STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Afif Fakhouri
Hearing dates:	**14 – 17 June 2016**
Date of findings:	**11 August 2016**
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate H Barry
Catchwords:	CORONIAL LAW – Excited Delirium, Positional Asphyxia, Restraint, Methylamphetamine Toxicity
File number:	2014/00265393
Representation:	Mr W Hunt Counsel Assisting the Coroner Instructed by Ms J Geddes Crown Solicitors Office Mr J Glissan QC and Mr J Wilcher representing the the Family Mr M Hutchings representing NSW train Employees Mr M Cahill representing NSW Trains Mr M Spartalis representing Commissioner of Police, NSW Ms J Curtain representing Mr P Verbeek Mr B Longville representing Inspector A Holmes Ms P Marinovic representing Dr P Gilhooly

Findings:	The *Coroners Act* in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Afif Fakhouri. I find that Afif (Jeff) Fakhouri died on 9 September 2014 at Cootamundra Hospital and that on the balance of probabilities his death resulted from a combination of factors including methylamphetamine toxicity and restraint leading to physiological stress and subsequent cardiac arrhymthmia due to forcible restraint by train staff in the prone position on Cootamundra Station.
Recommendations:	1. To the Minister for Police: That consideration be given to the review of the "Cootamundra Local Area Command Recall Procedures" to provide for officers to be recalled where assistance is requested in relation to passengers on NSW TrainLink trains. 2. To the Minister for Transport: That NSW Trains continue to develop protocols to assist staff to manage passengers in a way consistent with passenger and staff safety, from the time a decision has been made to request police assistance until police are in attendance.

Introduction

1 Afif (Jeff) Fakhouri died in the course of being restrained by train staff on 9 September 2014. He was 37 years old.

2 Jeff was a passenger on the XPT rail that was travelling between Sydney and Melbourne. He was planning to alight in Albury to visit his mother.

3 During the course of the journey, Jeff's behaviour became increasingly erratic and he appeared to be agitated.

4 Police assistance was sought to remove Jeff from the train.

5 When the train arrived at Cootamundra Station at about 3.24am, train staff were advised that Police would not be attending.

6 A direction was given to Jeff to leave the train. He refused.

7 A number of train staff physically removed Jeff from the train. They held him around the neck from behind and also by the torso and legs. There was a struggle getting Jeff out of the train.

8 Jeff was restrained on the platform face down. He was heard to say "I can't breathe properly"

9 Jeff became unresponsive and unconscious. He was placed in a recovery position and CPR was commenced. An ambulance was called.

10 He was transported to Cootamundra Hospital where he was pronounced life extinct.

Jeff Fakhouri

11 A number of statements prepared by members of Jeff's family were read to the inquest.

12 Jeff was described as a loving son, father and partner, who loved life.

13 Statements were read to the court from Mr Khoulio Fakhouri, Jeff's father, Christopher Fakhouri, Jeff's son and Jackie Brennan, Jeff's former partner.

14 Jeff was described as a man with a big heart who" loved openly and wholeheartedly".

15 He loved to sing and to talk.

16 Jeff's father referred to him as not only his son but his best friend.

17 Christopher looked up to his father as a hero and described him as a loving and devoted father and a generous family man. He was joyous and funny.

18 Jackie Brennan stated how she and Jeff had become loving friends even though they no longer resided together. She also spoke of his generosity and kind heartedness.

19 Jeff's family are shattered and they are left with overwhelming feelings of loneliness, grief and sadness for the loss of their son, father and partner.

The Role of the Coroner

20 The role of the Coroner is to investigate sudden and unexpected deaths and to determine the identity of the person who has died, the date and place of that death and the cause and manner of that death.

21 The inquest is not a quasi-criminal trial into either Jeff's behaviour or the involved railway officers but an inquiry into the manner in which the operation to remove Jeff from the train was conducted and how Jeff's death came about during that operation.

Background

22 At approximately 10.32 pm on 8 September 2014, Jeff Fakhouri boarded the train at Campbelltown Railway Station.

23 Maryanne Deery, a Passenger Attendant for NSW Trains escorted Jeff to his seat D61 in Car D. She stated that he was polite.

24 Jeff was in a double seat as D62 was not occupied.

25 Ms Deery advised Jeff she would wake him at Albury so that he would not miss his stop.

26 Between Yass and Harden, Jeff spoke to Christopher Hughson, another Passenger Attendant, and requested another seat because he was uncomfortable.

