IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3497

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Hizir Ferman
Delivered On:	5 July 2019
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, Victoria
Hearing Dates:	18 to 22 March 2019
Findings Of:	Coroner Rosemary Carlin
Representation:	Counsel Assisting: Mr Daniel Nguyen Family: Mr David Purcell SC with Stephanie Wallace instructed by Robinson Gill Lawyers Corrections Victoria: Mr John Langmead QC with Marion Isobel instructed by Victorian Government Solicitor's Office Correct Care: Ms Erin Gardner instructed by Meridian Lawyers

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INTRODUCTION

17. On 28 July 2016, Hizir Ferman, who was a prisoner in a minimum security prison, died after being forcibly removed from his room by prison officers. He was 35 years old.

18. Hizir, as his family wish him to be known, was no stranger to prison having spent considerable periods of his adult life incarcerated for various offences involving violence, firearms and drugs. At the date of his death, he was serving the balance of a six-year five-month sentence, having earlier had a period of parole cancelled and re-parole denied by the Adult Parole Board. This meant that upon his release, which was due to occur on 2 February 2017, he would not be on parole.

19. To ameliorate the risks arising from the fact Hizir would be released into the community without any form of supervision, it was decided to transfer him from the maximum security Barwon Prison to the restricted [1] minimum security facility of Middleton Annex (**Middleton**), near Castlemaine. There, he would live in shared cottage-style accommodation, be responsible for his own meal preparation and household duties and, after appropriate orientation, participate in various programs, all with the aim of rehabilitating him and preparing him for life in the community.[2]

20. So it was that Hizir arrived at Middleton on 20 July 2016. He was placed in a cottage with five other prisoners and initially seemed to be doing well. However, his behaviour soon deteriorated. He began pacing the cottage at night and boiling the kettle continuously, causing his cottage inmates to become fearful. One of them described Hizir at this time as *'real moody and almost arrogant'*. He surmised that he was on *'ice'*.

21. Hizir also failed to engage in the orientation process, meaning he was largely idle in the eight days before his death. On 26 July 2016, his assigned case manager also formed the view that Hizir was likely drug affected, with the result that Hizir was compelled to provide a urine sample on that day.

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[1] *'Restricted'* meaning that unlike some other open camp or farm type minimum security prisons, the facility had a secure perimeter fencing.

[2] The Office of Correctional Services Review concluded in relation to the transfer that *'the exercise of professional judgment was sound and within the prescribed guidelines for placement and classification decisions'*. However, I acknowledge that Hizir's family remain concerned at the decision, which was not within the scope of the inquest into Hizir's death.

22. In the morning of 28 July 2016 two prison officers were checking duress alarms fitted in Middleton's six prisoner accommodation blocks. When they reached Hizir's block, one of them knocked on Hizir's door, then entered. Hizir was underneath his doona making no attempt to hide the fact he was smoking, which was against prison rules. The prison officer retrieved the second officer and together they asked him to remove the doona.

23. Without warning Hizir began assaulting one and then the other prison officer, starting in his room and moving to the cottage common area. He repeatedly punched them to the hands, head and face until one officer lay bleeding on the ground underneath him. At that stage the other prison officer directed Hizir to return to his room, which he did.

24. Prison personnel quickly descended on the scene. As there was no ability to lock the door to Hizir's room from the outside, the cottage kitchen table was used to barricade him inside his room.

25. Emergency response protocols were instituted and the prison commenced a lockdown. The victims of Hizir's aggression were conveyed to hospital, one with a broken nose, broken teeth and a laceration to the forehead requiring stitches; the other with soft tissue injuries to the scalp.

26. Over the next few hours two other prison officers and one senior manager attempted to communicate with Hizir through his door. Although the officers knew Hizir and believed they had a good rapport with him, they were either told to *'fuck off'* or not answered at all. The manager had no better luck.

27. It was decided to transfer Hizir back to Barwon Prison as soon as possible. There was some urgency because the normal operations of the prison could not resume until the situation was controlled and the crime scene processed, and further it was not possible to see inside Hizir's room to determine his welfare.

28. A team of specialist prison officers from the Security and Emergency Services Group (**SESG**) were dispatched to Middleton from various locations around the State to effect the removal of Hizir from his room. A plan was devised which involved deploying CS gas (a type of tear gas) into the room with the aim of rendering Hizir compliant. Nursing staff were to be on standby.

29. Shortly prior to 3.00pm members of the SESG team assembled outside the room door carrying batons and wearing helmets, protective clothing and breathing apparatus. Without warning, at 3.01pm, they opened the door slightly and sprayed two short bursts of CS gas into the room, closing the door again. Various instructions were then yelled at Hizir until, less than a minute later, five SESG officers rushed into the room, one of them carrying a shield.

30. A struggle ensued behind the closed door whilst the officers sought to handcuff Hizir, who they described as having super-human strength. Ultimately, they managed to overpower Hizir who was dragged by his legs, face down with his hands cuffed behind him and the shield on top of him, from his room to the cottage bathroom so that he could be *'decontaminated'* from the gas exposure.

31. In the bathroom officers continued to hold the struggling Hizir face-down with his hands cuffed behind him and the shield on top of him, whilst they showered him, cut his clothing away and applied Velcro restraints to his legs. Throughout the process the officers applied varying amounts of downward force to the shield. Whilst removing his clothes they realised he had defaecated.

32. Just as he was about to be taken outside, Hizir vomited. At that point two prison officers were kneeling on the shield on top of him and were told to *'hop off'*. Hizir, who was completely limp and unresponsive, was rolled over to his side before being carried outside and placed in the recovery position. Soon after, attending nurses cleared his mouth, applied an oxygen mask and measured his pulse and respiration.

33. Whilst this was happening Hizir occasionally jolted his head or moved his legs. He remained handcuffed and shackled (the Velcro was replaced by metal) and surrounded by prison officers who held on to him. After a few minutes he began to groan rhythmically. The groaning reached a crescendo and then faded away. Not once did he speak or make any sensible utterance.

34. After he had been outside for 15 minutes the nurses approved Hizir being sat up so that he could be prepared for transport. They removed his mask and stood back whilst several prison officers manoeuvred Hizir into an upright position, finished securing a restraint belt to his torso and cuffed his hands to the front instead of the back. Throughout this process, Hizir's head hung limply to his chest.

35. When Hizir was laid back down the nurses resumed providing oxygen, but it was soon realised that he had no pulse. They commenced cardio pulmonary resuscitation (**CPR**) and use of a defibrillator, but as no shockable heart rhythm was ever detected, a shock was never administered. An ambulance was called and attending paramedics took over, but they could not revive Hizir either. At 4.25pm Hizir was declared deceased.

THE CORONIAL INVESTIGATION

36. Hizir's death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) both because he was in custody at the time and further, his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.

Explanation of coronial investigations

37. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and, with some exceptions, surrounding circumstances.[3] Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

38. Under the Act, coroners have another important function and that is, where possible, to help prevent deaths and promote public health and safety by making comments or recommendations about any matter connected to the death they are investigating.

39. When a coroner examines the circumstances in which a person died, this is not to lay blame or attribute legal or moral responsibility to any individual or institution.[4] Rather, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

40. Coroners do not make determinations of guilt or negligence; they are the province of other jurisdictions. Indeed, the Act specifically prohibits coroners from making a finding or comment that a person has, or may have, committed an offence. A coroner should set out relevant facts, leaving others to draw their own conclusions from the facts.

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[3] The exceptions being cases where an inquest was not held, the deceased was not in state care and there is no public interest in making findings as to circumstances: section 67 of the Act.

[4] Because the exercise is not to lay blame, I have not identified a number of individuals involved in this case.

41. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or mere background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

42. When assessing the actions of a professional person regard must be had to the prevailing standards of his or her profession or specialty. For example, it would be unfair and unreasonable to expect a nurse to have the same skills and knowledge as an emergency-medicine physician.

43. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately. This is particularly important in this case because there might otherwise have been a temptation to impermissibly reason that because Hizir died the operation was necessarily flawed. I am conscious of the need to judge the actions of all involved prospectively, having regard to the information then known to them.

44. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities with the *Briginshaw* qualification.[5] A finding that a person has caused or contributed to a death should only be made after taking into account the possible damaging effect of such a finding upon the character and reputation of that person and only if the evidence provides a comfortable level of satisfaction as to the finding.

45. The *Briginshaw* qualification is relevant in this case as the professional conduct of prison officers and prison nurses is under scrutiny. Given the serious consequences for those

[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially 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…'.

individuals of an adverse finding or comment by a coroner, such comment or finding should not be made without clear and cogent evidence.[6]

The position of persons in custody or care

46. Hizir's sister, Belle Ferman, said of her brother's death:

> *When he went to prison we had a certain sense of relief that he would do his time and the State would ensure his safety was not compromised. Nothing could have prepared us for the news that the last male member of our family would be taken from us at the hands of the same people who were employed to look after his safety.*[7]

47. All deaths of persons deemed to be in the care or custody of the State are reportable no matter what their cause. Further, whereas a coroner usually has a discretion as to whether to hold an inquest into a reportable death, a coroner is obliged to hold an inquest into the death of a person in custody or care unless the death was due to natural causes.[8] Hizir's death was clearly not from natural causes and so an inquest was mandatory.

48. The reason for this different treatment is to ensure independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or because the State has deprived them of their liberty, or for some other reason.

49. Without detracting from the impact and seriousness of Hizir's inexplicable violent assault on the two prison officers earlier in the day, neither that assault nor his significant criminal history, absolved the State from its duty of care towards him. Nor did they lessen the standard of care to be delivered, that being a reasonable standard in the circumstances. If anything, these matters give rise to the need for greater scrutiny of the conduct of those involved in his room-extraction and aftercare.

50. Prisoner deaths are not only investigated by coroners, they are routinely reviewed by an arm of government called the Justice Assurance and Review Office or **JARO** (formerly known

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[6] *Anderson v Blashki* [1993] 2 VR 89 at 95 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 74.
[7] Statement of Belle Ferman dated 21 January 2019.
[8] In general terms the other situations in which inquests must be held are suspected homicides (unless charges have been laid) and where the identity of the deceased is unknown: section 52 of the Act.

as the Office of Correctional Services Review or **OCSR)**. JARO is a part of the Department of Justice and Community Safety (**DJCS**) and reports to the Secretary of that Department, as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders.[9]

51. In preparing its report for the Secretary, JARO invariably has regard to a separate report prepared by another business unit of DJCS, namely Justice Health. Justice Health has responsibility for the delivery of health services (including drug and alcohol services) to Victoria's prisoners. It contracts out the delivery of primary health care in Victoria's 14 public prisons, including Middleton, to Correct Care Australasia Pty Ltd (**Correct Care**).

52. Whilst coroners are, as a matter of course, provided with JARO/OCSR and Justice Health reports, it is important to note that we remain independent investigators and form our own views of the matters in issue.

History of this coronial investigation

53. I was coroner on duty when Hizir's death was reported (28 July 2016) and decided, given the circumstances, to attend Middleton to view the scene. I was accompanied by Sergeant Sharon Wade from the Police Coronial Support Unit and met forensic pathologist Dr Matthew Lynch and investigating police, including homicide detectives, at the prison. We were given an overview of the circumstances by Middleton senior staff and shown various aspects of the prison, including Hizir's cottage and surrounds.

54. The coronial investigation was taken over by the State Coroner in August 2016. Her Honour held Directions Hearings on 20 October 2016, 6 September 2017 and 15 May 2018. Thereafter, the investigation was assigned to another coroner (who, prior to his appointment as coroner, was counsel assisting Her Honour) who, upon application by Hizir's family, recused himself in December 2018. I resumed control of the matter in January 2019 by which time the coronial brief had been compiled and distributed to the parties and the matter had been listed for inquest in March 2019. The witness list and proposed scope of the inquest had also been settled and notified to the parties.

