding Yucel's CCOs at the time of the death. It noted Yucel had limited capacity to undertake work due to injuries he sustained in an accident and could only undertake two hours of work a week (in a seated position). He had completed 52.5 hours of the 90 hours required. His criminal history included that he had served six terms of imprisonment and received 17 community based dispositions, all of which were breached.

33. On the day of his death, he attended for community work a half an hour late but was sent home as he had attended late on seven prior occasions.

34. Yucel had a history of drug use but he advised the court assessment writer in 2016 that he had been free of illicit drugs for several years. Given this, and the lack of specific condition relating to drug treatment, he was not required to undertake drug testing. The

[16] Submissions dated 23 February 2017.
[17] Now referred to as Justice Assurance and Review Office (JARO). Report at CB p. 341.

report noted that he was, however, on the wait list of offending behaviour programs and was under the care of his GP in relation to anxiety, depression and panic attacks.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Evidence of Murat Toygar prior to the commencement of the Inquest

35. Mr Toygar initially declined to give a written statement following the incident. His most contemporaneous accounts were, however, audio recorded by the Professional Standards Command (PSC), Victoria Police, shortly after the incident on 24 February 2016. A further recording was made by Yucel's family by mobile phone on 25 February 2016.

36. As noted by Counsel Assisting, the accounts of Mr Toygar:

> '*alleged in broad compass and to varying degrees, that police inappropriately assaulted Yucel by choking him, kicking and hitting him, and/or generally bashing him, that police tried to kill him, that police deliberately made him ingest the drugs that killed him, that police denied him treatment by the ambulance, or somehow caused him to swallow the drugs, or caused the bag he did swallow to open after he'd swallowed it.*'[18]

37. Mr Toygar related some of the above allegations to his friend, Bulent Misokka, and his brother Ahmed, and was informed that Yucel had died by the hospital while he was with them. He also said that he would be blamed by Yucel's family for his death.[19]

38. Mr Toygar also claimed that he started taping the incident on his phone, but the police stopped him.

39. Mr Toygar's account would naturally have raised concerns with the family and it is clear that the dispute about the facts in this matter largely arose as result of the varying accounts given by Mr Toygar.

40. Mr Toygar did, however, provide a statement to the Court dated 30 October 2017 prior to the commencement of the inquest, which retracted a number of his earlier assertions: '*I told you it was the second statement I gave is the correct one. The first one's rubbish.*'[20] His explanation for his earlier statements was that he was drug-affected at

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[18] Mr Toygar claimed that the police sent the AV away whilst he was begging them to stay and that Mr Arslan's eyes were rolling back and he was frothing at the mouth. '*It was like he was just about to have an epileptic fit*', prior to police and AV leaving the scene [CB at page 144].
[19] Bulent Misokka and Ahmet Misokka at p. 61 and p. 65 of the CB, respectively.
[20] Mr Toygar, T 73, L 18-20.

the time and scared and intimidated by the circumstances he found himself in, and shocked from the recent death of his friend. He also said that he feared retribution from Yucel's family at the time.

Evidence at the Inquest

41. At inquest, I sought evidence from every available witness who may have observed the interaction between the police and Yucel following the intercept. They included: Mr Toygar; the two police officers who intercepted the vehicle [Senior Constables (SCs) Samuel Cameron and Daniel Ruggierio]; a police officer in the vicinity (Mark Hardy); the senior officer police sought advice and direction from prior to leaving the scene (Sergeant Justin Mercovich); and the two ambulance paramedics who attended the scene (Mark Campbell and Steve De Silva).

42. A search was conducted for other witnesses as well as any relevant CCTV footage from the area, but none could be found.[21]

43. The following details are drawn from the statements of witnesses contained in the Coronial Brief and the evidence of witnesses at the inquest.

44. At about 1.50pm on 24 February 2016, SCs Samuel Cameron and Daniel Ruggierio (in plain clothes), Melbourne Divisional Response Unit, were travelling along Racecourse Road, Flemington when they spotted Yucel's vehicle, an orange Holden. Yucel's vehicle did a U-turn, turned right into Flemington Road and then did another U-turn before turning into Boundary Road.

