CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ali KIZILDAG
Hearing dates:	7 March 2022
Date of findings:	7 March 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Brett Shields, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2018/00279370
Representation:	Ms. B. Notley, Coronial Advocate Assisting the Coroner Ms. A. Heritage, Solicitor, for Corrective Services NSW Ms. N. Szulgit, Solicitor for Justice Heath NSW
Findings:	Identity: Ali Kizildag Date of death: 11 September 2018 Place of death: Dawn De Loas Correction Centre, Silverwater, New South Wales Cause of death: Acute opioid (heroin) toxicity Manner of death: Misadventure
Recommendations	Nil
Non-publication orders:	See Annexure A

1. Introduction

1.1. At the time of his death, Ali Kizildag was 47 years old and in lawful custody at the Dawn De Loas Correctional Centre ('DDCC') within the Silverwater Correctional Complex, Silverwater, New South Wales, serving a term of imprisonment.

1.2. On 11 September 2018 Mr. Kizildag failed to attend an appointment with a medical practitioner within DDCC and Corrective Services New South Wales ('CSNSW') officer went to his cell to locate him. The cell was locked from the inside and on entry Mr. Kizildag was found slumped over on the floor. CPR was commenced and emergency services attended however Mr. Kizildag could not be revived and he was pronounced deceased at the scene. A used syringe and a substance identified on analysis as Heroin were found beside Mr. Kizildag.

2. Reason for the inquest

2.1. The *Coroners Act* 2009 ('the Act') requires a Coroner to investigate a 'reportable death', as that term is defined in the Act, to enable a Coroner to the make the findings required by sec. 81 of the Act. The findings concern the identity of the person who died, when and where they died, and the cause and the manner of their death. In this context the manner means the circumstances in which they died.

2.2. A person charged with a criminal offence, or who is sentenced to a term of imprisonment upon conviction, can be detained in lawful custody and, in so doing, the State assumes responsibility for the care of that person. Sec. 23 of the Act makes an inquest mandatory in cases where a person dies while in the custody of the State. The open administration of justice requires, and the community appropriately expects, that the death of a person in the custody of the State will be properly and independently investigated to ensure that the State met its responsibility for the care of that person.

2.3. The coronial investigation into the death of Mr. Kizildag did not identify any evidence to suggest that he was not appropriately cared for and treated while in custody.

3. Mr. Kizildag's life and background

3.1. Mr. Kizildag was born in Sydney on 22 March 1971 and he was aged 47 at the time of death. Mr. Kizildag and his family are of Turkish descent and the family resides in New South Wales.

3.2. Mr. Kizildag was not married and he had a de facto partner who resides in Western Australia.

4. Mr. Kizildag's custodial history

4.1. Mr. Kizildag had a lengthy criminal history and he had previously served terms of imprisonment. In October 2017 Mr. Kizildag was arrested and charged with break and enter and possession of housebreaking implements.

4.2. Mr. Kizildag appeared before the Central Local Court on 19 October 2017 when he was sentenced to a term of imprisonment of 1 year and 6 months with a non-parole period of 1 year and 1 month commencing on 19 October 2017. Mr. Kizildag's earliest possible date for release was on 18 November 2018. At the date of his death Mr. Kizildag had served the majority of the non-parole period of his sentence and he would have been eligible for release in approximately 2 months.

4.3. After sentence Mr. Kizildag was classified as 'C2 Minimum Security' inmate and he was held in the Metropolitan Remand and Reception Centre until he was transferred to DDCC on 16 November 2017. In May 2018 Mr. Kizildag was reclassified as 'C3 Minimum Security' and he was a participant in the Works Release Program. During his previous time in custody Mr. Kizildag had two breaches of discipline and sanctions and none during the last period of imprisonment. He received visits from his de facto.

5. Mr. Kizildag's medical history

5.1. Mr. Kizildag underwent a Reception Screening Assessment on 27 October 2017 which included a mental health assessment. Mr. Kizildag reported diagnoses of type 2 diabetes mellitus, hepatitis C, heart disease, various ongoing mental health problems for which he was medicated and that he was on a Methadone program. His previous custodial experience was noted and he was appropriately referred for treatment and review. At the time of the assessment Mr. Kizildag denied any suicidal ideation.