[9] Section 7 of the *Corrections Act 1986.*

55. Anxious not to do anything which might derail the inquest and therefore cause further delay, I adopted the scope of the inquest, albeit with some refinement, and added a single witness to the witness list, namely one of the attending nurses. The final scope was as follows:

(a) the mechanism and cause of death of Hizir and the respective contributions of CS gas and physical restraint, if any;

(b) the appropriateness of the plan to '*extract*' Hizir from his cell using force and CS Gas given the particular configuration and confines of the cell;

(c) the amount of force used by the prison officers during the execution of the plan;

(d) the adequacy of the response of the attending nurses; and

(e) the training of prison officers and nurses to recognise an acutely unwell person in the circumstances of Hizir.

55. The inquest proceeded on 18 to 22 March 2019 with Hizir's family, Corrections Victoria and Correct Care all represented. The following witnesses gave evidence:[10]

(a) Associate Professor Louis Irving, Director of Respiratory and Sleep Medicine at the Royal Melbourne Hospital (**Dr Irving**);

(b) Dr Mathew Lynch, senior forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) (**Dr Lynch**);

(c) Registered nurse White who administered most of the initial care to Hizir (**nurse White**[11]);

(d) Christine Fuller, Chief Nursing Officer for Correct Care;

(e) the attending SESG dog handler (**the dog handler**);

(f) the SESG extraction team supervisor (**the Supervisor**);

[10] In recognition of the difficult environment in which prison officers work I have preserved the anonymity of those directly involved in Hizir's room extraction.

[11] I have used a pseudonym as she works in the prison environment and it would be unfair to identify her and not the other two nurses, merely because she was the only one to give evidence.

(g) the SESG Operations Manager (**the SESG Operations Manager**);

(h) Operator 113, a member of the Victoria Police Special Operations Group with specialist qualifications and experience in chemical munitions, including CS gas, and experience in cell extraction (**Operator 113**);

(i) Bruce Polkinghorne, Acting Assistant Commissioner, Security and Intelligence Division (**Mr Polkinghorne**); and

(j) Detective Senior Sergeant Stephen McIntyre, then at the Homicide Squad, who was the main coronial investigator (**DSS McIntyre**).

56. Written submissions were filed by all parties on or before 26 April 2019. Correct Care filed further submissions and documents by way of reply and elaboration on 3 and 27 May 2019.

Sources of evidence

57. This finding is based on the coronial brief,[12] which included a redacted version of the OCSR report, the oral evidence of all witnesses who testified at inquest, any documents tendered at inquest or submitted for my consideration afterwards and the final submissions of Counsel who appeared for the parties.[13]

58. It is unnecessary to summarise all this material, which will remain on the Court file.[14] I will refer only to so much of it as is relevant or necessary for narrative clarity.

CAUSE OF DEATH

59. The circumstances of Hizir's death begs the question of whether the CS gas and/or the manner in which he was restrained by the SESG officers contributed. This requires an explanation of the nature of CS gas and the phenomenon of restraint asphyxia.

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[12] Version 6. Referred to in these footnotes as '*CB*'.
[13] Guidelines, policy and training documents were submitted afterwards by Corrections Victoria and Correct Care.
[14] From the commencement of the Act, that is, 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

The use and effects of CS gas

60. VIFM's Chief Toxicologist, Dr Dimitri Gerostamoulos, explained the use and effects of CS gas as follows.

> *Chlorobenzylidene malononitrile (CS) is a tear gas used by authorities to subdue individuals or large groups of people. CS reacts with the moisture on the mucous membranes and irritates the eyes, nose, mouth, skin, and respiratory tract in the presence of moisture....*
>
> *The mechanism of action of CS in humans is not fully understood. There are few deaths reported resulting from use of CS and it is largely considered a non-lethal means of subduing individuals. The risk of toxicity increases with higher exposure doses and prolonged exposure durations.*
>
> *The lethal effect of CS gas by inhalation is due to lung damage, which leads to asphyxia and circulatory failure.*[15]
>
> *On exposure to CS humans manifest immediate signs and symptoms that disappear in minutes on cessation of exposure.*[16]

61. Dr Lynch agreed that CS gas is generally considered safe, but said it is recognised that individuals exposed to high concentrations may possibly suffer serious complications or die. He noted that reports of deaths related to the use of tear gas although uncommon, do exist in the scientific literature. He explained: *'[the] substance has the capacity to induce bronchospasm and respiratory compromise, particularly in susceptible individuals and this risk appears, not unsurprisingly, to increase with higher concentrations of the inspired chemical, particularly in confined and poorly ventilated spaces'*.[17]

62. Dr Irving also reviewed relevant literature. He concluded that there was limited evidence about the use and safety of CS gas in confined spaces. He noted that deaths had been reported following its use in prisons and enclosed and poorly ventilated spaces, albeit in those cases other factors, such as pre-existing respiratory disease, were present and may have contributed.[18] He referred to a recent study which expressed concern about its long term

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[15] Riot control agents: pharmacology, toxicology, biochemistry and chemistry. Eugene J. Olajos, Journal of Applied Toxicology, 2001, Vol. 21(5), p. 355-391.
[16] VIFM Toxicology Report (undated), CB p34.
[17] Autopsy Report dated 21 March 2017, CB p 13.
[18] Tear Gas: an epidemiological and mechanistic reassessment. C Rothenburg, S Achanta, E Svendsen, S-E Jordt, Ann NY Acad Sci, 2016 1378, 96-107.

safety[19] and another recent study which highlighted the possibility of more serious acute respiratory effects from exposure in a confined space or at high concentration, including laryngospasm, bronchospasm, pulmonary haemorrhage, chemical pneumonitis, pulmonary oedema, asphyxia, heart failure and death.[20]

63. The manufacturer of CS gas publishes a Safety Data Sheet for the use of CS gas in Australia and New Zealand. This document contains a number of *'Hazard statements'* and *'Precautionary statements'* including, relevantly, that CS gas is *'Toxic if inhaled'*; *'May cause allergy or asthma symptoms or breathing difficulties if inhaled'*; *'May cause respiratory irritation'*; and *'Use only outdoors or in a well ventilated area'*.[21]

The phenomenon of restraint asphyxia

64. In a 2006 article forensic pathologist Professor Noel Woodford (now Director of VIFM) said:

> *The concept of restraint asphyxia as a distinct pathologic entity has not met with universal agreement, but sudden death occurring in the setting of restraint is a scenario not uncommonly encountered by most, if not all, forensic pathologists. Typically a restrained individual is extremely agitated and violent, and a number of people are required to secure the individual in a position such that the risk of violence to bystanders and the individual is minimized or so that some type of restraining device can be applied. The individual is usually held in the prone position with pressure applied to the back of the arms, shoulders or torso.*[22]

65. After noting the difficulty in identifying the actual mechanism of death in such cases Professor Woodford said:

> *Despite the conflicting physiologic studies, intuition suggests it may not be unreasonable to postulate that extreme, prolonged physical exertion could result in a degree of hypoxemia, lactic acidosis, catecholamine surge, and hyperkalemia to which restricted ventilation is added, resulting in a*

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[19] Ibid.
[20] Riot control agents: the tear gases CN, CS and OC – a medical review. L Schep, R Slauhter, D McBride, JR Army Corps, 2015, 161: 94-99.
[21] Version as at 3 August 2016, CB p 1287-1300.
[22] Injuries and death resulting from restraint. N.W.F. Woodford in Essentials of Autopsy Practice (Springer, 2006) 181.

potentially lethal combination alone or in association with other factors such as cardiovascular disease.[23]

66. An online training module for SESG officers contains very useful information about the phenomenon, which it calls *'positional'* asphyxia and defines as *'when the position of a person's body interferes with respiration, resulting in death by asphyxia or suffocation'.*[24] It lists various potential risk factors, including:

- respiratory muscle fatigue, from fighting or fleeing, resulting in hypoxia (deficiency of oxygen);
- restricted respiration by being held prone, especially if there is downward pressure on the person's back and especially if multiple officers are involved by *'attempt[ing] to sit on, or hold down the subject'*; and
- the use of OC spray.

67. The module warns that the risk is increased if the subject is held in the prone position for a lengthy period of time and explains that *'the process is insidious, and a person might not exhibit any clear symptoms before they simply stop breathing'*. The module also elucidates the *'conflict spiral'* by which, after a struggle, the person being held prone becomes increasingly distressed. Desperate to escape the discomfort and to breathe freely the person fights harder, leading to even more force from those restraining him who perceive a continued threat of harm. The module describes the conclusion to the conflict spiral thus:

While in a prone position the individual will continue to expend what energy they have left, just trying to breathe. Rapidly, the individual becomes lethally exhausted.

Hizir's medical history

68. As Hizir had spent much of his adult life as an inmate of correctional facilities his medical history was well documented. Apart from complaining of chest pain in early 2012, at which time he had an impending court attendance, his complaints were minor. On that occasion

[23] Ibid.
[24] Exhibit M. Critical Incident and Safety Management Tactical Response Training Manual 1, Module 3: Positional Asphyxia Version 2.1 September 2015.

Hizir was referred from Barwon Prison to the Geelong Hospital for investigation of the pain, which resolved by itself.

69. On 20 July 2016 Hizir signed a form in relation to his transfer to Middleton which indicated he had no known allergies or significant medical or psychiatric illness. At the date of his death, he was not on any prescribed medication.

Toxicology

70. Toxicological analysis of pre and post-mortem specimens taken from Hizir was reflective of remote use of drugs only. That is, methylamphetamine and amphetamine were detected in Hizir's beard hair, but all other specimens, including the urine sample obtained two days prior to his death, were negative for common drugs and alcohol.[25] No components of CS gas were detected but Dr Gerostamoulos explained that this was not surprising as cyanide and thiocyanate are formed in very low concentrations in circumstances of acute exposure to CS gas.

Medical examinations

71. On 29 July 2016, a full body CT scan of Hizir revealed fractured right sided 9th and 10th ribs posterolaterally and no pneumothorax or head injury.

72. The same day Dr Lynch externally examined and then performed an autopsy on Hizir's body. External inspection revealed multiple bruises and abrasions involving face, scalp, chest, abdomen and upper and lower limbs, all having the appearance of recent injuries with no significant subcutaneous bleeding. UV torchlight showed luminescent material on Hizir's face, chest, abdomen, back, upper and lower limbs and external genitalia, finely distributed, in keeping with the history of exposure to CS spray.

73. Autopsy confirmed the presence of the fractured ribs and external injuries described above, but additionally revealed:

    (a) pulmonary oedema;

    (b) gastric contents within airways;

[25] Some of the newer psychoactive substances (so-called "NPS") will not necessarily be detected by current toxicological testing.

(c) bridging of the proximal left anterior descending coronary artery;

(d) patchy subarachnoid haemorrhage and small volume intraventricular haemorrhage;

(e) probe patent foramen ovale.

74. In relation to the right rib fractures Dr Lynch found no obvious overlying cutaneous (skin) manifestation, no significant underlying haemorrhage and no pneumothorax. He described them as being *'down low, sort of on the side but moving around towards the back'*.[26] He considered they were reflective of non-specific blunt force trauma, but their distribution was not typical of rib fractures sustained during CPR which are usually higher up and more to the front. He did not, however, exclude CPR as the cause.