45. Due to the manner of driving observed by police they decided to perform an intercept. It was also an area known for drug activity. Lights and sirens were activated by police and the vehicle turned left into Sutton Street and pulled over west of Buncle Street at about 2.00pm. In Mr Toygar final account, he described Yucel as *paranoid* and that he insisted that Yucel pull over.[22]

46. SC Ruggierio approached the passenger side and SC Cameron approached the driver side.

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[21] Two other witnesses referred to in the statement of Detective Spillane at p. 110 of the CB saw the incident but did not witness any physical altercation between the parties. For completeness I asked my investigator to obtain statements from these witnesses, but Commonwealth authorities confirmed that they were no longer residing in Australia.

[22] CB at p. 405.

47. Mr Toygar was holding a white pill bottle and said that it belonged to his friend, the driver of the vehicle. He produced ID and said that he was on methadone.

48. SC Cameron asked Yucel for his driver's licence and he replied that he did not have one but provided his name, address and date of birth. Yucel said there was nothing in the car or on his person that would be of interest to police. He was advised that the vehicle would be searched. SC Cameron said Yucel was compliant and cooperative but appeared nervous.

49. Yucel took some money from a black Adidas bum bag that was around his waist which started to blow around on the bonnet of the vehicle. SC Cameron told him to put it back and remove the bum bag. He said Yucel continued to fumble around in the bag while repeatedly being asked to remove his hands from the bag and remove the bag from his body. SC Cameron then observed a small zip lock bag (the size of a 10 cent piece) with white substance in it. Yucel was observed to put the bag in his mouth, turn 180 degrees and move away from SC Cameron.

50. SC Cameron said:

> '*This happened very quickly and I was unable to stop him from doing it. He moved away from me. He turned 180 degrees and started walking away from me. He did not say anything to me and remained mute from that point on. I yelled out to him something along the lines of, 'hey spit it out, spit it out.' ...I grabbed the male from behind. I put two hands on his shoulders and was continually saying, 'Spit it out.'*
>
> *At this stage Danny came over to assist and was holding the male on the right hand side. At this stage I told Danny that the male had swallowed something. I grabbed the male underneath the mouth, the jaw, with my left hand to prevent him from swallowing. It was flat handed. I wasn't choking him. It was more to prevent him from swallowing. My left hand was under his mouth on the front of his throat and I was using minimal pressure.*
>
> *... he wasn't responding to us, he was tensed up and he had swallowed the bag. He looked set on swallowing whatever was in that bag.*
>
> *At this time I kneed him a couple of times to the upper thigh, like two or three times to break his grip on the fence.*'[23]

[23] CB at page 33-34

51. SC Ruggierio said '*Sam was on the left of the driver and I was standing on the right of the driver. He was up against a 2 foot fence and was holding the fence with both of his hands. I was able to manipulate his right arm and placed it behind his back. He was facing the fence. I didn't know whether to pull him down or keep him up right. I was thinking what would be the safest way from stopping him swallowing what was in his mouth. Sam was still cupping his jaw. I held onto the male's right arm and started yelling repeatedly to spit it out. We said it countless times. We were not wrestling with the male just holding him and trying to get him to spit out what he had swallowed. ...At one stage Sam pulled his OC spray out and said to him that if he didn't spit it out he would spray him.*'[24]

52. Yucel eventually showed them his empty mouth with his tongue out and denied swallowing anything.

53. SC Cameron estimated that the incident (from placement of the item in his mouth until suspected ingestion) took 10 to 15 seconds.[25]

54. SC Ruggierio said that Mr Toygar became quite aggressive and they handcuffed him for their safety.

55. Mr Toygar gave varying accounts of his observations which included Yucel telling him (in Turkish) that the police were trying to '*choke him*', '*bash him*' and '*hurt him*', but also that he '*didn't see exactly what was happening but ... could hear what was going on*'.[26] He also later said that Yucel told him that he had swallowed ice at that time. Mr Toygar told the family the day after the death that Yucel swallowed 8 grams of Ice.[27]

56. Police communications were contacted to arrange for an ambulance as police were concerned that Yucel had swallowed something that could be dangerous. While waiting for an ambulance to arrive, Mr Toygar and Yucel were in handcuffs seated on the footpath.