27 In his Recorded Interview with Police, Mr Hughson described Jeff as "erratic" and his sentences were "hard to follow".

28 Mr Hughson believed Jeff's behaviour to be "bizarre". He said that at that time Jeff demanded to be moved to First Class which was Car C. he appeared "agitated and aggressive and was talking very fast:"

29 Ms Deery attended. She also described Jeff as "agitated" and "unable to stand still". In her oral evidence she described his presentation as" jumbled and disconnected" and he was "constantly moving and "unable to complete a sentence".

30 Jeff said words to her to the effect:
"I am a nice person, I am a nice person. I don't deserve this, there are poofters behind me and in front of me. I just visited my son for Father's Day. I am a schizophrenic and I am not on medication and I do not need it".

31 There followed a conversation between Jeff and Ms Deery whereby Jeff stated he wanted to get off at the next stop because he did not believe he could make the full journey.

32 Ms Deery suggested to Jeff that he not alight at Harden as it was dark and it would be safer for him to alight at Cootamundra as there was a well- lit Waiting Room and a Security Guard at the station.

33 She discussed the position with Mr David Harrison, Passenger Services Supervisor, with a view to offering Jeff 4 seats (2 seats facing each other), so that he would feel less crowded. Mr Harrison described Jeff as thought disordered and "rambling".

34 Jeff wanted to sit in seat 7 Car C and that seat was allocated to him.

35 During this interaction, Ms Deery stated that Jeff was seeking phone reception. He also said to her words to the effect:
"You don't understand, I have to live with this head."

36 Mr Hughson went to check Jeff's original seat and found pretzels on the floor and a 1.25 litre bottle of Coke that smelt of spirits.

37 After Harden, Mr Harrison approached Jeff and asked him about the alcohol in the bottle. He informed Jeff that it was unlawful for him to drink his own alcohol on the train.

38 Mr Harrison did not accept that he told Jeff the Police would be called. The evidence reveals that after this conversation about the Coke bottle Jeff remained very agitated and from time to time aggressive.

39 During this time, many passengers describe Jeff as “pacing” the carriages, including between carriages B and C, speaking loudly and appearing agitated.

40 Ms Angelica Murphy described Jeff as becoming ”more and more upset and pacing up and down”.

41 Ms De–Silva heard a guard say to Jeff in a polite tone of voice “you have to get off the train, you’re not supposed to drink and you had alcohol on you”. She stated that Jeff was “angry and pacing up and down.”

42 At approximately3.00am Mr Craig Stevens, train driver, sought, via the Junee Control Room, Police assistance to remove the male passenger.

43 Another passenger, Ms Ibrahim, was sitting in B carriage with her 5 children. At about 3.16am she observed Jeff walking up and down the aisle talking loudly to himself. He turned the overhead light on and said “I swear to God I’m not getting off”

44 She told the Court she was scared because of the agitated and angry behaviour and “thought it necessary to get him off the train – the kids were scared”.

45 Unsurprisingly, there are differing views relating to Jeff’s behaviour at this time, although the weight of the witness statements tends towards an observation of Jeff becoming increasingly agitated.

46 Jeff had been seeking to enter restricted areas and continued to talk loudly and erratically on his mobile phone.

47 At 3.12am Jeff spoke with his mother on his mobile phone for about 16 minutes. He told her he was being kicked off the train. Mrs Fakhouri in her statement says his speech was normal and he did not sound affected by alcohol.

48 At 3.24am the train arrived at Cootamundra Railway station.

49 At 3.35am, Junee Rail Control room called the train driver, Mr Stevens and informed him the police would not be attending.

50 At approximately 3.40am Mr Stevens gave Jeff a formal direction to leave the train. Jeff refused.

51 At that time a decision was made to physically remove Jeff from Carriage B of the train. Craig Stevens, Christopher Hughson and David Harrison physically removed Jeff from the train onto the platform. There was a struggle. Lee Salmon, another Passenger Attendant, assisted in removing Jeff from the train.

52 At 3.37am, Ms Ibrahim called 000 reporting a male acting paranoid and that attendees were trying to restrain him. Her call lasted almost 7 minutes. At the beginning of that call she described how Jeff did not want to get off the train, how he was restrained and was kicking and screaming. She went on to describe him being dragged off the train and being restrained on the platform

53 During this time a number of passengers on the train heard Jeff saying that he could not breathe.

54 On the platform, Jeff was restrained face down. Mr Hughson lay sideways on Jeff's back while holding Jeff's hands. Lee salmon knelt across his hamstrings to prevent him kicking his legs.

