IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2302

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**IAIN WEST, ACTING STATE CORONER**
Deceased:	**SEKER YILDIZ**
Date of birth:	3 February 1956
Date of death:	10 May 2015
Cause of death:	Sharp force injuries to the neck
Place of death:	22 Morwell Crescent, Dallas, Victoria

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. Mrs Seker Yildiz (**Mrs Yildiz**) was born in Turkey on 3 February 1956 and was 59 years-old at the time of her death. Mrs Yildiz married Mr Hasan Sahin in 1974 and they had two sons named Tuncay Sahin (**Tuncay**) and Olcay Sahin.[1]

2. Mrs Yildiz separated from Mr Sahin in 1983 and then re-married with Mr Dursun Yildiz (**Mr Yildiz**) in Turkey during 1985. Mr and Mrs Yildiz had two children of their relationship, a daughter and son.[2]

3. In 2008, Mrs Yildiz migrated to Australia without Mr Yildiz and lived with her son Tuncay and his family in the outer north suburbs of Melbourne. In 2009, Mr Yildiz also migrated to Australia and lived with Mrs Yildiz and her son Tuncay.[3]

4. In 2013, Mr and Mrs Yildiz rented a house together in the suburb of Dallas and then later in 2014 they moved to another property at 22 Morwell Crescent, Dallas where they resided together until the fatal incident.[4]

5. Both Mr and Mrs Yildiz had limited English language skills and had minimal contact with services in their community. Ms Yildiz attended the Blair Medical Clinic for general medical care and English language classes at Melbourne Polytechnic.

6. Mr Yildiz had contact with Centrelink and received a Carers payment from 17 May 2013 until the time of the fatal incident as he cared for Mrs Yildiz who suffered chronic foot and back issues due to her weight.[5]

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mrs Yildiz's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[6]

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[1] *Coronial Brief,* Statement of Tuncay Sahin dated 27 May 2015, 86
[2] Psychiatric report of Dr Clare McInerney dated 14 April 2016, 3; Psychiatric report of Dr Lester Walton dated 19 November 2015, 3
[3] *Coronial Brief,* Statement of Tuncay Sahin dated 27 May 2015, 87
[4] *Coronial Brief,* Statement of Tuncay Sahin dated 27 May 2015, 88
[5] Psychiatric report of Dr Clare McInerney dated 14 April 2016, 3

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[7] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[8]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[9] It is also not the coroner's role to determine criminal or civil liability arising from the death under investigation,[10] or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred*,"[11] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[12]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[13] and

    (c) 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.[14] These powers are the vehicles by which the prevention role may be advanced.

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[6] Section 4 Coroners Act 2008
[7] Section 89(4) Coroners Act 2008
[8] See Preamble and s 67, *Coroners Act 2008*
[9] *Keown v Khan* (1999) 1 VR 69
[10] Section 69 (1)
[11] Section 67(1)(c)
[12] Section 72(1)
[13] Section 67(3)

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[15] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[16] 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 that they caused or contributed to the death.

15. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

16. Upon reviewing the available evidence, Coroner Phillip Byrne completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 15 May 2015, concluding that the identity of the deceased was Seker Yildiz born 3 February 1956.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

18. On 12 May 2015, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Lynch provided a written report, dated 25 August 2015, which concluded that Mrs Yildiz died from sharp force injuries to the neck.

19. A full toxicological analysis was negative for alcohol and only detected trace amounts of paracetamol[17] (less than 5.0 mg/L).

20. Dr Lynch commented that:

    (a) External examination of the body revealed evidence of multiple sharp force injuries to the head, neck and chest area. There were at least 35 incised type injuries observed to the head and neck region and at least 10 of these extended through the skin to the subcutaneous fat and muscle tissue;

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[14] Section 72(2)
[15] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[16] (1938) 60 CLR 336
[17] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.

(b) There were two major injuries on the anterior aspect of the neck which had resulted in division of the larynx and oesophagus, divided major blood vessels and incised the anterior cervical spine;

(c) There were injuries noted to both hands on the body compromising bruise and sharp force injuries of a defence type; and

(d) The requisite degree of force required to produce the observed injuries was "*severe*" given the significant bony injury.

21. I accept the cause of death proposed by Dr Lynch.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

22. The available evidence in the coronial brief suggests that Mr Yildiz had armed himself with a small axe whilst at home at 22 Morwell Crescent, Dallas and killed Mrs Yildiz using the small axe. This occurred at some point during the evening of the 10 May 2015.

23. On 11 May 2015 at 12.45pm, Mr Yildiz attended the Broadmeadows Police Station where he confessed to the Police that he had killed Mrs Yildiz the night before and that her body was still at their home.

24. Police arrested Mr Yildiz at approximately 1.30pm and attended the residence on Morwell Crescent, Dallas at approximately 1.57pm. Police found Mrs Yildiz's body lying on her back on the lounge room floor with a blood-stained small axe in the kitchen.

25. Police observed that Mrs Yildiz's body was covered with a blue coloured blanket and the upper body was covered with a scarf. Police confirmed that Mrs Yildiz was deceased and noted major wounds to her neck and the right-hand side of her face.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal Proceedings

26. On 27 February 2017, Mr Yildiz was found liable to a Custodial Supervision Order and was committed to the custody of the Victorian Institute of Forensic Health for a nominal term of 25 years of supervision from 11 May 2015.