57. The police asked whether the incident had been filmed by Mr Toygar and SC Cameron grabbed the phone from the roof of Yucel's car and pushed Mr Toygar down when he got up to protest. SC Ruggierio asked if he had any footage on the phone and tried the

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[24] CB at page 41-42
[25] T. 148, L. 23
[26] CB at p. 406
[27] CB at p. 383

screen, but it didn't turn on. Mr Toygar said he hadn't filmed the scene as he didn't know how to use it. At that time the handcuffs were removed from Mr Toygar.

58. The phone was subsequently downloaded by PSC. There is no footage of the incident and no evidence that anything had been deleted. Mr Toygar later said that he pretended to video tape the incident.[28]

59. An ambulance was dispatched to a 'drug overdose' at 2.10pm, arrived at 2.25pm and were with Yucel at 2.26pm. The police officers explained that they thought Yucel had swallowed an unknown drug and they had concerns for his welfare. Ambulance paramedics told police that they would like to take him and keep him under observation. Yucel's demeanour at that time was described by the police as good and not aggressive.

60. SC Cameron said he told Yucel that he would not be in trouble for telling the paramedics what he had swallowed.

61. The paramedics were left to attend with Yucel privately and his handcuffs were removed. Mark Campbell said '*There were numerous times that I expressed my concerns to Mr Aga that if he had ingested a drug substance, its unpredictable absorption, nature of substance and packaging could pose a true life threat. Aga told me several times that it was just salt in a small bag and that he would not hesitate to come to hospital with me if he had actually ingested and swallowed a drug. I tried to get around this denial by stating that just by swallowing a small plastic bag he could develop ill health and that I was unsure of the dangers of swallowing a single greater than normal quantity of salt. I hoped this alone would encourage him to come by ambulance to hospital but it didn't. Mr Aga was at all times calm and cooperative, in fact he was very polite and friendly. ...before we departed....he was standing smoking a cigarette, having a drink of water and interacting normally with his friend at the scene.....I emphasised strongly that should he develop any symptoms of ill health to please phone for an ambulance. I asked him to please not be alone for the rest of the day at least so somebody could keep a watch over him.*'[29]

[28] CB at p. 405.
[29] CB at page 53-54.

62. In a later version of Mr Toygar evidence, he said that he told Yucel to accept the help of the paramedics but '*he didn't want their help*'[30] and that they '*tried really hard to get Yucel to go with them but Yucel was really stubborn*'.[31]

63. SC Cameron called his crew supervisor, Sergeant Justin Mercovich, regarding the matter and was told there was nothing more they could do if Yucel would not willingly go with the ambulance.[32]

64. After the ambulance left at about 2.35pm, SC Cameron again told Yucel that he should go to the hospital. The police observed him to be very '*blasé*' about the matter but happier at that point. There was nothing in his demeanour to cause the police any concern.

65. The police left at about 2.38pm and observed Yucel leave with Mr Toygar driving the vehicle. Police communications record the police saying that Yucel had been checked by ambulance paramedics, that he didn't want to go with them and that '*they've both been cut loose*'.

66. While in the car, SC Ruggierio said '*we talked about whether it was ok to grab someone around the jaw line in trying to get them to spit something out you thought was drugs. I said imagine we did nothing and he swallowed it and he died.*'[33]

67. Once they returned to the station, a Use of Force form[34] and a field contact were completed as directed by Sgt Mercovich.

68. SC Mark Hardy, who was performing surveillance, observed what occurred at the interception from a distance and partially obscured by a wire fence. He said: '*Both officers were holding him by the arms. From where I was it looked like the police members were holding the male by his upper arms. The male appeared to be struggling to get away. The male in the green singlet stood up and walked over towards the officers who had their back to him and I was concerned for their welfare. This made me pay attention as I was concerned about what could happen. At this stage I came up on the police radio and enquired about where my colleagues were in case assistance was needed.*

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[30] CB at page 407.
[31] CB at page 408.
[32] Call made at 2.23pm. CB at page 77
[33] CB at page 44-45.
[34] CB at page 299.