55 Given the conflicting evidence it is difficult to resolve the exact manner in which Jeff was restrained or the length of time that he was restrained.

58 Mr Harrison and Mr Stevens believed Jeff was restrained for about 2/3 minutes. Mr Hughson and Mr Salmon believed it to be about 10 minutes.

59 Mr Chaffey,a Security Guard employed to patrol Cootamundra Station, and independent of earlier events, observed train staff attempting to remove Jeff from the train. This was between 3.30am and 3.40am. Mr Chaffey thought the time of restraint to be between 10 – 15 minutes, more likely 10 minutes.

60 Mr Hughson, in his statement, said that Jeff was “huffing and puffing” and then he stopped. He thought he had “gone to sleep”

61 Ms Deery was asked to check on Jeff. She touched him and believed he reacted.

62 Both Mr Hughson and Mr Salmon released their hold of Jeff.Mr Harrison gave Jeff a shake and there was no response. Jeff was then rolled into the recovery position.

63 The police were called.

64 At 4.06am Police arrived and Senior Constable Banner began chest compressions with the assistance of Senior Constable Ismay. Paul Gilhooly, a student doctor assisted with compressions.

65 At 4.12 am and 4.16am Paramedics David Wilson and Maree Pulis arrived at the scene and continued CPR until Jeff was transported to Cootamundra Hospital.

The Autopsy and Cause of death

66 Dr Rexson Tse, Forensic Pathologist Registrar, supervised by Professor Tim Lyons(Forensic Pathologist) conducted an autopsy on 11 September 2011.

67 In his report, Dr Tse concluded that the cause of death was Methylamphetamine intoxication and restraint.

68 The results of quantitative tests on a sample of Mr Fakhouri's femoral blood were:

Alcohol not detected

Amphetamine 0.04mg/L, and

Methylamphetamine 0.52mg/L

69 Dr Tse described the case as "complex" and stated:
"the mechanism of death is from the combined effects of methylamphetamine intoxication and restraint leading to high physiological stress and subsequent cardiac arrhymthmia. However, an element of positional/mechanical asphyxia from restraint cannot be excluded. The relative contribution from methylamphetamine intoxication and restraint to the cause of death cannot be determined definitely"(p3)

70 He further opined that the cause of death was not due to excited delirium.

Excited Delirium

71 Professor Christine Hall is an Emergency Physician and the Medical Director of the Trauma Programme at Victoria General Hospital B.C. Canada.

72 In addition, she has completed studies on the phenomenon known as "excited delirium" and prone positioning. Professor Hall prepared a report dated 3 June 2016 and also gave oral evidence at the inquest.

73 Her evidence was that:
"Delirium is a well- recognised medical condition, with many possible underlying reasons for its presence. The presence of delirium in any medical setting significantly increases the odds of an individual dying and it is considered a medical emergency when it occurs in a hospital setting." (p.5).

74 She described the features of excited delirium as follows (p.10):

Constant or near constant anxiety
Not responding appropriately
Hot
Swearing/ diaphoric
Rapidly breathing
Superhuman strength
Failing to tire despite heavy exertion
Naked or partially clothed
Glass attraction
Pain tolerance

75 The observations of the witnesses were that Jeff appeared “hot and sweaty” and that he was struggling and “puffing and panting” and was very strong. Three people struggled to restrain him.

76 Professor Hall determined that on the observations of the witnesses, Jeff displayed at least five of the published features of excited delirium, and more than likely demonstrating seven of the recognised features of excited delirium by the time Jeff was removed from the train.

77 She concluded that Jeff was intoxicated with methylamphetamine and was not displaying behaviour necessarily consistent with that of intoxication; he was displaying the biological changes in a person experiencing excited delirium - that being “increased heart rate , increased respiratory rate, increased temperature and increased mental and physical activities.”

78 She stated that whilst travelling on the XPT, Jeff was in acute medical distress, displaying multiple features of excited delirium and it is “ more probable than not that those issues led to his demise”

79 Dr John Vinen is an Emergency Physician and Director Medical Services – Medicine at Calgary Hospital, Canberra Emergency Department. He also

stated that in his opinion Jeff's behaviour was consistent with behaviour associated with excited delirium and consistent with cases of excited delirium that he has seen in the Emergency Department. He described the condition as a "medical emergency associated with significant morbidity and mortality rates.