75. Subsequent to the autopsy Dr Lynch viewed video footage of Hizir's extraction and aftercare (**the video**).[27] The video was taken by SESG officers and depicted, to varying extents, the events in Hizir's room, the bathroom and outside. He also had regard to Justice Health records for Hizir, a police summary of the events, the CT scan and toxicology results.

76. Dr Lynch provided a report dated 21 March 2017 indicating that the post mortem examinations did not reveal the precise cause and mechanism of Hizir's death. However, he noted that his death occurred in the setting of agitation, exposure to CS gas and restraint. He postulated a *'possible'* mechanism of death to be cardiac arrhythmia occurring in the setting of his clearly agitated state following inhalation of CS gas and in the context of a pre-existing *'potentially'* significant coronary artery anomaly.[28]

77. In relation to the bridging of the left anterior descending coronary artery, Dr Lynch described it as a not uncommon autopsy finding, usually considered benign. He had, if ever, rarely ascribed a cause of death to it, and not in the last 20 years – even in the absence of any other cause. However, he acknowledged that according to the literature *'[it] can precipitate myocardial ischaemia and sudden death, especially in the setting of strenuous exercise, arrhythmias, acute coronary syndromes and coronary spasm'*. In relation to Hizir's death he could only say that it was potentially significant.

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[26] T136.25.
[27] Labelled Disc B.
[28] Italics in the original report.

78. The heavy lungs (oedematous and haemorrhagic) and the evidence of aspiration of gastric contents were non-specific features which Dr Lynch considered to be agonal phenomena,[29] although he could not exclude the possibility that the inhaled CS gas contributed. He gave evidence that heavy lungs was an almost invariable finding in autopsies and aspiration of gastric contents was also very common and not necessarily causative.

79. Similarly, neuropathological examination revealed that the subarachnoid and intraventricular haemorrhages were more consistent with agonal congestion and prolonged resuscitation than trauma. There was no neuropathological evidence of traumatic brain injury contributing to death.

80. Dr Lynch believed it possible that the CS gas contributed to Hizir's death either by causing some bronchospasm and consequent reduction in air entry (which might have happened without apparent wheezing or stridor) or by the development of pulmonary oedema (fluid in the lungs) *'lots of minutes later'*.[30] If Hizir was able to violently resist restraint despite the gas, he thought an acute response was less likely but a delayed reaction was still possible.

81. Dr Lynch considered the possible causes of death of excited delirium neuroleptic malignant syndrome and serotonin syndrome but dismissed them as vital features were missing.

82. Ultimately, Dr Lynch gave the cause of death as *'Cardiorespiratory arrest in the setting of acute agitation and physical and chemical restraint'*. He suggested seeking an opinion from a respiratory physician as to the possible contribution of CS gas to Hizir's demise.

Dr Irving

83. In the event Dr Irving was the respiratory physician from whom such an opinion was sought. He was provided, inter alia, with Dr Lynch's report, the Justice Health records, a number of witness statements and the video. He submitted a report on 30 October 2017 and a clarifying letter on 3 April 2018.

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[29] Pertaining to the period immediately preceding death – usually a matter of minutes but occasionally up to several hours.
[30] T145.16.

84. Dr Irving had no prior experience of CS gas but reviewed relevant literature and, having been specifically asked to interpret Hizir's respiratory symptoms from the video, carefully examined the video.[31]

85. Initially Dr Irving believed that some unusual wheezing and coughing sounds on the video came from Hizir. Once it became apparent that these sounds emanated from the SESG dog and not Hizir, Dr Irving indicated that the only evidence he could discern of the effect of the CS gas on Hizir's respiratory system was his excess mucous secretions, they being a sign of acute irritation.[32] He did not hear any sounds of respiratory distress such as wheezing, stridor or irregularity and noted that at various stages Hizir made noises suggestive of an ability to breathe normally.

86. Ultimately, Dr Irving was satisfied that the CS gas was not a major cause of Hizir's death. Nevertheless, having regard to the concerns in the literature about its use in confined spaces, he could not exclude it as contributing to the death in some way.[33]

87. What Dr Irving did consider to be the major (*'most significant'*) cause of Hizir's death was the method of restraint, with the terminal event likely to be his being sat upright when outside. He explained that Hizir would have had an increased need for ventilation because of his struggle with the prison officers and possibly the adverse effects of the CS gas. The fact he was held prone in the bathroom with his hands behind his back and a shield on top of him, sometimes with additional weight, prevented him from meeting this increased need (a state of hypoventilation), which ultimately led to a reduction in conscious level.[34]

88. Dr Irving pointed to two instances on the video where at least some force was applied to the shield, namely an officer standing on the edge of the shield soon after Hizir was in the bathroom (07:07 to 07:51) and *'at least one officer'*[35] alighting from the shield after Hizir vomited. He believed it was likely that '*Mr Ferman was progressively suffocated whilst being restrained, initially in his room and then in the shower room. At the time he was*

[31] Letter of instruction dated 13 September 2017.
[32] Excess mucous secretions were apparent at various stages on the video, namely: his room, whilst being dragged from the shower room, and after being placed in the recovery position outside.
[33] Dr Irving agreed with counsel for Corrections Victoria that given the number of unknown variables he could not quantify the concentration and duration of Hizir's exposure to the gas to compare it to cases in the literature.
[34] Dr Irving explained that hypoventilation causes a low blood oxygen level (hypoxaemia) and an elevated blood carbon dioxide level (hypercapnoea) and acidosis. Any worsening of gas exchange exacerbates this. Both hyperaemia and hypercapnoea will cause a reduction in conscious level.
[35] T83.

removed from the shower room he appears on [the video] to be unconscious and unresponsive'.[36]

89. Dr Irving explained that the problem with being held prone is that it compromises the ability to breathe because the respiratory muscles are hindered. Having one's hands secured behind one's back exacerbates the problem. Any additional pressure on the chest would further compromise the breathing as would fractured ribs and possibly excess mucous secretions.

90. Dr Irving believed the act of sitting Hizir upright would have further compromised his probably already critically compromised cardiac and respiratory functions. His flaccidity (which may or may not have existed prior to him being sat up) was probably due to inadequate cerebral perfusion causing cerebral hypoxia. The act of raising his head above his heart imposed a need for his circulatory system to overcome a gravitational effect to maintain cerebral perfusion and precipitated his cardiac arrest.

91. Dr Irving explained that moving from the lying to the sitting position is not normally a problem in healthy people as '*there is sufficient blood pressure and reflex mechanisms to prevent inadequate cerebral perfusion ... The fact that this did not occur with Mr Ferman implies that his blood pressure and heart rate responses were already abnormal or compromised before being put in the sitting position.*'[37] In evidence he estimated that Hizir had been declining over a period of ten minutes.

92. Dr Irving's evidence as to the significance of the restraint was challenged on the basis that he relied too much on his interpretation of the video, an interpretation which was possibly flawed. Dr Irving agreed that his opinion was based on the video. He said *'I wasn't even thinking about it until I saw the video and then it occurred to me, well, this is clearly important.*'[38] He conceded that the video did not provide all the information, such as the degree and duration of pressure and when Hizir's ribs were broken, but was confident the video provided *'enough of a picture'* to form his conclusions.[39]

93. It was also suggested that Dr Irving may have been finding a cause of death *'at any cost'*, and that he was choosing the most likely cause out of a number of possible causes, when

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[36] Report dated 30 October 2017.
[37] Letter from Dr Irving dated 3 April 2018.
[38] T63. The letter of instruction from the Court focussed more on the CS gas.
[39] T118.27 and see also the discussion at T101.

none might be likely in an absolute sense. Dr Irving said *'I'm wanting to explain why Mr Ferman died and so I'm being absolute not relative, and in my view the most likely explanation [for] it was hypoventilation whilst he was being restrained.'*[40] There was considerable debate about the meaning of terms used by Dr Irving (a debate which originated in correspondence from the court[41] and continued into submissions), but the upshot was that Dr Irving did not think there was any other explanation for Hizir's demise. In the absence of any other obvious cause, Dr Irving maintained his *'firm belief'* that hypoventilation whilst being restrained was the *'the most likely cause'*[42] of Hizir's death.

Additional comments of Dr Lynch

94. Dr Lynch gave evidence after observing Dr Irving's evidence and having read his report and letter. He indicated that in general he agreed with Dr Irving and deferred to *'some of his more nuanced clinical observations'*[43] such as the concept of hypoventilation, which he found a very useful explanation of what can occur in situations when an individual does not breathe enough to meet his or her needs, even though that individual does not appear *'to an untrained observer'* to have significantly impaired breathing.[44] He identified three reasons for Hizir's hypoventilation: inhalation of a noxious substance; being in a position which restricted his chest movement, whether or not there was any external pressure; and agitation and exhaustion.

95. After listening to Dr Irving, Dr Lynch agreed that the postulated possible mechanism of death in his report (paragraph 76 above) should more properly be expressed as cardiac arrhythmia occurring in the setting of his clearly agitated state following inhalation of CS gas and in the context of a pre-existing *'potentially'* significant coronary artery anomaly *'with a contribution by hypoventilation and position'*.[45]

96. However, Dr Lynch indicated that he did not wish to change his formulation of the cause of death as he thought that cases like this were *'the paradigm of the narrative cause of death for a forensic pathologist because there are invariably so many different components'* which

[40] T87.13. He agreed this phenomenon could be characterised as restraint or positional asphyxia.
[41] Letter from Senior Legal Counsel to Dr Irving dated 27 November 2017.
[42] T94.13.
[43] T145.24.
[44] T146.5
[45] T154.28. I note that the transcript almost invariably records hyperventilation instead of hypoventilation.

are impossible to tease out in terms of respective contributions.[46] He believed all three factors (CS gas exposure; agitation and likely exhaustion; and restraint in the prone or side position with his arms behind his back) contributed to Hizir's death but he could not say by how much.[47] As to Hizir's heart abnormality he said *'I don't think the answer to what happened to Mr Ferman lies in his pre-existing medical condition, which is minor'*.[48]

Conclusions

97. Whilst acknowledging that Dr Irving appeared to have studied the video *'much more closely than [he] did'*,[49] Dr Lynch expressed some disquiet about drawing conclusions, particularly about degree of force, from the video.

98. I agree that caution is required in interpreting the video. However, far from undermining his evidence, in my view Dr Irving's careful analysis of the video indicates the diligence with which he approached his task. It does not mean he was oblivious to its limitations.

99. As discussed below, I am satisfied as to the correctness of Dr Irving's interpretation of the salient parts of the video, it being axiomatic that I cannot accept his opinion unless satisfied as to the facts underpinning it. In particular, I have no doubt that Hizir was unconscious and unresponsive immediately prior to his removal from the bathroom and that he remained in an altered conscious state thereafter. I am also satisfied that at least some pressure was applied by the officer who stood on the edge of the shield, that significant pressure was applied by two people (not one) who alighted from the shield after Hizir vomited, and that at least some pressure was applied at other times.

100. I accept Dr Irving's opinion that hypoventilation occurred because of the way Hizir was restrained by the SESG at a time when he had an increased respiratory demand. That is, he was held in the bathroom for just over six minutes in a prone position with his hands cuffed behind him, a shield on top of him and additional weight applied to the shield at various times; on at least one occasion, significant weight. I accept that the terminal event was Hizir being sat up, although it is possible that he would have died even if that had not occurred.

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[46] T142.12.
[47] T164-165.
[48] T163.28. Dr Lynch subsequently confirmed that the transcript incorrectly omits the word 'don't'.
[49] T148.22.