Within about 15 seconds one police officer turned around and gestured to the male in the green T-shirt to move away, which he did. The two police members then sat the two men back down where they were before.'[35]

69. The evidence of this witness was not inconsistent with that given by the attending members.

70. As already noted, Mr Toygar later recanted his earlier claims and as noted in the submissions of Counsel Assisting:

'his version of events..., is now largely consistent with the corroborated evidence of the police and ambulance officers. He states he heard more than he saw, and only says parts of the interaction between police and Mr Arslan were seen by him. He doesn't differ from the police accounts in regards to some significant matters. They are the circumstances in which the traffic stop occurred, the actions of police in separating the two of them when they were out of the car, the fact Mr Arslan was nervous when he was pulled over, the fact that senior constable Cameron yelled repeatedly at Mr Arslan to "Spit it out", or words to that effect, the fact that there was a physical altercation between Cameron, Ruggiero, and Mr Arslan, and that it involved Cameron putting his hand on Mr Arslan's throat. He also doesn't dispute the fact that the ambulance did attend the scene and he now says that Mr Arslan would not go in the ambulance or receive any treatment. ... the weight of the evidence therefore supports a finding that Mr Toygar's initial statements regarding the circumstances of the death, were not truthful to the extent that they differ from his current version of events.'

71. I accept the evidence of SCs Cameron and Ruggiero, which was consistent regarding their accounts of what occurred following the interception of Yucel's vehicle and once the ambulance arrived. I also accept the evidence of the police and both paramedics regarding the treatment that was offered to Yucel and his response.

Accounts after 2.35pm on 24 February 2018

72. Yucel's mother said that about 2.45pm on the day of his death, she received a call from her son who said he would not be able to pick her up as the police had 'bashed' him 'quite a bit' and he was in a bad way. He said his friend was taking him to the hospital.

[35] CB at page 49-50.

He told her that '*An argument broke out and then they bashed me. They hit me on the head, the legs and other parts of my body.*'[36]

73. Just prior to 3.00pm, Yucel also called his lawyer's office to say he was unable to attend his appointment that day as he had a medical emergency and he needed to go with someone to the hospital. He was apologetic.

74. At about 3.30pm, Yucel arrived at the RMH with Mr Toygar who was observed to be running and yelling for assistance. Yucel was noted to be grey, very diaphoretic, agitated with a white powdery substance around his lips.[37] Yucel told staff that he had taken his own medication and he felt like he was going to die. Even at the hospital he did not admit to what he had taken.

75. Mr Toygar told a hospital paramedic that Yucel had been '*drugged by police earlier that day*'.[38]

76. Yucel was taken to the Emergency Department after which he went into cardiac arrest. CPR was administered for about 40 minutes but at 4.40pm continuing CPR appeared to be futile, and he was declared deceased.

77. Yucel's attendance at hospital is captured on CCTV footage, which I was able to view as part of my investigation, including identifying whether he appeared to have any observable injuries around his chest and throat area.

78. An ice pipe and cannabis were later located in Yucel's underwear.[39]

79. After Yucel died, Mr Toygar told hospital staff that Yucel had swallowed an unknown quantity of Ice following being intercepted by police. The medical records note the following:

'*Hx from Murat is that he was with patient today – they went to pharmacy to pick up a bottle of diazepam – were driving after and were? stopped by police – during this altercation Murat reports patient swallowed unknown quantity of ICE . Murat reports approx. 30 min after this patient began to become diaphoretic ..., agitated....Murat brought patient to RMH.*'[40]

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[36] CB at p.26
[37] CB at p.57
[38] CB at p.59
[39] CB at p. 71.
[40] RM Hospital Records

80. The distance between the location of the interception and the hospital is between 1.7km and 2.3 km.

81. As to his movements after the police and ambulance left, there was approximately 57 minutes which investigating police were unable to determine Yucel's movements.