80 Professor Tim Lyons concurred with the conclusion expressed by Dr Tse.

81 Professor Lyons is the Clinical Director Newcastle Department Forensic Medicine and was the supervising Pathologist at the time of the autopsy .In oral evidence, Professor Lyons stated that the syndrome known as excited delirium is a contentious concept and is not generally used by Pathologists in Australia.

82 Historically, Professor Lyons stated, the concept came out of the use of cocaine, especially amongst psychiatric patients exhibiting a "pot pourri" of clinical symptoms and signs.

83 As Professor Lyons stated, a person presenting with possible symptoms of excited delirium in an Emergency Department, is available for the testing of a whole host of symptoms, including raised body temperature, blood levels, whether the patient is acidotic and any breakdown of skeletal muscle.Such measures are not available to a Forensic Pathologist.

84 The principal role of the Pathologist, according to Professor Lyons is to "paint a picture around the physiological principal sequence leading to death".On the available evidence, he agreed with Dr Tse, that the high amphetamine level and the element of restraint almost certainly triggered a cardiac arrhythmia.

Methylamphetamine Toxicity

85 The test results revealed a high level of methylamphetamine in Jeff's blood. It is conceded that the appearance of amphetamine is a metabolite of methylamphetamine.

86 All experts agreed that the behaviour exhibited by Jeff on the train was consistent with the features of methylamphetamine toxicity.

87 Dr Tse stated:

"Methylamphetamine is a potent stimulant which mainly acts on the central nervous system and cardiovascular system. Acute intoxication can initially cause agitation, aggression and violence, and can rapidly lead to very high body temperatures, with elevated heart rate and blood pressures. This would produce significant physiological and psychological stress which may be prodromal to death."

88 Professor Whyte, Director Department of Clinical Toxicology and Pharmacology at the Calvary Mater Hospital, Newcastle, reported that in his expert opinion:

89 "Death is usually associated with blood methylamphetamine concentration above 0.5mg/L but has been noted with concentration as low as 0.09mg/L.

90 Dr Vinen believed there could be a number of contributing factors and it is difficult to say that a particular level of methylamphetamine is likely to cause death. He concluded that the level found in Jeff was above the medium level but at the lower end of that level and he had seen patients with higher levels who had survived.

91 In the light of Professor Whyte's experience and expertise, however, Dr Vinen stated he would defer to Professor Whyte.

92 Professor Hall concluded that Jeff was in a state of excited delirium as a result of methylamphetamine toxicity and Jeff's "methylamphetamine toxicity directly contributed to his demise."

Positional Asphyxia and Restraint

93 Dr Tse in the Autopsy Report documented a number of injuries consistent with restraint. There is no contest that Jeff was restrained on the platform. The exact mechanism of the restraint and the length of time the restraint was applied is unclear from the evidence, although the most likely mechanism can be found in the statement of Mr Hughson and the evidence of Mr Salmon, the two persons who imposed the restraint.

100 Mr Hughson in his recorded interview described holding Jeff on his stomach on the platform. Mr Hughson was leaning over him on Jeff's back on the top of his torso.

101 Mr Salmon described restraining Jeff's hamstrings with his own legs and holding the bottom part of Jeff' legs upwards in a right angle to the ground.

102 Dr Tse concluded that restraint, especially prolonged and active, would produce significant physiological stress to the body together with an element of asphyxia.

103 Dr Vinen stated that the occurrence of death with persons suffering agitation and following restraint in the prone position is well recognised.

104 In such cases,Dr Vinen stated, death is,
"due to hypoxia and hypercapnia (increased blood carbon dioxide levels) due to impaired respiration and oxygenation as a result of an inability to breathe adequately or at all (" positional/ restraint asphyxia") resulting in cardiac arrest".