101. I am satisfied that Hizir's earlier violent struggle contributed to his increased respiratory demand. Given the evidence of Dr Lynch (including as to the fact CS gas can have a delayed effect) and Dr Irving as to the possible effect of excess mucous secretions, I am also satisfied that it is likely that Hizir's exposure to the CS gas contributed to his increased respiratory demand to some extent, but I cannot determine by how much.

102. Notwithstanding Dr Irving's opinion that the manner of restraint was the most significant cause of Hizir's death, I believe Dr Lynch's formulation – *cardiorespiratory arrest in the setting of acute agitation and physical and chemical restraint* – remains appropriate because it captures all contributing factors, CS gas exposure, agitation and restraint. I am satisfied that the way Hizir was restrained was significant, but without the prior struggle or the CS gas exposure, he presumably would not have had an increased respiratory demand and the manner of restraint may not have been lethal, depending on the degree and duration of the additional force that was applied.

CIRCUMSTANCES OF DEATH

103. The broad circumstances in which Hizir died are set out in the introduction to this finding. As indicated, during the investigation some aspects of the circumstances were identified as warranting further scrutiny and became the focus of the inquest. The discussion of those matters follows.

The plan to extract Hizir

104. Middleton is a relatively new correctional facility next to the medium security Loddon Prison in Castlemaine, with a capacity of 236 prisoners. It consists of clusters of cottages designed to simulate post-incarceration life. Each cottage has individual prisoner bedrooms as well as common recreation and meal preparation areas.[50]

105. Hizir was accommodated in a cottage complex called Golden Point. Golden Point is a two-storey building divided into three ground floor cottages and three upper level cottages. Hizir's cottage, Golden Point B, was located on the ground floor, in the centre. Golden Point A and Golden Point C were situated on either side of Golden Point B.

[50] With the emphasis on rehabilitation, individual prisoner's rooms were referred to as bedrooms rather than cells.

106. Hizir shared Golden Point B with five other inmates. All the bedrooms in Golden Point B had solid, inward swinging doors which were lockable from the inside, but not the outside. They had half-slider external windows with external *'crimsafe'* style security screens and internal curtains. Further, and unusually for a prison, the doors did not have an opening *'trap'* nor any sort of viewing window, meaning that if a prisoner locked himself into a bedroom and closed the curtains, not only was there no way to *get* in, there was no way to *see* in.

107. Hizir's bedroom measured 3.52 metres by 2.65 metres with a 2.68 metres high ceiling. The window frame was 1170 mm wide by 1555mm high and the size of the open window was 500mm by 1475 mm high. If both the door and window were closed there was no source of fresh air, as although Golden Point B had a central ventilation system, it was not directly piped into the bedrooms.

108. After their arrival at Middleton the SESG Operations Manager and the Supervisor were briefed by Middleton's acting General Manager, Christopher Corbell. They were aware of Hizir's history of violence and the fact he had seriously assaulted two prison officers earlier in the day for no apparent reason. They knew he was refusing to come out of his room. They were told, in addition, that he had stopped communicating with prison officers and his condition was unknown; that he had been acting erratically in the last few days and it was suspected he had been using the drug *'ice'*; and that he may have wrapped a towel around his arms or his head and pushed his mattress against the door to protect against chemical agents or a dog (this was based on the muffled sound of his voice earlier in the day). Further, it was possible that he was armed.[51]

109. The SESG Operations Manager and the Supervisor and another SESG officer inspected Golden Point for themselves. The bedroom configuration was unique in their experience and presented specific challenges. Normal cell doors open outwards and have a trap which permits viewing of prisoners and facilitates communication. Prisoners who are being *'extracted'* usually place their hands through the trap or the outward opening door to be handcuffed. Further, the furniture in normal cells is fixed in place and cannot be used against prison officers.

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[51] Whilst cutting knives in the cottage were tethered, cutlery was not and the evidence was that some prisoners are adept at fashioning weapons out of a range of materials.

110. The SESG Operations Manager, the Supervisor and that other SESG officer formulated a plan for the extraction which they presented on a whiteboard to the SESG team. The surrounding cottages (Golden Point A and B) were to be evacuated and the power (and possibly some water) turned off. The SESG would be divided into two teams. All officers were to wear personal protective equipment (including batons) and gas masks.

111. The first team would assemble outside the bedroom and insert the nozzle of a Pratt device[52] into the room and discharge the CS gas. The nozzle would either be put under the door or the door would be breached, with a Halligan tool if necessary. The second (back-up) team would assemble at the external window with a second Pratt device and Halligan tool ready to break the window and deploy CS gas that way if necessary.

112. In normal extraction operations the SESG issues a *'proclamation'* before deploying the CS gas. That is, the prisoner is warned that the gas is about to be deployed and given the opportunity to surrender beforehand by putting his hands through the trap in the door so they can be handcuffed. Many, if not most, extractions are peacefully resolved in this way. In this case it was decided there would be no proclamation. Rather, because of Hizir's violence and unpredictability and the inability to see him, the element of surprise was considered paramount.

113. After the gas was discharged the door would be held shut until it was determined safe to open it. The gas had to be kept within the room as much as possible and Hizir could not be allowed to just rush out and run around the prison.[53]

114. It was hoped the discomfort of the CS gas would render Hizir compliant and therefore minimise the risk of harm to Hizir and prison officers. It was intended that he put his empty hands out the door, so they could be cuffed. If this did not happen, SESG officers would enter the room and manually subdue him. One of the SESG officers would carry a shield which was to be used to force Hizir onto the bed, so he could be handcuffed.

115. In accordance with usual practice, if Hizir was observed to be armed and unaffected by the gas, the SESG dog under the control of its handler would be deployed into the room instead of SESG personnel.

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[52] A reusable pressurised vessel.
[53] CB p 408, 1351, T381.

116. Once restrained Hizir would be taken to the cottage bathroom and decontaminated. Medical staff were to be in the immediate vicinity ready to treat Hizir or anyone else exposed to the gas and needing treatment.

117. The Supervisor was to conduct all communications with Hizir and give directions to the other SESG officers. He explained that did not mean he would direct every single action, but if he saw someone do something they should not be doing, he would stop it. The operation would be video recorded by another SESG officer from a safe distance.

Requirements for use of CS gas

118. In July 2016 (and still now), members of the SESG were permitted to use tear gas to manage or control prisoners by an order of the Governor in Council under the *Control of Weapons Act 1990*, providing they were not a prohibited person under that Act, had received appropriate training and complied with any Commissioner's Requirement as to the storage, possession, carriage and use of tear gas. There was no such Commissioner's Requirement at the time.

119. There was, however, a Deputy Commissioner's Instruction (**DCI**) dated 2 December 2014[54] and an SESG Local Operating Procedure (**LOP**) dated 25 April 2014, both headed USE OF CHEMICAL AGENTS. The DCI provided that the only chemical agent approved for use within prisons was CS gas and that prior to its deployment authority must be obtained from the Assistant Commissioner Security and Intelligence Commissioner, which occurred in this case.

120. The LOP stated (my underlining):

> *Chemical agents are only to be used where it is strictly necessary to maintain the security of the prison or to prevent injury to any person, and only after all avenues of negotiation have failed.*

Discussion and conclusions

121. Hizir's assault of the prison officers occurred around 10.00am. The extraction plan was devised just after 1.00pm and it was put into action at 3.00pm.

[54] Provided to the Court via email on 11 June 2019.

122. The fact it was a minimum-security prison imposed a degree of urgency. Since the affected area could not be isolated the whole prison had to be in lockdown until the crime scene from the morning assault was processed and Hizir removed from his room. Further, as there was no means of viewing Hizir there was no way of ascertaining whether he was injured in any way.

123. I accept that it was a complex situation because of Hizir's unpredictable and violent disposition and the configuration of his room. The complexity increased the potential for something to go awry during a forced extraction, especially one involving CS gas, and therefore made a peaceful resolution more, not less, important.

Whether negotiations had failed

124. The LOP required all avenues of negotiation to have failed before CS gas was used. It is difficult to make an assessment about this because details of the negotiations are somewhat scant.

125. A Crime Scene Log was commenced at 10.10am and recorded the names of persons in and out of the cottage, as well as other events. The last recorded communication with Hizir was at 12.01pm when he told the prison's operations manager, Mr McCoombe to *'fuck off'*.[55]

126. An Emergency Coordination Centre (**ECC**) Log of Events was commenced at 10.00am.[56] At 12.01pm it recorded that the prisoner was still not complying with directions to open the door and advised that he was '*alright*'. At 12.42pm it recorded that the prisoner was *'still not engaging. GP Dog at bedroom door. Approximately every 15 minutes attempting to engage'*. At 1.03pm it recorded *'3 x SESG at Unit, engaged with prisoner. Currently at rear of the Unit'*, but thereafter no further communications or attempted communications with Hizir were recorded.

127. Mr McCoombe was not called as a witness but a report he made of the incident two days later simply stated that he and the dog handler *'attempted on many occasions to engage with Ferman and were met with "fuck off" or silence'*.[57] Statements from other witnesses were

[55] CB p 1303.
[56] CB p 1277.
[57] CB p 1345.

similarly non-specific. According to the statement of Mr Corbell, at about 2.42pm Mr McCoombe advised him that *'Ferman was not communicating and not coming out of his bedroom'* but it is not clear when the last attempted communication actually occurred.[58]

128. In response to a suggestion from counsel for the family that Hizir might have been more receptive to someone other than a prison officer, for example the prison psychiatric nurse who was on hand at the prison, the SESG Operations Manager said they did not consider that option because they regarded the negotiation component of the exercise as exhausted. Further, he said that Corrections Victoria no longer has trained negotiators.

129. Because I do not know exactly when the last attempted communication with Hizir occurred I cannot be definitive about whether all avenues of negotiation had been exhausted. However, the evidence indicates there were a number of attempts by different people, some of whom considered they had a reasonable relationship with him. I am therefore not satisfied that it was necessarily unreasonable to regard the negotiations as having failed.

The decision to dispense with a proclamation

130. The DCI countenanced not giving a proclamation in certain situations including where there was a barricade or it *'would have an adverse effect on the execution of the mission'*. In this case the decision was said to be justified on several grounds. It was argued that with advanced warning Hizir might barricade himself into his room or prepare by wrapping material around his wrists meaning *'there would be an even bigger struggle trying to get handcuffs on'*,[59] or that he might arm himself and react in a violent and volatile way.

131. The Supervisor had never before been involved in a cell extraction when a proclamation had not been given, however, he said *'but in our training, I have been told that it is a possible tactical ploy'*.[60] When asked *'what effect, if any, would it have had on the prospects of a successful extraction, warning him, as opposed to not warning him?'*, he said *'I'd suggest that it would have made things more difficult'*.

132. It is worthy of note that neither that question nor that answer contemplated that Hizir might actually surrender in response to a proclamation.

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[58] Statement of Christopher Corbell dated 26 May 2017.
[59] The Supervisor at T499.
[60] T383.2.

133. The decision to dispense with a proclamation was significant as it was realistically the last chance of securing a peaceful resolution to the situation. Whilst it may have been right to regard the chance of Hizir surrendering in response to a proclamation as very slim, in my view the chance that he would surrender after the discharge of tear gas into his bedroom without warning and without any way for him to escape, was even more slim. It does not matter whether Hizir was motivated by fear, anger or pain, discharging the gas without warning was bound to cause confusion and panic. It was predictable that he would have an extreme reaction and that a physical altercation would result.

134. Whether the belief that the extraction '*would'* be rendered *'more difficult'* as a result of an advanced warning was sufficient reason to throw away the best chance of a peaceful resolution is a difficult question, especially since the extent of that difficulty may be debatable.