82. Mr Toygar later said that they stopped outside a chemist and he intended to get some medicine to help Yucel throw up but there were too many customers. He also said that he was trying to convince Yucel to go to the hospital during that time.

83. Yucel's mother commented that her son '*obviously didn't think that it would cost him* [his] *life, but that was his way of concealing it*'.[41]

Medical Evidence

84. Dr Martin Dutch, who was part of Yucel's treating team at the RMH, and Dr Parsons, who performed the autopsy, both gave evidence at the inquest.

85. Dr Dutch was of the view that Yucel was already exhibiting signs of a toxidrome incident (a cluster of symptoms associated with drug use) and his physiology was deranged consistent with serotonin syndrome. Further, that from the moment Yucel went into cardiac arrest his chances of survival were negligible '*...and even if there was survival, I'm very concerned about the severe impact that would have on all of the other body organ systems including the brain*'.[42]

86. Dr Parsons gave evidence that the presentation at hospital was consistent with her finding as to the cause of death.

87. Dr Dutch was of the view that Yucel's chances of survival may have improved if he had attended the hospital earlier and they had been informed of his ingestion of methamphetamine by swallowing, but to what degree he could not say.

88. It is, however, speculative as police did not have the power to take him to hospital and the hospital could not enforce treatment against his will if Yucel had not consented. It is not known whether Yucel would have accepted treatment if he had been taken to the hospital by police.

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[41] Ms Arslan, T. 464, L. 28-29.
[42] Dr Dutch, T. 317-318, T. 29 -1.

89. I note Yucel repeatedly and steadfastly refused to tell anyone other Mr Toygar what he had ingested and refused any offer of treatment prior the situation becoming a medical emergency.

Victoria Police Guidelines

90. Inspector Darryl Thompson, Officer in Charge of the Centre for Operational Safety, gave evidence on behalf of the CCP regarding the Search of Person VPM.

91. With respect to the guideline it was apparent that:

    a. The attending members utilised force against Yucel in an attempt to prevent him from swallowing the item that he placed in his mouth;

    b. The CCP agreed that the attending members used force contrary to the *guideline* but that it was unusual for a *mandatory* direction to be in a *guideline*;

    c. The attending members were unaware of the *guideline* at the time of the incident;

    d. The evidence of the attending members was that they would still act contrary to the *guideline*, even in hindsight: '*Because albeit that I'm a police officer, I still have a human element to myself and knowing that someone's possibly swallowing something that's going to harm them, I will want to try and prevent that from happening.*'[43];

    e. Inspector Thompson was not concerned that the members would conduct themselves in the same manner, even though it was contrary to the existing *guideline*;

    f. There was no expectation that the members would be familiar with the *guideline*; and

    g. There was no training regarding what a member should do in the situation faced by the members on 24 February 2016.

92. In view of this situation, Counsel Assisting called into question the utility of the guideline itself. I would agree with that assessment which is discussed further as part of my comments regarding this issue.

93. I do not, however, criticise the attending members for their actions although they were contrary to the *guideline* in circumstances where they were not aware of it.

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[43] SC Cameron, T 125, L 19-23

FINDINGS

94. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[44] Adverse comments or findings are not to be made with the benefit of hindsight but only what was known or should reasonably have been known or done at the time.

95. Having applied the applicable standard of proof to the available evidence, I find that:

a. At approximately 2.00pm on 24 February 2016, Yucel Arslan, born on 7 April 1976, was lawfully intercepted whilst driving his orange Holden (registration 1AS1FW) by Senior Constables Cameron and Ruggiero, Melbourne Divisional Response Unit in Sutton Street, North Melbourne. His passenger was Murat Toygar;

b. Yucel was carrying on his person an unknown quantity of methamphetamine in a small plastic clip-sealed bag. The quantity of methamphetamine was however substantially more than what would ordinarily be consumed as a single dose;

c. During the course of the police interception Yucel placed the small plastic clip-sealed bag containing the methamphetamine into his mouth, having taken it from his *bum bag* following requests by police to remove the *bum bag*;

d. That in an attempt to prevent Yucel from swallowing the bag containing the white powder Senior Constables Cameron and Ruggiero used force in the following manner:

- Senior Constable Cameron grabbed Yucel's shoulders with both hands from behind;
- Senior Constable Cameron placed his left hand up and under his jaw and held it in that position;
- Senior Constable Ruggiero seized Yucel's right arm, forcing his right hand to let go of the fence to which he was holding on to, and then held Yucel's right hand behind his back;

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[44] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

- Senior Constable Cameron kneed Yucel two or three times in the upper thigh; and
- Senior Constable Cameron held a canister of OC spray up near Yucel's face and threatened to spray him if he did not spit out the object (but did not deploy any OC spray);

e. The use of force exercised by Senior Constables Cameron and Ruggiero is contrary to a direction in the Victoria Police Manual *Procedures and Guidelines* – Search of Persons (the *guideline*);

f. Despite a breach of the *guideline*, I am not critical of the attending members for their actions in circumstances where they were not aware of the *guideline*, were apparently not expected to be aware of the *guideline* and received no training in its operation;

g. It is likely that Yucel by his actions intentionally swallowed a substance he knew to be methamphetamine in order to prevent police seizing the substance;

h. The ingestion of the methamphetamine by Yucel was not caused by the actions of police members or the force applied by them;

i. Mr Toygar was present during the intercept, but he did not witness the entire event as he was not in a position to do so. There is no evidence to suggest that he recorded any of the events during the intercept on his phone;

j. At approximately 2.08pm, the police called an ambulance to attend for assistance with a job described as a 'drug overdose';

k. Senior Constable Cameron sought advice from the crew supervisor, Sergeant Justin Mercovich, by a telephone conversation at 2.23pm as he had formed the view that Yucel had ingested a drug which may cause him harm. Sergeant Mercovich advised that the circumstances did not permit Yucel to be detained or taken against his will to a hospital;

l. The use of force exercised by Senior Constables Cameron and Ruggiero was recorded in an official police form at the direction of Sergeant Mercovich;

m. Ambulance paramedics arrived at 2.25pm, and by 2.26pm, Yucel was being attended to;

n. Yucel refused to go to the hospital to seek medical assistance despite police and ambulance personnel repeatedly encouraging him to do so. Yucel refused to disclose to police or paramedics the true nature of the substance he had swallowed, and at the time he was assessed, he was showing no signs of drug ingestion when in the presence of police and paramedics;

o. Senior Constables Cameron and Ruggiero did not believe that they had the power to force Yucel to go to the hospital and seek medical treatment;

p. The ambulance departed the scene of interception at approximately 2.35pm followed by the police at approximately 2.38pm;

q. Yucel made a call to his mother and solicitor at 2.45pm and 3.00pm respectively, and at that time appeared lucid and able to make decisions;

r. Yucel was taken to the Royal Melbourne Hospital at 3.32pm by Mr Toygar;

s. There is no evidence to support Mr Toygar's original claims that Yucel was yelling out for help and alleging police were trying to kill him; that Yucel was frothing at the mouth with his eyes rolling into the back of his head when paramedics attended; that someone other than the police called the ambulance; that the police sent the ambulance away and that Mr Toygar begged the paramedics not to leave;

t. Appropriate medical care was provided by Royal Melbourne Hospital to respond to Yucel's presentation, but he was unable to be assisted at the time of his arrival, at which time his chances of survival were negligible;

u. I am unable to determine with any degree of certainty whether Yucel's death could have been prevented had earlier medical treatment been sought, although it is apparent that his chances of survival would have improved;

v. It is likely that Yucel did not appreciate the danger of his actions by swallowing the methamphetamine and the potential to cause his death;

w. The haemorrhage within the muscles of the neck and fractured ribs noted by Dr Sarah Parsons was likely to be an artefact of the resuscitation attempts which occurred at the Royal Melbourne Hospital; and

x. Yucel Arslan died as a result of 'Methamphetamine Toxicity' on 24 February 2016.