105 Dr Vinen said in this case, the position of Mr Hughson in lying sideways on Jeff's back increased the risk of asphyxia. Further, he stated a number of factors can render an individual more susceptible to death due to positional restraint. These include :

Drug/alcohol toxicity
Obesity
Excited Delirium
Pre-existing disease
Violent muscular activity

106 Dr Vinen concluded:
"This lack of a clear causation of death, associated with amphetamine use, restraint and or positional asphyxiation is well recognised…

These findings , the post mortem findings and the description of events associated with his removal from the train and restraint on the platform leading to his death lead me to the conclusion that cause of death was due to a combination of positional(prone position) and restraint asphyxia as a result of restraint"

107 A contrary view was expressed by Professor Hall. She stated a "*person must be in a compromised ventilatory position for a long period of time to suffer positional asphyxia".* She was sceptical of the theory that the prone position may result in positional asphyxia. Asphyxia as a result of the prone position was not, in her opinion well established.

108 She concluded:
"Without compelling evidence of the existence of positional asphyxia from a physiological view and without the presence of the restraint position accompanied by the conditions required to generate complete asphyxia, it is impossible to determine a degree to which positional asphyxia as an entity could have contributed to Mr Fakhouri's death, particularly in the presence of significant mitigating issues (methylamphetamine toxicity, Excited delirium)…

109 And further:

"The contribution of restraint to Mr Fakhouri's death would be limited to the generation of physiological stress incurred due to the struggle against restraint"

110 It is clear from the evidence of Dr Vinen, Professor Hall and Professor Lyons that there is considerable debate about the existence of positional restraint asphyxia and the role it played in Jeff's death.

111 There is also considerable debate about the syndrome of excited delirium. Whilst Dr Tse ruled out Excited Delirium as a cause of death, there is no doubt that Jeff was suffering significant psychological and physiological stress. Acute intoxication such as methylamphetamine toxicity can result in this stress as can Excited Delirium, if the syndrome is accepted, and this stress may lead to sudden death.

112 As Professor Lyons stated:
"Methylamphetamine is cardiac toxic and increases the heart rate. Likewise, restraint causes an increase in adrenaline resulting in a neurological overload on the heart."

113 I am satisfied on balance that the cause of death was multifactorial, being contributed to by both methylamphetamine intoxication and restraint.

114 The level of methylamphetamine was at a toxic level.

115 The issue of restraint cannot be excluded.

116 A cardiac event, brought on by the combination of these factors was the cause of death

The Actions Of The Train Staff

117 The on- board staff had been trained and understood that actions should be taken to de-escalate conflict with passengers wherever possible. They also all

understood that they were not to remove passengers from the train. Each of the staff gave evidence that it was their understanding that it was the obligation and responsibility of police to remove passengers if necessary.

118 In November 2011 a Memorandum of Understanding between Transport NSW and NSW Police Force was signed. The objectives of that Memorandum include:
"…to facilitate the most efficient and effective means of cooperation, communication and logistical support between the parties, so as to best ensure the safety and security of passengers, staff and infrastructure on the Public Transport Network."

119 That Memorandum(MOU) outlined the responsibilities of the Police force in relation to the NSW Public Transport Network.

120 That MOU was followed by a Media Release dated 14 February 2012 which stated in part:
"The NSW Police Force will take over security for the entire public transport network under a new dedicated Police Transport Command".

121 Mr Spartalis submitted that the MOU was about intelligence based policing and was not meant to encompass responses to 000 calls. He further submitted that the MOU and the Press Release had no application to a 000 call, such a call was always to be prioritised against resources and other urgent situations.

122 The MOU clearly envisages that police are to play a role in the maintenance of safety and security on the Public Transport Network. The document describes the policing functions to be performed by the Police. These include, inter alia, the targeting of crime and anti- social behaviour on the various transport services.

123 Although 000 calls to police is not specifically mentioned, there can be no doubt that police should have been aware of the objectives of the MOU and

the functions that the police were expected to perform in maintaining security and safety on the Public Transport Network. The objectives outlined in the MOU and the Media Release are consistent with NSW Trains having removed any security presence from the train network.

124 Indeed, each of the train staff giving evidence was aware of an Information Bulletin issued 18 August 2011 for the information of staff.

125 The purpose of that Bulletin was:
" to *assist Country Link Crew when dealing with difficult or disruptive passengers and to ensure a consistent procedure is followed".*

126 That document mandates that if a decision is made by the Passenger Services Supervisor, in this case Mr Harrison, that a passenger is to be removed, then he must notify the Driver that Police are required. The Bulletin then outlines what is to take place in circumstance where Police may be delayed.