135. That is, the planning had proceeded on the assumption that Hizir had barricaded the door and might have wrapped cloth about himself anyway. Further, the opportunity for Hizir to arm himself existed whether a proclamation was given or not since the gas was always going to be discharged prior to the SESG officers entering. Further, it was speculative as to whether Hizir was armed. Although there was a suggestion that a wound from the morning assault looked as though it may have been caused by a sharp edge, both victims only reported being punched by Hizir. Neither victim saw a weapon, although they could not rule it out. Also, if there was a weapon the dog could have been deployed.

136. On the other hand, if the element of surprise enhanced the safety of the SESG officers even slightly, that was an important consideration and clearly that was the view taken by specialist prison officers with experience in this area.

137. I consider it would have been preferable to give a proclamation, however the decision was so finely balanced I do not consider that it was necessarily wrong not to have done so.

The back-up plan

138. The coronial investigator DSS McIntyre identified another issue with the plan, more particularly the back-up plan, that being that the discharge of gas into a locked or barricaded room via the window had the potential to trap Hizir inside with no means of rescuing him from continuing exposure. In this regard it is relevant to note that the DCI states *'[a]n evacuation route must be available before a chemical agent is used'*. DSS McIntyre doubted there was the means to enter the room via the window. In any event it had not been tested.

139. In response the Team Supervisor maintained his absolute confidence that the team would have been able to open the door using the Halligan tool, somewhat begging the question of why the back-up plan was necessary at all. It may be that the team would have been able to gain entry through the locked door to rescue Hizir, but who knows how long it would have taken. I agree with DSS McIntyre that the back-up plan was, at least, potentially flawed for this reason.

The decision to use CS gas

140. So far, I have not even considered the safety aspects of the decision to deploy CS gas into a confined space with no ventilation. This use was contrary to the manufacturer's instructions and, according to scientific literature, potentially dangerous.

141. In his statement Mr Polkinghorne said that CS gas was *'the chosen chemical agent'* to be used by SESG for various situations, including cell extractions, because:

    (i) it maintains the option of using canines as CS gas has minimal effect on them;

    (ii) cleaning up after deployment of CS gas is quicker than for other chemical agents; and

    (iii) CS gas disperses over a large area and it is more effective than other products. [61]

139. In evidence he disclaimed (ii) and (iii) as relevant to cell extractions because cells are easy to clean and the dispersal properties were only advantageous in open air situations such as riots. However, he confirmed the relevance of (i) saying *'we have an option to use a ...*

[61] Statement of Bruce Polkinghorn dated 9 February 2019 at [42](c).

canine post the CS gas not working'[62] (the dog handler having earlier given evidence that capsicum spray affects dogs so severely it effectively eliminates them).

140. Operator 113, who was a senior sergeant in the Special Operations Group of Victoria Police with specialist qualifications and experience in chemical munitions, including CS gas, and experience in cell extractions, gave evidence that Victoria Police would not use CS gas in a cell clearance. However, upon analysis the reasons for that seem not so much to do with it being unsafe in a confined space, although he did say that,[63] but more to do with a preference for Tasers[64] and the fact that Victoria Police deploy their chemical munitions in a different way, namely by grenade. Further, when the circumstances confronting the prison authorities in this case were explained to Operator 113, he did not take issue with their approach.

141. I do not criticise the individuals involved in the plan for following the accepted practice within their workplace of using CS gas for cell extractions. Given the official sanctioning of CS gas in such circumstances they could not have been expected to stop and consider the health implications of discharging the gas into a confined space. Further, I accept that although the amount of CS gas used was unquantifiable, it was the *'minimal amount ever used in cell extractions'*.[65]

Contingency, coordination and communication

142. There are two more aspects of the decision-making that warrant comment. Planning for an event such as a cell extraction should include planning for the worst, even if it is hoped or believed that it will not occur. In this case there was no planning for the contingency of a protracted struggle in which various members of the primary team might become fatigued, or incapacitated or unable to fulfil their designated role (the chance of fatigue being significantly increased by the wearing of gas masks). Even though the Team Leader's role as an uninvolved observer was vital, an alternate Team Leader was not nominated, nor consideration given to replacing other primary team members with nominated secondary team members who were already kitted up and ready to step in.

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[62] T 537.29.
[63] At T523.20 he said if the gas is discharged in a confined space and a person is *'left in that environment exposed to the gas for a long period of time, that – that is a potential risk for asphyxiation'*.
[64] According to Operator 113 although Tasers had their own risks, Victoria Police found they were more effective in cell clearances and the threat of their use produced greater compliance than the threat of gas.
[65] Corrections Victoria written submissions [98], 29.

143. Similarly, it does not seem to have been contemplated, let alone planned for, that at the end of the extraction process someone, most likely Hizir, could be seriously ill, whether from the gas, a violent struggle, or the manner of restraint. Rather than simply conveying the message that the nurses might need to provide aftercare, including oxygen, for the gas, the nurses should have been included in the planning, or at the very least, they should have been fully briefed about what might occur, including the possibility of force and prolonged restraint. In this way, if the nurses considered the task beyond them, appropriate medical staff could have been arranged. Further, it would have afforded them the opportunity to raise any medical concerns, such as Hizir's medical history contraindicating the proposed method of extraction.

The amount of force used by the SESG

144. In examining this subject I will not revisit the appropriateness of the plan, but rather consider the way in which it was implemented, including the method of restraint.

145. The guiding principle for use of force across all Victorian prisons as set out in Commissioner's Requirements is that force must be *'the minimum necessary for the least amount of time to resolve the situation'.*[66] Further, the relevant Commissioner's Requirements state that *'[n]o person should be exposed to undue risk and that only reasonable force is used to control persons where no other means of control are suitable or available. Physical intervention must only be used as a last resort.'*

146. Dr Lynch noted that the location of Hizir's two fractured ribs were not typical of normal resuscitation injuries. The video shows that the CPR which was administered on rotation by the three nurses and prison officers to Hizir was applied to the top left or top area of his chest which would seem to increase the likelihood that Hizir's rib fractures were sustained in the struggle in his room or while restrained in the bathroom.

147. I have examined the video and witness accounts to determine what happened in Hizir's room and the bathroom. The video footage of Hizir is intermittent due to the camera operator not venturing into either room and different people or objects obscuring the view. I have only relied upon it to the extent I am satisfied that my interpretation of events is correct, either

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[66] The *Commissioner's Requirements 1.1.1, Use of Force, Tactical Options.* Section 23 of the *Corrections Act 1986 (Vic)* provides that where necessary a prison officer may use reasonable force to compel a prisoner to obey a relevant order.

because it is confirmed by other evidence, or because careful viewing of the video (with earphones and reduced speed if necessary) puts it beyond doubt. As to the events not captured on video I am dependent on witness accounts and reasonable inference. Proceeding in that way, the following is a summary of what occurred, with references being to elapsed time on the video.

148. After the team assembled outside Hizir's bedroom the Supervisor quietly tried the door handle and was surprised to find that it was not locked.[67] Another officer then opened the door and discharged two short bursts of gas into the room before pulling the door closed and the Supervisor held it closed (00.48-00.50).

149. The Supervisor yelled at Hizir to *'come out and put your hands through the trap'* (or similar). Hizir tried to pull the door open, but the Supervisor held it shut.[68] Hizir screamed from inside. The Supervisor yelled repeatedly to *'get everything out of your hands Hiz and get down on the floor'*. The Supervisor opened the door again. Hizir advanced towards him from the back of the room carrying a large object, so he pulled the door shut whilst Hizir tugged at it. Hizir then either threw or bashed an object at the rear window. The Supervisor yelled at Hizir repeatedly to *'get down on the ground'*. He opened the door again and upon seeing Hizir at the rear window directed the team enter, repeatedly yelling at Hizir to *'get down on the ground'*. The five SESG officers rushed in, at least one of them with his baton drawn, and closed the door behind them (01.35).

150. None of the SESG officers anticipated the strength Hizir would display inside the room. They described him as having super-human strength beyond anything they had encountered before. The shield carrier was the first into the room but lost control of the shield and became disorientated when his gas mask dislodged. The struggle was such that the Supervisor, who was supposed to be *'hands off'*, became involved and grabbed one of Hizir's arms.

151. Eventually Hizir was handcuffed behind his back, however, he continued to resist by using his legs which he wrapped around the bed leg to anchor himself to the floor. He was also spitting at the prison officers.

152. After about two minutes the door was opened and Hizir was on his right side with one officer holding a knee to his head (03.45) to stop him spitting. Hizir kept struggling and another

[67] T414.3.
[68] Confirmed by the Supervisor in evidence, T445.24-446.5.

officer repeatedly kneed him, seemingly to his back (04.00). The door was closed again for over a minute. After the door opened Hizir was face down with officers around him. The Supervisor said to someone *'jump off his chest'* (or similar) before grabbing his ankle and pulling him from the cell with the assistance of the other officers (06.05). By this time Hizir had been exposed to the gas in the confines of his room for over five minutes.

153. Hizir was dragged by his legs out of his room with his face on the ground. Once out of the room, an officer placed the shield over him, covering his head and the top part of his body. That officer, who claimed the shield was only lightly applied to prevent Hizir from rolling over and kicking his legs free or spitting, can be seen leaning into the shield with both hands as Hizir was dragged towards the bathroom (06.16). The dog handler described the use of the shield in this way as standard practice, saying *'we apply pressure so that the person can't regain their feet and get movement with their arms and shoulders'*.[69] By contrast, the Supervisor said *'I don't believe it was for deliberate downward pressure as you wouldn't be able to drag somebody if they had a shield heavily placed on them I wouldn't have thought so it was just a barrier'*.[70]

154. In the bathroom the pressure on the shield was released but Hizir yelled and struggled again, whereupon the shield was abruptly pushed down onto the top part of his body – twice (06.30 and 06.38). Hizir continued to groan and struggle while the Supervisor explained to him that he was being decontaminated. An officer in the doorway stepped onto the top edge of the shield, which extended beyond Hizir's head, holding it to the floor (07.06). Another officer was astride Hizir, bending over and holding the shield in place, mostly using both hands (07.20ff). The Supervisor told Hizir to stop resisting and relax and that he was going to be decontaminated. Hizir kept either yelling or groaning loudly. At 07:30 Velcro straps were brought to the room.

155. At 9.05 a knife was requested (for the purpose of cutting clothes) and at 9.55 an officer brought a knife into the bathroom and handed it over. At some point, which is not clear on the video, officers began using a shower head to hose the residue from the gas off Hizir.

156. Throughout the decontamination process, one or two officers stood in the doorway and a number of other officers were in the room (five at 09.28) crouching over or standing around

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[69] T269-270.28.
[70] T384.19.

Hizir, who remained face down on the ground with his arms handcuffed behind him and the shield above him. Hizir moaned intermittently and the Supervisor yelled instructions such as *'Hiz, just breathe okay'* (09.42) then *'relax and breathe'* (09.42). At 10.16-10.20 an officer in black had a knee on top of the shield. At 10.50 a number of officers changed position around Hizir, who was face down on the ground with the shield held in place on top of him. The Supervisor yelled *'Hiz do your best to relax Hiz, it's better for everyone'* (11.00).

157. From 11.30 onwards the officers pulled Hizir's clothes out from under the shield. As they were doing this the Supervisor told the officers *'be careful of faeces guys, he's making quite a mess here'* (or similar). At 11.42 at least one prison officer was kneeling on the shield. Immediately after the clothes were removed, the Supervisor, who was kneeling down next to Hizir's head, told him *'Hiz, what we are going to do with your assistance is to move you out of this bathroom and put a [unclear] on you. Do not resist the staff, it will be much easier'* (12.00). At the time two officers were kneeling on top of the shield with a significant part, if not all, of their body weight (12.08-12.30). At 12.30 one of those officers lifted a leg entirely off the floor. Simultaneously, the Supervisor noticed that Hizir had vomited and yelled *'hop off'* whereupon the two officers on top of Hizir stood up. The Supervisor then left the room and called a *'code black'* before a limp Hizir was dragged from the room to outside.