Family Violence

27. The unexpected, unnatural and violent death of a person is a devastating event. It is important to recognise that violence perpetrated by an intimate family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

28. For the purposes of the *Family Violence Protection Act 2008* (**the Act**), the relationship between Mr and Mrs Yildiz clearly fell within the definition of '*family member*[18] under that Act. Moreover, Mr Yildiz's actions by attacking Mrs Yildiz and causing her death constitutes 'family violence.'[19]

29. Considering Mrs Yildiz's death occurred under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[20] examine the circumstances of Mrs Yildiz's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[21]

30. Following the fatal incident, Mr Yildiz was psychologically assessed by two independent psychiatrists who formed the opinion that Mr Yildiz had *"developed the delusional belief...ultimately that his life was at risk...developed the idea that both he and his wife would be better off dead"*.[22] Dr McInerney noted that Mr Yildiz believed in the moments prior to the fatal incident that *"his stepson was outside the window with a gun aimed at him. He reports also hearing a voice at that time telling him to kill himself and his wife, in order to enter heaven"*.[23]

31. The CPU accessed the Victorian Homicide Register[24] (**VHR**) and retrieved data on similar intimate partner homicides with comparable factual backgrounds, including where an intimate partner homicide had occurred, there was no discernable history of family violence prior to the homicide and a schizophrenic, schizotypal or delusional disorder was present in the perpetrator. The cases extracted from the VHR included both open and closed cases.

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[18] Family Violence Protection Act 2008, section 9(1)(b)
[19] Family Violence Protection Act 2008, section 5(1)(a)(i)
[20] The Coroners Prevention Unit 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
[21] 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
[22] Psychiatric report of Dr Clare McInerney dated 14 April 2016, 11
[23] Psychiatric report of Dr Clare McInerney dated 14 April 2016, 11
[24] The Victorian Homicide Register is a database maintained by the Coroners Prevention Unit that contains detailed information on the offender(s) and deceased(s) in all Victorian homicides reported to the Coroner since 2000. It comprises 223 data fields which capture information such as: socio-demographic characteristics; location information; presence and nature of physical and mental illness; service contact; and in cases where there was a history of family violence, information on the presence and nature of the violence.

32. Since 2000, there have been 38 cases of intimate partner homicides where there has been no discernable history of family violence.[25] In only four of these cases, the perpetrator had some form of schizophrenia or suffered an acute psychotic delusional episode at the time of the fatal incident.[26]

33. The available evidence suggests that there was no discernible history of family violence between Mr and Mrs Yildiz. The only services that had contact with both parties proximate to the fatal incident were Mrs Yildiz's general practitioner at Blair Medical Centre and Melbourne Polytechnic, both of whom provided statements to the Court indicating that no incidents or concerns of family violence were reported to them.[27]

34. Whilst the death of Mrs Yildiz occurred within a family violence context, Mr Yildiz appears to have been driven at the time of the fatal incident by his undiagnosed mental illness.[28]

35. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

36. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Seker Yildiz, born 3 February 1956;

    b) the death occurred on 10 May 2015 at 22 Morwell Crescent, Dallas, Victoria, from sharp force injuries to the neck; and

    c) the death occurred in the circumstances described above.

37. I convey my sincerest sympathy to Mrs Yildiz's family.

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[25] COR 2000 0272; COR 2000 0456; COR 2000 1886; COR 2000 2180; COR 2000 3534; COR 2001 0497; COR 2001 2575; COR 2001 3882; COR 2002 0301; COR 2002 0361; COR 2002 1183; COR 2002 2384; COR 2003 0743; COR 2003 1273; COR 2003 1855; COR 2003 2563; COR 2003 2820; COR 2004 2341; COR 2004 2427; COR 2004 2782; COR 2004 4437; COR 2005 0173; COR 2005 1444; COR 2005 2768; COR 2006 1838; COR 2006 1863; COR 2006 2212; COR 2006 2328; COR 2007 2016; COR 2007 3505; COR 2008 2804; COR 2008 5577; COR 2010 1224; COR 2011 3580; COR 2013 5843; COR 2015 0145; COR 2016 2320; COR 2018 3620; COR 2015 3627

[26] COR 2015 3627; COR 20013882; COR 2003 2820; COR 2004 2427; COR 2006 2212

[27] Statement from Melbourne Polytechnic dated 16 October 2018; Statement from Blair Medical Clinic dated 4 December 2018

[28] Psychiatric report of Dr Clare McInerney dated 14 April 2016, 9-12, 21; Psychiatric report of Dr Lester Walton dated 19 November 2015, 3-4; *Coronial Brief,* Statement of Constable Ryan O'Donnell dated 11 May 2015, 49-50; *Coronial Brief,* Statement of Hakki Behaettin dated 18 June 2015, 57

38. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

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

    a) Tuncay Sahin, senior next of kin; and

    b) Detective Leading Senior Constable Sean Patrick Toohey, Victoria Police, Coroner's Investigator.

Signature:

IAIN WEST
ACTING STATE CORONER
Date: 15 February 2019