127 At no time does that Bulletin authorise Train Staff to remove a passenger from the train.

128 Each of the staff who gave evidence, told the inquest that they were aware that the driver had requested the assistance of Police and it was their understanding that Police would be attending.

129 When Mr Stevens advised the Crew at 3.35am, that Police would not be attending and Jeff refused a demand by Mr Stevens to leave the train, a decision was then made by Mr Harrison and Mr Stevens to remove Jeff from the train with the assistance of Mr Hughson and Mr Salmon.

130 There is no doubt that train staff on NSW TrainLink trains (formerly known as CountryLink Trains)are regularly faced with difficult passengers. Each gave evidence to that effect, and each gave evidence as to what actions should be taken to try to contain a passenger whose behaviour was causing distress and

alarm. They were also mindful of considering the welfare and safety of all other passengers on the train

131 Mr Salmon stated that it would be appropriate to try to isolate the passenger if the Police are not readily available or otherwise move passengers away from the difficult passenger.

132 Mr Verbeek told the court that he believed it was necessary to try to diffuse the situation but stated “I am not sure what to do when the Police are unable to come”.

133 He further stated: “It is a catch 22, because we need to keep in mind a duty of care to other passengers”

134 Ms Deery was not aware of any strategy available to separate difficult passengers. She believed “there needs to be a strategy or protocol to help us protect ourselves and passengers to feel safe”

135 Mr Stevens stated that whilst keeping the train running to timetable was a priority, safety was the first priority. He further stated that Police usually turn up when he has requested assistance. “This is the first time it has ever happened to me that Police did not come”

136 Essentially, Mr Stevens believed that the situation warranted the removal of Jeff from the train in order to protect passengers on the train. He stated he was concerned Jeff would “strike someone.”

The Police Response

137 At 3.00am Craig Stevens, the train driver contacted Dani at ARTC(Australian Rail Track Corporation) seeking Police assistance at Cootamundra with a man with his own alcohol who is loud and aggressive. Any request for police assistance needed to be made through the Junee Communications Centre, where operators would then communicate with Police Radio Operations.

138 At 3.05am there was a Police Radio broadcast:

139 ”Cootamundra vehicle to attend the Railway station to remove an intoxicated passenger.”

140 At 3.10am Jessica at Police radio told Dani:

141 “We don’t have anyone on Duty in Cootamundra,”…is it possible to have police meet you at Wagga”…. “there’s definitely someone at Wagga, we can try and get someone at Junee”

142 At 3.16am Dani called Police and said:

143 ”about the XPT at Cootamundra wanting Police there…yeah he does want police there still, he is willing to wait. The passenger is very aggressive now and getting a bit out of control…”.

144 At about 3.19am Sergeant Senff, Radio Operations Group Oak Flats contacted the on – call duty officer for the Cootamundra Local Area Command to initiate a Police recall to duty.He spoke with Inspector Holmes who was the on-call duty officer for the Cootamundra Local Area Command on that night. As Cootamundra does not have police on duty 24 hours a day, after hours police are available on a call out basis from their homes.

145 Inspector Holmes requested information from the callout procedure for the Cootamundra Local Area Command. This information is contained in a document titled “Cootamundra Local Area Command Recall Procedures”. That document lists the situations when a call out may be warranted and was noted as correct as at 26 March 2012.

146 Sergeant Senff read out the various headings to Inspector Holmes under which a decision could be made to call out Police.

147 The following conversation took place:

148 Inspector Holmes:
"Intoxicated persons"?

149 Sergeant Senff :
"No it doesn't address intoxicated persons. It's a tough one, personally I like to see the train people hang onto him and turf him out at Wagga. But they reckon they're not prepared because he's so aggressive. I mean really what they'd have to do they'd have to bloody almost sit on him or lock him up somewhere but I don't know if they've got the authority to do that"

150 Inspector Holmes:
"*What's the worst that could happen?"*

151 Sergeant Senff:
"The worst that could happen, they turf him out at Cootamundra, as long as he doesn't fall underneath the wheels, until the trains gone, if he survives that long he might damage some rail property. But there can't be too many trains going through Cootamundra that time of night. He could create a bit of a nuisance I suppose. But what are you guys going to do with him? Yeah I don't know, it's a tough one, I just got no idea which way you wanna go with this one"

152 Inspector Holmes:
"I think they can drop him off at Cootamundra and he can sleep it off on the railway platform at Coota."