Discussion and conclusions

158. I have no doubt the SESG officers faced a real challenge in extracting Hizir. It was always going to be difficult to communicate with Hizir once the gas was discharged. Almost immediately afterwards he tried to open the door but was prevented from doing so. It is understandable that the Supervisor wanted to control the manner of Hizir's exit even though all he may have been doing was trying to escape. Given that Hizir could not comply with the request to put his hands through the trap (there being no trap) and it was obvious that asking him to put his hands through an open door was not going to work, the Supervisor had little choice but to demand that he *'get down on the floor'*. Once Hizir failed to do that I consider the SESG were entitled to enter his room and forcefully restrain him.

159. Inside the bedroom, I accept that Hizir was uncooperative and resistant, whatever the reason for that might have been. I also accept that he showed immense strength. It is difficult to

know why the forceful kneeing to Hizir's person occurred (04.00), but it may have been to release his hold on the bed, as the bed can be seen to move at that point. Asked for his explanation, the Supervisor said that knee strikes were part of their training to compel compliance and he considered this reasonable force.

160. My assessment of what went on in the bedroom was hindered by the lack of video evidence. This has meant that I have not been able to reach a definitive view that what occurred was reasonable, but at the same time, I have certainly not reached a view that it was not. Even if the forceful kneeing was the cause of Hizir's rib fractures, I cannot say it was necessarily unjustified given his resistance and the imperative to get him out of the room and decontaminated.

161. As to the way Hizir was conveyed from the bedroom to the bathroom, I am not satisfied there was anything inappropriate about that given the need to keep Hizir under control and the struggle in getting him to that point. I am satisfied there was downward pressure applied to the shield, but not that it was unreasonable to do so in the circumstances. That said, the downward pressure and the fact of holding Hizir prone at this stage is not to be ignored, adding as it does, to the total time Hizir was restrained in that position.

162. The events in the bathroom are not so easily disposed of. For over six minutes Hizir was held in a prone position with his hands cuffed behind him and a shield over his head and back. During those six minutes varying degrees of pressure were applied to the shield and Velcro restraints were applied to his legs. There were at least five powerful men in the room and more in the doorway and outside the room. Apart from the group immediately surrounding Hizir, the rest of the men seemed to be just standing around observing.

163. As explained above Hizir would have had an increased respiratory demand in the bathroom caused by his exertion and exposure to the gas. It was therefore inherently unsafe to restrain him in the prone position for a prolonged period, let alone with his hands cuffed behind his back, a shield on top of him and pressure applied to the shield. Each of those additional aspects of restraint would have added to the burden of his breathing.

164. As to the amount of pressure applied to the shield, there are occasional glimpses of officers holding it down on the video. As the shield remained over him the whole time, even when

his clothes were removed,[71] it is reasonable to infer that for most, if not all, of the six minutes at least some force was used to hold it in place. It is inherently improbable that officers happened to be holding the shield only at the precise moment of the glimpses and at no other times.

165. It is also clear that for some of the six minutes considerable weight was applied to the shield because SESG officers knelt on it. Indeed, two officers were kneeling on the shield at the very time the Supervisor realised that Hizir had become critically unwell. The Supervisor agreed that they were doing this (from the video) but doubted that it would have been their full body weight. He also said that he was unaware it was happening at the time and would not have condoned it.

166. A proffered explanation for the continued use of the shield in the bathroom was that Hizir was scooping faeces out of his buttocks and flicking it at, or towards, SESG officers. There are three things to say about this. First, the Supervisor gave evidence that he observed faeces when they were removing Hizir's clothes. This is consistent with the warning that can be heard on the video as the clothes were being removed to *'be careful of faeces'*. As this happened at 11:30, five minutes after Hizir was taken to the bathroom, it provides no explanation for use of the shield at an earlier stage.

167. Secondly, Dr Irving explained that such behaviour could have been the product of confusion due to hypoxia. Not only that, Dr Irving said the fact he defaecated at all could have been due to reduced consciousness. This means that rather than warranting more restraint, the fact that Hizir defaecated should have signalled to the officers that they needed to back off and seek immediate medical attention.

168. Finally, even the most offensive behaviour could never justify a response which would endanger life.

169. The Supervisor gave evidence that although he was aware of positional asphyxia and the conflict spiral (described in the SESG training module above), he did not consider the prone position, without anything more, to be dangerous. That may be so, but in this case clearly there was more. There was exhaustion. There was gas. There were hands cuffed behind

[71] T394.25ff.

the back. There was a shield. There was pressure from above and there were possibly fractured ribs. As to the existence of any additional features, the Supervisor said that he did not consider the use of the shield and *'half kneeling'* on it to be *'excessive'*.[72]

170. The Supervisor also said, that although it might not have appeared that way in the video, *'my team and I all felt as though he fought all the way up until the time that he'd stopped'* referring to when he vomited.[73] He also explained that what was not apparent on the video was that at times he was kicking out.

171. I have some sympathy for the Supervisor and the SESG members who were directly involved in extracting Hizir from his room. The protracted struggle, especially with gas masks, was fatiguing and no doubt they were justifiably apprehensive about their own safety. However, it did not occur to any of them that Hizir may have simply been struggling to breathe. Indeed, it did not occur to any of them that Hizir may have been fighting for his life.

172. I am sure the SESG officers did not mean to endanger Hizir's life by their method of restraint and I am sure they did not appreciate that they were doing so, but that was the reality of the situation.

173. The fact the Supervisor had become involved in the extraction and remained involved with the decontamination meant his objectivity and situational awareness were impaired. This was no more apparent than in the lead up to Hizir vomiting when two officers were kneeling on the shield, apparently unbeknownst to him. By this time Hizir had calmed down. He was no longer a threat. His legs and hands were restrained and there were at least seven SESG officers in the immediate vicinity to lend assistance if necessary. On any view, this force was not *'the minimum necessary for the least amount of time to resolve the situation'* as stipulated in the Commissioner's Requirements.

174. Despite all the men standing around during the six-minute decontamination no-one was monitoring the danger that Hizir posed, nor the degree and manner of restraint required, nor the danger that the continued restraint posed to him. In evidence the Supervisor agreed that

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[72] T472.22.
[73] T475.5.

his involvement did make it hard to be objective and that having someone independent, who said *'hey everyone, just back off. Let's just see what he's like'* would have been beneficial.[74]

175. This lack of objective monitoring continued even after Hizir was taken outside. Once the Supervisor realised that Hizir had vomited and was unresponsive he immediately sought help. I have no doubt he was genuinely concerned about Hizir, whom he recognised to be critically unwell and no longer posing a threat. It is remarkable then that so many officers continued to hold onto Hizir once he was outside, albeit that at least he had been placed in the recovery position.

176. Indeed, since officers were still holding Hizir at the moment it was realised he had no pulse (albeit lightly), they were probably holding onto him even after he had died. As Dr Irving identified, *'it's a training issue for the officers'*.[75]

177. When asked about the Special Operation Group's method of restraint Operator 113 said that they would start off with the subject prone, but '*as soon as they are secured or restrained to our satisfaction, then we put them into the recovery position'*.[76] This should have happened in this case. Putting Hizir in the recovery position in the bathroom, certainly after his legs were secured by Velcro, if not before, would have afforded the SESG sufficient control of Hizir without endangering his life.

The response of the nurses

178. Immediately prior to Hizir being taken outside he was limp and unresponsive. The video clearly shows his head flopping as he is rolled to his side in the bathroom (12.30). The Supervisor gave evidence that he considered him to be critically unwell at that point, so he went outside, yelled that he was unconscious and to get the nurses.

179. The video also shows that as Hizir was pulled by his arms from the bathroom his head was hanging, secretions drooled from his mouth, and his legs dragged on the floor. There was no sign of life, let alone any resistance. As he was placed in the recovery position outside, the Supervisor yelled '*Hiz, Hiz, are you okay? Can you hear me [man]?*'[77] There was no

[74] T512-513.
[75] T94.18.
[76] T533.31.
[77] The last word is not clear.

response. He repeated the questions, but again there was no response and Hizir just lay on the ground.

180. Hizir was then moved further out from the cottage and again placed in the recovery position. He was drooling from his mouth onto the concrete (15:08). He spontaneously moved his head and legs for the first time (15.26). The Supervisor lifted Hizir's head and placed a makeshift pillow underneath. Another prison officer asked Hizir again if he was *'okay'* but there was no apparent response. Hizir moved his head and legs again, more vigorously this time, and thereafter made occasional movements.

181. It was at this point that the nurses arrived. Dr Irving was concerned about the *'lack of urgency'*[78] in the nursing response to an apparently unconscious man (an observation the Supervisor also made). He did not think they were proactive in assessing Hizir's conscious level. They spoke to him, but they did not perform a comprehensive assessment by asking questions to determine if he was orientated or confused. They did not attempt to take his blood pressure and they did not apply, or attempt to apply, a pulse oximeter. Dr Irving considered a pulse oximeter should have been used to measure oxygen saturation and heart rate, particularly in the initial nursing assessment.

182. Dr Irving did not believe Hizir regained consciousness after he was taken outside. He said *'there are movements and there are sounds but he's not the same person that came out of [his] room'.*[79] He believed the period of rhythmic moaning that occurred when Hizir was outside (starting from about 19:45) was probably due to cerebral irritation caused by hypoxia, rather than anything else.

183. This opinion was challenged on the basis of contrary statements from prison officers and nurses who described Hizir as resisting, moving and conscious. Dr Irving maintained his belief, saying *'the video gives a very good impression of whether he's, you know, sitting up, talking, responding or not, and the video shows that he's not.'*[80] He explained that people who are semiconscious or unconscious can still make noises and move their limbs. At no stage did he observe Hizir respond to anyone (a very important determinant of conscious state), nor say or do anything indicative of being conscious. He also considered it unlikely

[78] T100.
[79] T30-31.
[80] T111.5.

that the process of Hizir being sat up would have had such immediate and drastic consequences if Hizir had been conscious beforehand.

184. I accept Dr Irving's evidence on this point. I am satisfied his interpretation of the video is correct and further, his conclusion is supported by the evidence of the Supervisor and nurse White.[81] The statements of some of the prison officers, for example that Hizir was thrashing around and screaming when outside and looked like he was trying to get up, were patently wrong and I do not accept them.

185. The Supervisor gave evidence that Hizir was unresponsive from the moment he vomited in the shower room. He said, *'I do believe he – he came to outside to a degree'*.[82] He remembered him pulling his head away when the nurses tried to put the mask on, but he did not believe he was ever intentionally resisting. He did not believe he was playing possum and he never considered him a threat. Contrary to the submissions of counsel for Correct Care that any request by the nurses for a reduction in restraint was unlikely to be acceded to, the Supervisor also said he would have had no hesitation in removing the restraints if asked by the nurses.

186. It was suggested that because Hizir had his hands cuffed behind his back it would have been impractical for the nurses to use the pulse oximeter and blood pressure cuff, both of which were, apparently, in their emergency kit and available.[83] Dr Irving considered that was no reason for them not to have tried. He said the need for ongoing restraint should have been tested once Hizir was outside, if not before. He demonstrated that a finger pulse oximeter is a small and simple device to use and he believed it could have been applied to Hizir even with the handcuffs on. If the handcuffs had hindered proper monitoring the answer was to start to remove them and if Hizir started thrashing about there was probably no need for such monitoring anyway.

