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The National Justice Project
PO Box 587
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Attention: Mr George Newhouse

Dear Mr Newhouse,

RE: THE DEATH OF DAVID DUNGAY JR

I have been briefed to advise whether any criminal charges could be brought against Officer F and any members of the Immediate Action Team (IAT) in relation to their role in the events that led to David Dungay's death on 29 December 2015 at the Mental Health Unit at Long Bay Hospital. Mr Dungay's death was the subject of extensive evidence before the Coroner who made no referrals to the Director of Public Prosecutions pursuant to s.78 of the *Coroners Act*. It seems that the Coroner, Mr Lee, did not conclude that the evidence in the Inquest was capable of satisfying a jury beyond reasonable doubt that any known person had committed an indictable offence and that there was a reasonable prospect that the person would be convicted by a jury and that the indictable offence would raise the issue of whether the person caused the death with which the Inquest was concerned.[1]

I have concluded that the evidence at the Inquest is capable of satisfying a Court beyond reasonable doubt that officers F, A and C assaulted Mr Dungay. I have concluded that, in addition to evidence demonstrating that these officers assaulted the deceased, there is sufficient force in the evidence about Mr Dungay's cause of death such as to make a prosecution for manslaughter viable.

<u>The events leading to the incident</u>

Mr Dungay was transferred to Long Bay Hospital in late November 2015 as a correctional patient for involuntary mental health treatment under the Mental Health (Forensic Provisions) Act. He was suffering from a conjunction of difficulties relating to his mental health and his unstable blood sugar levels, as a long-standing diabetic. Throughout his

[1] S.78(1)(b) Coroners Act 2009 NSW

time at the Long Bay Hospital, there were problems calibrating his antipsychotic medication and difficulties controlling his blood sugar levels. Yet, by 22 December, Mr Dungay seemed to be improving. He was feeling better and not hearing voices. Unfortunately, his blood sugar level were still unstable, and he remained psychotic.

On 22 December 2015 Dr Spasojevic saw Mr Dungay and discussed his condition with an Endocrinology Registrar at the Prince of Wales Hospital. Mr Dungay's blood sugar levels and medication charts were to be sent to the hospital for review. Dr Spasojevic reviewed Mr Dungay again on 24 December and made arrangements for the blood sugar levels to be sent to the hospital.

On 29 December, Mr Dungay was housed in cell 71 in G Ward at the Mental Health Unit at Long Bay Hospital. That morning his blood sugar level was high (3.2 mmol/L). A registered nurse spoke with Dr Ma about the blood sugar reading and it was decided to withhold Mr Dungay's Novorapid injection because of the low blood sugar reading.

Mr Dungay's blood sugar levels were tested again at 10.00am. It was 17.4 mmol/L which was by this time very high. At midday it was over 25 mmol/L. At the midday examination, Mr Dungay refused to let RN Xu take his vital signs. Mr Dungay told RN Xu that he was feeling fine. There were no signs of a problem. He was not unwell. He was asymptomatic even though his blood sugar level was high. During the morning of 29 December, Mr Dungay spent time out of his cell in the exercise yard and appeared to be eating some biscuits.

At about 2pm his blood sugar levels were still at 24.2 mmol/L. Mr Dungay again refused to allow his observations to be taken.

Not long afterwards, when it was time to be locked back into his cell, Mr Dungay was calm and sought access to his "buy up". He helped himself to a packet of rice crackers and a packet of biscuits. Officer D claims that she said to him, "Remember what the nurse said, you've got to watch what you eat". Officer D gave evidence at the Inquest suggesting that once she reminded him of this issue he "immediately became very aggressive and abusive"[2].

He allegedly replied, "I am going to go off my fucking cunt if I can't have these biscuits. I have fucking paid for them and they're mine"[3].

After this exchange, Officer E spoke to Mr Dungay to try and persuade him to give him the biscuits. Mr Dungay was described as "remaining angry and agitated". Officer E referred the matter to Officer F who also failed to persuade Mr Dungay to give up the biscuits.

At or about 2.30pm Officer F decided that it would be safer to move Mr Dungay to a camera cell so that he could be observed. The camera cell remained within the confines

[2] Exhibit 1, p.122 at [7]
[3] Transcript 16/7/2018 at T56.9

of G Ward, which was gazetted as a mental health facility. Officer F contacted the IAT and directed them to move Mr Dungay.

At or about the same time RN Xu discussed Mr Dungay's agitation with a medical officer and another nurse. It was considered appropriate to administer an intramuscular injection of midazolam to calm Mr Dungay down.