5.2. The health care that was provided to Mr. Kizildag by Justice Health is set out in a report dated 10 October 2018. In relation to Mr. Kizildag's drug issues, the evidence shows that Mr. Kizildag had the following further contacts with Justice Health in addition to the initial assessment:

5.2.1. On 24 October 2017 Mr. Kizildag was seen and, after consultation, prescribed Methadone;

5.2.2. On 13 November 2017 Mr. Kizildag saw a medical practitioner concerning his poly substance abuse and intravenous Heroin use and his history of attempts at self-harm;

5.2.3. On 11 September 2018, the day of his death, Mr. Kizildag saw a medical practitioner concerning his renal issues however the consultation ended when Mr. Kizildag returned to cell to collect a urine sample, and he did not return; and

5.2.4. Again on 11 September 2018 in the circumstances described below.

6. 11 September 2018

6.1. As recorded above, at 11.00 on 11 September 2018, Mr. Kizildag saw a medical practitioner concerning his renal issues and he returned to his cell to collect a urine sample. When Mr. Kizildag failed to return by 14.30 he was summoned through the PA system and CSNSW staff then went to his cell, which was locked from the inside. On gaining entry at 14.31 Mr. Kizildag was found unresponsive on the floor under the desk. His face and feet were blue. CSNW staff moved Mr. Kizildag from under the desk and lay him on his back and CPR was commenced.

6.2. CSNSW staff report the incident via radio and the first Justice Health staff, including a medical practitioner, entered the cell at 14.37 and CPR was continued while awaiting the arrival of Ambulance. The Ambulance staff arrived at the cell at 14.49 and they continued the CPR and treatment until 15.01 when Mr Kizildag is removed from the cell and taken to a nearby landing. Mr. Kizildag was pronounced deceased at 15.21.

7. Further Investigation

7.1. Subsequent enquiries by Police and CSNSW failed to establish how Mr. Kizildag obtained the Heroin, however the most probable explanation is that Mr Kizildag or another unknown inmate obtained the syringe and the Heroin while in the community on the Work Release Program and brought it into DDCC secreted within cavities in their body.

7.2. Inmates on the Work Release Program are searched on a random basis when returning to correctional facilities in accordance with existing CSNSW Policies and Procedures. As a result of this incident those Policies have been reviewed and found to be appropriate in the operational context.

8. The cause Mr. Kizildag's death

8.1. Mr. Kizildag was taken to the Department of Forensic Medicine in Sydney where a post-mortem examination was performed by Dr. L. Du Toit-Prinsloo, forensic pathologist, on 14 September 2018.

8.2. In the autopsy report dated 18 October 2018 Dr. Du Toit-Prinsloo opined that the direct cause of death is acute opioid (Heroin) toxicity.

9. Conclusions

9.1. The evidence establishes on the balance of probabilities that the cause of Mr. Kizildag's death was acute opioid (Heroin) toxicity by self-administration of contraband drugs.

9.2. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health to alter the outcome or that any aspect of the medical care provided to Mr. Kizildag while in custody contributed in any way to his death.

10. Findings

10.1. The findings I make under sec. 81(1) of the Act are:

Identity	Ali Kizildag
Date of death	11 September 2018
Place of death	Dawn De Loas Correctional Centre, Silverwater, New South Wales
Cause of death	Acute opioid (Heroin) toxicity
Manner of death	Misadventure – unintentional drug overdose

11. Closing

11.1. I acknowledge and express my gratitude to Ms. B. Notley, Coronial Advocate, for her assistance both before and during the inquest. I also thank Detective Senior Constable Patrick Jones for conducting the Police investigations and for compiling the initial brief of evidence.

11.2. On behalf of the Coroners Court of New South Wales, I offer condolences to Mr. Kizildag's family.

11.3. I close this inquest.

Magistrate Brett Shields
Deputy State Coroner
Coroners Court of New South Wales