187. I again accept Dr Irving's evidence on this point. I note that in any case, impracticality was not suggested by the nurses themselves, as opposed to their counsel, as the reason for not

[81] I also prefer the evidence of Dr Irving to the evidence of Ms Fuller on this point because of his greater expertise and I found Ms Fuller to be less than impartial.
[82] T399.7 and 479 ff.
[83] This fact was put by counsel for Correct Care during cross examination and in submissions. Nurse White's evidence was that they did have a blood pressure kit in the emergency bag, but she did not know whether there was a pulse oximeter.

using these devices. Rather, it appears they had simply not turned their minds to it.[84] Further, if it was the case that a pulse oximeter was in their kit, nurse White, at least, was unaware of that fact.[85]

188. Dr Irving agreed that the nurses appeared compassionate towards Hizir. He said *'I'm sure they didn't knowingly not monitor. I'm concerned that they didn't realise the gravity of the situation.'*[86] In my view that effectively sums up the situation. The nurses failed to recognise from the outset that Hizir was critically ill and act accordingly, primarily by calling for an ambulance. This was no more evident than when they fatefully agreed to Hizir being sat up (29:16), something Dr Irving said should not have happened, certainly not without first establishing that it was safe to do so.

189. On that point, before the officers asked if Hizir could be sat up, they had removed one hand from the handcuffs (this can be seen from 28:00 onwards). Far from fighting, Hizir lay motionless and at 29:05 his left arm can be seen on the ground by his side. Any fear that he would become violent if unrestrained was certainly dispelled at that stage and there was absolutely no impediment and no excuse for not taking his blood pressure or applying a pulse oximeter.

190. Even as it became apparent during the lifting of Hizir to an upright position that he had no muscle tone and was completely inert (29:30), rather than intervening the nurses stood back and allowed the prison officers to complete the fastening of the security belt and the securing of his hands in front. No-one was attending to Hizir's airway during this process, which was likely compromised by his head hanging to his chest.

191. There was also a distinct lack of urgency after Hizir was laid back down (between 30:10 to 30:15). The nurses simply resumed administering oxygen and verbally reassuring him (nurse White can be heard telling him that oxygen is good for him) until, at 33:49, nurse White asked, *'are you still with us Hizir'* and at 33.58 a prison officer said *'he's got no pulse'*. Nurse White continued calling his name and asked him again *'are you with us'* before he was rolled onto his back and chest compressions (no ventilation) commenced at

[84] T185.18.
[85] T174.17ff.
[86] T115.30.

34:20, almost five minutes after he was first seen to be floppy.[87] At this stage an operator can be heard on the video arranging for the calling of an ambulance.

192. At around 35:40 defibrillator pads were applied and quickly removed after it was realised Hizir still had metal handcuffs on. They were reapplied, but no cardiac rhythm was detected (36:15). At 38:55 a bag mask valve oxygen device was used for the first time, although ineffectively applied.

193. It is notable that it was a prison officer and not a nurse who first detected the lack of a pulse.

194. As I said at the outset the nurses are not to be held to account to the standards of an emergency or respiratory physician. Rather, they are to be judged by the standards expected of nurses of their experience and qualifications. I also do not differentiate between the three nurses even though I only heard evidence from the one. They each had different levels of experience, but they were all present and any one of them could have intervened if they had thought it necessary.

195. I am cognisant of the fact that an extraction of this sort was extremely rare in a minimum-security prison and had never before happened at Middleton. That said, it was still a prison and it is reasonable to expect that nurses in that environment would know how to recognise an unconscious patient and when to call an ambulance. Indeed, Ms Fuller, who was the chief nursing officer for Correct Care and responsible for overseeing the policies, training and equipment of its nurses, gave evidence that at the time of Hizir's death all Correct Care clinical staff received annual training in basic life support to ensure competency in line with current Australian and New Zealand Council on Resuscitation (**ANZCOR**) Guidelines.

196. The relevant ANZCOR Guideline, Number 8, reads:

> *Initial steps of resuscitation are:*
> ***DRS ABCD***
> *1. DANGERS Check for danger (hazards/risks/safety)*
> *2. RESPONSIVENESS Check for response (if unresponsive)*
> *3. SEND Send for help*
> *4. AIRWAY Open the airway*
> *5. BREATHING Check breathing (if not breathing / abnormal breathing)*
> *6. CPR Start CPR (give 30 chest compressions followed by two breaths)*

[87] This was almost 22 minutes after Hizir first vomited.

7. DEFIBRILLATION Attach an Automated External Defibrillator (AED) as soon as available and follow the prompts.

197. In my view the nurses clearly failed at step 2 and step 3, if not also, 5 and 6.

198. Nurse White was the only attending nurse to give evidence. She was a division 1 registered nurse as well as a psychiatric nurse, the latter being her main role at Middleton. She had only ever experienced death in a nursing home or in palliative care. She had never before administered CPR. She had never before dealt with anyone who had been restrained by police or corrections officers and had received no specific training in cell extraction or the effects of gas. She had never heard of the concept of positional or restraint asphyxia. In short, she felt that she had not received enough training to deal with this situation.

199. In her words:

We were just advised that he was um – they were gonna extract him with gas and that we were gonna be on standby. We – us nurses, sort of never been in that situation before, so we just sort of discussed that the best course of action was just to administer oxygen. We didn't know how much at the time and to give him first aid for cleaning his eyes and his mouth, cause we assumed it would have been still burning. We weren't aware that um he was gonna be showered or anything like that.

200. She described how the three nurses searched the internet to try and determine what the gas was and its effects. They assumed it was capsicum spray as that was all they could find and *'we just tried to talk to each other how to do the sort of first aid for that'*.[88]

201. She said there was no particular reason why she assumed the main role in caring for Hizir, rather her instincts just took over. Her focus was on *'keeping him comfortable and maintaining first aid to his eyes and his mouth at the time'*.[89] She said the nurses thought that he was conscious based on the fact he was warm, breathing, had a pulse and was moving and groaning. She said his eyes never opened but she assumed that was because they were still burning.

202. Although describing Hizir as *'resisting, grunting and ... conscious'* at every stage of his treatment in her statement, in evidence she agreed that his movements were infrequent and

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[88] T198.20.
[89] T184.2.

consisted of nothing more than appeared on the video and she had assumed that he was frustrated and uncomfortable and that his movements amounted to resistance.[90]

203. She confirmed that he never responded in any way to her or said anything that had a meaning to it.[91] She agreed that she was constantly reassuring him and explaining what she was doing, but he never said or did anything to indicate that he understood what she was saying. When asked what she made of that (lack of response) she said *'my assumption was that he may be – that he was still agitated, he was – he didn't want to – I don't know, I – I can't answer that, I don't know'*.[92]

204. Counsel for Correct Care submitted that *'the fact Hizir did not expressly verbalise anything in the presence of the nurses was understandable in the context of the events'*,[93] but the point is they did not proactively seek to elicit a response. They did not assess whether he was capable of giving one.

205. As to Hizir being sat up nurse White said that *'initially'* she did not see a problem with it, but *'as he flopped forward'* she thought *'there was something wrong because that just – that didn't look right'*.[94] Notwithstanding that observation she did not intervene. She did not tell the officers to put him back down immediately. She did not immediately take his heart or respiration rate, start CPR or call for an ambulance.

206. As to what knowledge she has gained subsequently, nurse White said she now realised that sitting Hizir upright would have caused his blood pressure to drop. Further, she now accepts that he had been in an altered conscious state. Faced with the same situation again she said she would have made more of an effort to get him to open his eyes and respond and perhaps they would have asked the officers to undo the restraints, so they could see how he was presenting.

207. The above recitation of nurse White's evidence amply demonstrates how ill-prepared and out of their depth the nurses were. They were committed to the idea of administering first aid for capsicum spray instead of, as a priority, establishing and then reassessing the conscious state of their patient. They had no clear plan of treatment nor assigned roles

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[90] T188.3-14, 205.29
[91] T183.23 and T204.19
[92] T184.28.
[93] Submissions on behalf of Correct Care at [34].
[94] T 191.26.

amongst themselves. They also had no framework within which to act or react, such as knowing when to call an ambulance.

208. Further, nurse White's evidence indicates a lack of situational awareness. She was not processing what she saw or thinking about what to do next.

209. Not only were the nurses provided with very little information before they attended Hizir, they were given no handover once they did. They were not told that there had been a violent struggle - although Hizir did have numerous cuts and abrasions, including an obvious cut on the top of his head. They were not told that he has been held prone for a number of minutes (six in the shower room alone), that he was handcuffed for that whole time, that a shield was on his back and that officers intermittently applied force to that shield, sometimes significant. They did not realise that the SESG had already decontaminated him. They were not told of the Supervisor's assessment that he was critically ill or unconscious.

210. Surprisingly, Ms Fuller did not consider the lack of information significant because, she said, nurses are trained to assess and treat the patient before them. That may be true, however when relevant patient history is available it is clearly preferable to have regard to it, rather than treating the patient in a vacuum. If nurse White had been aware of the dangers of prone restraint (which she was not) then being told how Hizir had been held may have helped her appreciate the seriousness of the situation before her and respond accordingly.

211. I have already adverted to the fact the prison officers did not brief the nurses as to what might occur in the extraction process. In my view this was significant not only because it deprived the nurses of important information, but also because it created an expectation in them as to what their role was going to be, namely that they were just there to administer first aid and oxygen. That said, the nurses also had a voice. They could have, and indeed should have, been more proactive in seeking information before the extraction occurred, and indeed, after it had happened.

212. As to whether different treatment from the nurses would have saved Hizir, Dr Irving was unsure. Managing a patient with compromised breathing or conscious state is difficult even in optimal circumstances. However, Dr Irving believed that a pulse oximeter would have assisted the nurses to assess and respond more appropriately to Hizir's condition. He could not identify the precise point at which Hizir's decline became irreversible but considered it

possible that he might have recovered if he had not been sat upright. Clearly, once Hizir's heart stopped beating, it was too late.

The training of the SESG and Correct Care nurses

213. Whilst the inquest scope was confined to training to recognise of an acutely unwell person in the circumstances of Hizir, the issue of training more broadly was canvassed during the inquest.

The SESG

214. The Supervisor was able to recognise that Hizir was acutely unwell after he vomited. However, once the nurses were involved he considered the responsibility for his care rested with them. Correct Care submitted, in effect, that if that was his perception, his responsibility did not end there and that he should have called an ambulance.

215. The evidence was that members of the SESG received introductory and annual training in defensive tactics, first aid, escorting tactics and cell extraction, including use of a shield. The training occurs by online modules and hands-on training and covers positional asphyxia. Indeed, I have already detailed the positional asphyxia online training module in paragraph 66 above.

216. After explaining the risk factors and the *conflict spiral* in which an increasingly desperate person fights harder and receives more force in response (paragraph 67 above) the positional asphyxia training module concluded:

As can be seen by this description of events, an incident can escalate in a manner that could easily result in a tragic outcome. This knowledge may enable officers to recognise the pattern and may prevent such an undesirable event.

217. Clearly no such recognition occurred in this case. The SESG officers did not appreciate the dangers of their method of restraint even though there were obvious parallels between the conflict spiral and the events in this case.

218. I consider the training in relation to restraint asphyxia could be improved and will return to this in the comments section of this finding.