153 Inspector Holmes made a decision not to call out police. His explanation for so doing was that there was no suggestion that Jeff had assaulted anyone or committed any offences. He was aware that the train was already at the station or would be within a couple of minutes and he knew it would take 20 minutes for Police to arrive.

154 This decision was his responsibility. His claim that what was operating on his mind was that staff could demand that Jeff leave the train and if that did not eventuate then a further request made, is not a credible one.He knew that Jeff was aggressive because he had been told so by Sergeant Senff. He knew that rail staff wanted Jeff off the train. He simply failed to turn his mind to what those conditions might mean. He failed to turn his mind to the obvious possibility of the need for physical removal of Jeff from the train.

155 Inspector Holmes was not aware of the MOU between the NSW Police Force and Transport for NSW

156 There is no question that the failure by Inspector Holmes to respond to the request for police call out contributed to the catastrophic result that night..At the very least, the call out procedure miscarried.

157 Inspector Holmes' unsatisfactory response is deserving of criticism - for his failure to act at the time of the call out. In addition it is disturbing that Inspector Holmes was not aware of the Memorandum of Understanding between Police and NSW Transport, especially given that Cootamundra is a significant station for the transport route between Sydney and Melbourne.

Submission pursuant to Section 78 Coroner's Act

158 Mr Glissan QC, submitted that a recommendation be made for the referral of Mr Hughson, Mr Harrison ,Mr Stevens and Mr Salmon to the DPP for investigation for prosecution for manslaughter by unlawful and dangerous act and/or criminal negligence.

159 Any such recommendation must comply with Section 78 of the Coroner's Act.

160 Section78 (1) (b) states:
……if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all the evidence given up to that time) that:

the evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and

there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

The indictable offence would raise the issue of whether the known person caused the death….with which the inquest is concerned.

…the Coroner may refer the matter to the Director of Public Prosecutions

161 This matter was not canvassed during the evidence. The cause of death is multifactorial. I am not satisfied that the standard required by Section78 (1) (b) has been met on the basis that there is no sufficient basis on the evidence before me to do so and I do not propose to refer this matter.

Conclusion

162 The events of 8 September2014 and the death of Jeff Fakhouri were as a result of a cavalcade of poor judgments, inappropriate action and a failure to understand the risk involved in removing Jeff from the train and restraining him in the fashion undertaken on the platform.

163 Jeff exercised poor judgment in consuming methylamphetamine at a toxic level, leading to his unpredictable behaviour:

164 The Police demonstrated poor judgment in failing to respond to a call for assistance from Craig Stevens, the train driver, and,

165 The train staff who removed Jeff from the train behaved in an inappropriate manner bearing in mind their understanding of the limits of their authority.

166 The Train staff perceived the situation to require urgent action. They were placed in what they believed to be an invidious position – the protection of the

passengers and staff and the knowledge that they were not to receive assistance from police.

167 The actions of the train staff in restraining Jeff on the platform clearly demonstrated a failure by them to appreciate the risk of their actions. This is not surprising. They had no training in the use of restraint and even the medical experts do not agree on the question of the risk surrounding restraint.

168 What is particularly concerning is that it is unclear from the evidence of the train staff whether they now have an understanding of what action should be taken if such a situation should arise if the future.

169 The evidence clearly established that train staff are regularly confronted with aggressive, difficult and/or unpredictable passengers. There is a need for clarity.

170 For this reason I have determined to make two recommendations which hopefully will go some way to preventing such a tragedy again occurring.

RECOMMENDATIONS

1.To the Minister for Police:

That consideration be given to the review of the “Cootamundra Local Area Command Recall Procedures” to provide for officers to be recalled where assistance is requested in relation to passengers on NSW TrainLink trains.

2. To the Minister for Transport:

That NSW Trains continue to develop protocols to assist staff to manage passengers in a way consistent with passenger and staff safety, from the time a decision has been made to request police assistance until police are in attendance.

FINDINGS s.81 Coroners Act 2009

I find that Afif (Jeff) Fakhouri died on 9 September 2014 at Cootamundra Hospital and that on the balance of probabilities his death resulted from a combination of factors including methylamphetamine toxicity and restraint leading to physiological stress and subsequent cardiac arrhythmia due to forcible restraint by train staff in the prone position on Cootamundra Station.

I offer my sincere condolences to Jeff's family for the loss they have suffered.

Magistrate Helen Barry
Deputy State Coroner