COMMENTS

96. Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death.

97. The Search of Person VPM, which was a focus of my investigation, is under review by the CCP. I note that the draft version of the policy presented at the inquest did not differentiate between officers in a custodial setting and those performing operational duties in the field. In addition, I was advised that that the intention of the revised policy was that force would be permissible at an officer's discretion. It was apparent however that this change is not clearly conveyed in the words used.

98. Prior to the inquest, the CCP was unable to provide me with the rationale unpinning the current guideline (that no *force* be permitted) and similarly, Inspector Thompson was unable to refer to any rationale (such as a body of research) to support the proposed draft change (that *force* be permitted). This is entirely unsatisfactory.[45]

99. Whilst I accept that a *life threatening* situation faced the members on 24 February 2016, and the basis for the use of force was motivated by concern for Yucel's welfare, the use of force was clearly not an effective means to achieve the goal of preventing him from swallowing the drug, once he had placed it in his mouth. No evidence was provided to me to support the proposed change including that the instinctive responses of officers will produce the outcomes for all persons involved in these circumstances.

100. In my view, any policy which permits a use of force, should be informed by properly considered investigations, research and best practice regarding why (or why not) a use of force (described by Counsel Assisting as an *interference with liberty and any encroachment on such liberty*) could be justified for the person against whom the use of force is applied, that is:

what may be the best for the person who has concealed or ingested drugs in their mouth. That the change should only be permitted until matters pertaining to the welfare of the person have been properly and thoroughly considered. Including consideration

[45] I note the following remarks from Counsel for the CCP, '*I confess that it is embarrassing that I cannot stand here and say to Your Honour, this is the providence of the section, it sprung from a concern about X, Y, or Z. It's the first incarnation was this, and the second incarnation was that. That's not the first time I've made that statement, it was made in the preliminary submissions to Your Honour, back in February.*' T. p. 458, L. 17-23.

of any empirical research. Itself including but not limited to best policing practice and experience in other jurisdictions.[46]

101. Police in the field should know what to do and what is expected of them at the time they are dealing with an incident of the kind presented on 24 February 2016, without ambiguity and with the benefit of a thorough investigation of all the risks involved.

102. Any future instruction to members should provide clear guidance of the expectation of members in the field, where a person places an item, suspected to be drugs in their mouth, and the response required of members, as contemplated by Victoria Police as an organisation. Any instruction should be supported by appropriate training.

RECOMMENDATION

103. Until there is a clear policy basis for a change to the current *guideline*, and in particular, that a use of force is an effective means to prevent a person swallowing an item once placed in their mouth, it is difficult to make any specific recommendations for change which promote public health and safety.

104. In these circumstances pursuant to section 72(2) of the **Coroners Act 2008**, I make the following broad based recommendation connected with the death:

The CCP provide clear guidance to police members in the field of the expected response where a person places an item, suspected to be drugs in their mouth. This guidance should be based on research and best practice regarding why (or why not) a use of force should be justified for the person against whom the use of force is applied. Any guidance should be supported by appropriate training.

[46] Counsel Assisting Submissions T. 431, L. 11-15

105. Pursuant to section 73(1) of the **Coroners Act 2008**, I order that my findings following inquest be published on the internet.

106. I direct that a copy of this finding be provided to:

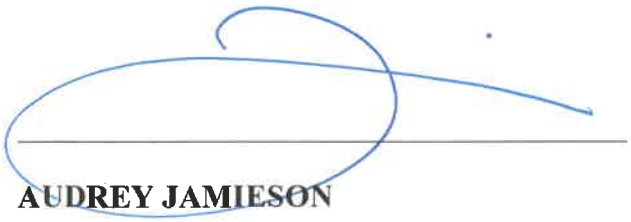
Cengiz and Fatma Arslan, mother and father of Yucel Arslan

Legal representatives for the Arslan family

The Chief Commissioner of Police

Detective Sergeant Chris Spillane, Yarra Criminal Investigation Unit, Coroner's Investigator

Signature:



AUDREY JAMIESON

Coroner

Date: 14 December 2018