Correct Care nurses

219. Ms Fuller gave evidence that she had never encountered a situation of restraint asphyxia and that she did not *'have a lot of knowledge of it'*.[95] She confirmed that as at July 2016 the three nurses involved in this incident would not have had specific training on chemical exposure, cell extraction or restraint asphyxia. In my view, given Correct Care's role in providing health care within the prison system where cell extractions using CS gas were a known occurrence, it is unsatisfactory that it did not routinely offer this training to its nurses at that time.

220. As previously noted, Correct Care nurses did, however, have annual training in basic life support. Theoretically, this training should have equipped the nurses in this case to deal with the situation before them, even without the other training. The fact it did not illustrates the risk of training not transferring to practice, especially in a minimum-security prison where incidents of this type are rare and complacency would not be surprising.

221. Whilst maintaining that the response of its nurses was appropriate, to its credit, after Hizir's death Correct Care did review its training, policies and equipment across all sites. It introduced a range of improvements, including further life-support training and chemical agent exposure training and updating its emergency guidelines. However, at the time of the inquest there was still no specific training on positional/restraint asphyxia.

222. Amongst those improvements was the introduction of a two page MEDICAL AND NURSING RECORD designed to prompt nurses to document their response to a medical emergency outside a health centre. Page one contains a table in which is to be recorded various vital signs, including blood pressure and oxygen saturations. Page two of that document is headed *'Neurological Observations'*. Underneath, next to the heading *'Glasgow Coma Scale'* the nurses are meant to record observations of the person's eye opening, best verbal response and best motor response. Further down is a heading *'Pupils'* with space to record the size and reaction of a person's pupils (left and right). At the bottom of the page is a heading *'Limb Movement'* which deals with the arms and legs to test the power in them.

[95] T 238.11.

223. Although this document serves to highlight the inadequacy of the nursing assessment in this case, its introduction should assist prison nurses in the future to know what to do.

224. After the inquest Correct Care introduced even further improvements by amending its CHEMICAL AGENT EXPOSURE fact sheet and introducing a CELL EXTRACTION CHECKLIST, and two new fact sheets: RESPONDING TO A CRITICAL INCIDENT and RESTRAINT AND POSITIONAL ASPHYXIA.

225. In introducing the various changes outlined above, I am satisfied that Correct Care has earnestly endeavoured to respond to the issues revealed in this case. In addition to providing clinical guidance, it is pleasing to note that the fact sheets stress the importance of communication between prison officers and nursing staff as to any proposed, or past, critical incident involving a prisoner and make it clear that nursing staff should be proactive in seeking out relevant information.

FINDINGS

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings in respect of the death:

226. Having investigated the death of Hizir Ferman and having held an inquest in relation to his death between 18 to 22 March 2019 at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Hizir Ferman, born 31 May 1981;

    (b) Mr Ferman died on 28 July 2016 at Middleton Prison, Matheson Road, Castlemaine, Victoria, from cardiorespiratory arrest in the setting of acute agitation and physical and chemical restraint; and

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

COMMENTS

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

1. I have previously said that a coroner's role is not to attribute blame. The reason coroners seek to identify shortcomings that may have contributed to death is to try and prevent similar deaths from occurring in the future by making comments and recommendations. I acknowledge that the extraction of Hizir presented unique challenges. However, if the planning and coordination of the event had been better, the method of restraint not unsafe and the aftercare administered by the nurses adequate, his death may have been prevented.

2. I recognise that broad sweeping reforms are not necessarily justified by extraordinary events, but I do consider this case has highlighted some areas of potential improvement in training and procedure in relation to cell extractions.

3. Any forced extraction of a prisoner from a cell or room requires careful planning and coordination between prison officers and medical staff. This is especially so if the extraction involves the use of CS gas. The potential for something to go wrong should never be underestimated. Consideration should be given to what could go wrong at every stage, and alternative approaches devised in advance. I note that since Hizir's death the SESG Cell Extraction Manual has been amended to ensure that every cell extraction has an emergency exit plan, although I am unaware of the details.

4. Prior to a forced extraction, particularly one involving CS gas, it is imperative that all means of peacefully resolving the situation be considered. This should, if possible, include allowing the prisoner time to *'cool down'* and ensuring that all avenues of negotiation with the prisoner have been exhausted. Depending on the urgency and feasibility, consideration should be given to presenting someone other than a prison officer to negotiate, such as mental health professionals, trained negotiators, or possibly even family members by telephone.

5. Once it is realised that a prisoner may need to be forcibly extracted there should be a log of all communication attempts and outcomes. A decision to dispense with a proclamation before the use of a chemical agent should be exceptional and the reasons contemporaneously

recorded. These two steps (the log and reasons) will not only ensure rigour in decision making but facilitate subsequent review of events.

6. Where possible prison medical staff should be included in the planning for the extraction, including discussion of proposed methods and likely scenarios, or otherwise fully briefed prior to the extraction proceeding.

7. The SESG and medical staff should have a clear understanding of their respective roles and responsibilities during and after the extraction. Such an understanding might, for example, eliminate the type of debates that occurred in this case about whether the prison officers would have released Hizir from restraint if they had been asked to do so by the nurses, or whose responsibility it was to call an ambulance.

8. Prior to any forced extraction, especially one involving a chemical agent, the SESG and medical staff should consult the prisoner's health records to determine if there are any matters relevant to the risks for the prisoner or, indeed, the prison officers.

9. In preparation for the extraction, the medical staff should allocate clear roles amongst themselves and devise their own plan of response, including when to call an ambulance or seek additional medical help. They should seek additional medical help before the extraction if they consider the situation may require a greater expertise than they possess.

10. Prior to the extraction an alternate SESG team leader should be nominated in the event the primary team leader is unable to fulfil his role because he has become involved in the altercation or for any other reason. There should also be a process for replacing fatigued team members. I am informed that since Hizir's death the issue of fatigue management has been incorporated into the Cell Extraction Manual and forms part of the planning of every incident, although again, I do not know the details.

11. The team leader should actively monitor the extraction as it unfolds and the condition of the prisoner during any subsequent restraint and aftercare. If continued restraint is necessary, the prisoner should be placed in the recovery position as soon as it is safe to do so. The team leader should ensure the prisoner is not restrained in an unsafe manner and is not restrained for longer than is necessary, particularly not in the prone position. After any extraction involving chemical agents, violence, or prolonged restraint, the team leader should also ensure the prisoner is medically reviewed as soon as possible.

12. Once the prisoner has been extracted and decontaminated (if applicable) there should be a handover by the SESG to the medical staff detailing all relevant information, including details of any force, method and duration of restraint. Both the SESG and medical staff should ensure this is done.

13. After any violent extraction involving prolonged restraint, or if the prisoner appears unwell medical staff tending to the prisoner should undertake clinical assessments in accordance with the Medical and Nursing Response Record form, which has been introduced since the death of Hizir and includes oxygen saturations.

14. There should be enhanced training of the SESG and medical staff as to the dangers of prone restraint, particularly when combined with additional risk factors, such as handcuffs, use of a shield or pressure on the chest. In that regard, the SESG positional asphyxia online training module (paragraph 66 above) should be updated in several respects. First, the word *restraint* should be used instead of, or in addition to, the word *positional* (for example restraint related positional asphyxia) to highlight the context in which the asphyxia can occur in a custodial setting. Secondly, CS gas should be included as a risk factor as well as OC spray. Thirdly, whilst the module clearly highlights the risk factors and conflict spiral, it does not provide clear guidance on how to avoid the phenomenon. In that regard, it should direct officers to place the restrained person in the recovery position as soon as it is safe to do so. Further, it should be made clear that it is potentially dangerous for officers to sit on, or in other ways apply pressure, especially prolonged pressure, to the subject's back or chest during the restraint.

15. There should be enhanced training of the SESG and medical staff as to the signs and symptoms of restraint related positional asphyxia and the fact that it may develop insidiously, that is, without any obvious signs that the person is struggling to breathe or has impaired breathing. Of course, the primary aim should be to prevent the condition from occurring at all.

16. There are several aspects of the new Correct Care RESTRAINT AND POSITIONAL ASPHYXIA fact sheet which could possibly be improved. First, the fact sheet explains the phenomenon as occurring when the patient is *'not getting enough oxygen'*. It may be helpful for medical staff to know that inadequate ventilation can lead to elevated levels of carbon dioxide which may also impair conscious state and that this can occur even before there is a

significant reduction in oxygen levels. Secondly, given the evidence of Dr Irving as to the possible significance of Hizir's defaecation, the list of the signs of restraint and positional asphyxia (which includes vomiting) should probably include defaecating. Finally, as part of the response to signs of restraint or positional asphyxia the document recommends health care staff consider *'placing the patient in the upright position with their head elevated'*, a suggestion which appears contraindicated by the outcome of this case. In my view the fact sheet should be reviewed by an appropriately qualified medical practitioner to ensure it is accurate and represents best clinical practice.

17. Whilst the video in this case was valuable, it would have been more so if the view had not been so often obstructed by people who seemed to be performing no function at all. Since Hizir's death Corrections Victoria has implemented a policy that requires all supervisors to wear *'Body Worn Cameras'* during cell extractions.[96] This is a welcome development as long as there is also a designated video operator, which I understand to be the case. That video operator should be assertive about obtaining a clear view whenever practical and safe to do so, including instructing the SESG dog handler to move the dog away if it is likely to interfere with the sound recording, as happened here. According to the Supervisor it is within a video operator's rights to ask people to step away, but that certainly did not appear to happen in this case, nor did the operator move to get a better picture.

18. Although the precise role CS gas played in Hizir's demise is uncertain, I remain concerned about its continued use in circumstances where its safety is uncertain. It is unclear why the manufacturer disavows its use in confined spaces and it may simply be because it causes the very symptoms that are desired in cell extractions.

19. At the date of Hizir's death CS gas was the only chemical agent approved for use within prisons. Since then, a number of other chemical agents have been approved for use by the SESG in escorting prisoners, but I do not know whether this applies to cell extractions. Given the important role CS gas has hitherto played in cell extractions and in the absence of a full examination of the efficacy and safety of any alternatives, I do not consider a formal recommendation that Corrections Victoria desist from using CS gas in cell extractions is warranted. That said, the continued use of CS gas for this purpose must be accompanied by

[96] Statement of Bruce Polkinghorne dated 9 February 2019.

great care. It is imperative that any cell extraction using CS gas be coordinated with properly trained medical staff as set out above.

20. I recognise the purpose of the cottage style accommodation in Middleton prison and that it might be impractical and possibly counterproductive to introduce traps into every bedroom door. However, to deal with the situation of a potentially violent prisoner being accommodated in Middleton in the future, in my view a select few bedrooms could be fitted with doors with a trap without derogating from the overall nature of the prison.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. Corrections Victoria should update its SESG cell extraction training, including any relevant manuals, to incorporate the matters set out in my comments.

2. Corrections Victoria should update its Critical Incident and Safety Management online training module on positional asphyxia in accordance with my comments.

3. Corrections Victoria should review the configuration of the bedrooms in Middleton to assess possible means of allowing prison officers to view or enter the bedrooms in emergency situations, and at the very least arrange the modification or replacement of one or more doors to insert a trap.

4. Correct Care Australia should have the RESTRAINT AND POSITIONAL ASPHYXIA fact sheet reviewed by an appropriately qualified medical practitioner having regard to the matters raised in comment 16.

I convey my sincere condolences to Hizir's family on the loss of their brother and son.

I direct that this Finding be distributed as follows:

(a) Hizir's family;

(b) Justice Assurance and Review Office;

(c) Corrections Victoria;

(d) Correct Care Australasia Pty Ltd; and

(e) Detective Senior Sergeant Stephen McIntyre.

Signature:

ROSEMARY CARLIN
CORONER
Date: 5 July 2019