Six members of the IAT attended on the ward (officers A, B, C, M, N and O). They were briefed by Officer F, the most senior officer present, and Officer A, who was in charge of the IAT. Together with Officer F, they went to Mr Dungay's cell door. He was in cell 71. It was their intention to move him, if necessary forcefully, from cell 71 to nearby cell 77 which had a camera operating in it. One of the officers was using a handheld video camera. The incident thereafter is quite well captured by the footage.

The course of events thereafter were accurately described by Coroner Lee in his findings[4]. Officer A spoke to Mr Dungay through the door of cell 71 and twice asked him to come to the door, place his hands through it so he could be handcuffed and then be moved to another cell. Officer A also indicated that if Mr Dungay did not comply with the direction, force may be used. Mr Dungay continued to eat his biscuits and did not comply with the direction. He made it clear he intended to physically engage with the IAT. At one point, he pulled his shirt over his head and appeared to shadow box.

About 2.43pm, the IAT entered cell 71. Officer C was the first officer into the cell. He was carrying a riot shield. As the officers entered, Mr Dungay collided with the shield. The IAT members gained control of Mr Dungay and restrained him, pinning him down on the cell bed. It is evident from the IAT footage that Mr Dungay resisted and officers described him clawing at them and attempting to bite.

In the course of Mr Dungay being restrained on the bed of cell 71, with officers above him and seemingly placing weight on him, he began to scream "I can't breath". He repeated those words on a number of occasions while he was in cell 71, while being transferred to cell 77 and inside cell 77. The IAT members moved Mr Dungay from the bed onto the floor of cell 71. After the IAT members gained control of Mr Dungay, they applied handcuffs to him with his arms in front. He was then raised from the ground, though his head was kept down, with the officers stating that Mr Dungay continued to spit blood.

At approximately 2.46pm, Mr Dungay was led by the IAT from cell 71 into corridor A and then through corridor B to cell 77. Mr Dungay continued to scream that he could not breath and at one point during the transfer dropped to his knees. The officers remonstrated with Mr Dungay to stand up and to stop spitting blood.

Mr Dungay was led into cell 77 at approximately 2.47pm. He was placed onto the bed faced down and again restrained by the IAT officers placing weight onto him. Soon after Mr Dungay's arrival in cell 77 and after being summoned by the IAT, RN Xu entered and

[4] Paras 9.12 to 9.24 of the Coroner's findings

administered an intramuscular injection of midazolam into Mr Dungay's right buttock. Mr Dungay continued to scream that he could not breath while RN Xu was in the cell.

RN Xu departed the cell after administering the injection of midazolam. He said that he observed Mr Dungay becoming increasingly aggressive during the midazolam injection and that as a result, he spoke to Dr Ma to report the further escalation of aggression. Other evidence suggests it was a different nurse. In any event, Dr Ma subsequently provided a verbal order for an intramuscular injection of haloperidol, an antipsychotic.

While RN Xu was absent from cell 77, CSNSW officers continued to restrain Mr Dungay, based on their understanding that a second sedative was to be administered. Officer G said that he yelled out to Officer F to say that the IAT members should continue to restrain Mr Dungay based on a discussion he had with nursing staff regarding the need for a second sedative to be administered. The CCTV from corridor B is consistent with that evidence.

Mr Dungay continued to be restrained by the IAT members and he continued to scream that he could not breath. At one point during the restraint, Officer B asked that Mr Dungay's head be turned to the side, which Officer C attended to. The officers observed Mr Dungay to be breathing. One of the officers said to him that as he was talking, he was breathing.

Approximately 60 to 90 seconds after the midazolam injection was administered, Mr Dungay became unresponsive and the CSNSW officers described his body going limp. That seems to have occurred at approximately 2.49pm. After Mr Dungay became unresponsive, IAT members called for a nurse and began providing cardiopulmonary resuscitation after moving Mr Dungay to the floor.

Within roughly 90 seconds of Mr Dungay becoming unresponsive, nurses from the Justice Health were on the scene with resuscitation equipment. About 30 seconds later, Dr Ma attended and took over the attempts of resuscitation from the CSNSW officers. A call was made for an ambulance and it was booked at 2.52pm. In the interim, Dr Ma led the resuscitation efforts with RN Netra Thapa and RN Rajana Maharjan also assisting. A defibrillator was used. Dr Ma also utilised a hand held suction device because of concern about an obstruction in Mr Dungay's airway.

After attempts at resuscitation did not result in Mr Dungay breathing or any chest rise, bag ventilation was attempted. Mr Dungay vomited onto the floor. Continued attempts with the defibrillator resulted in no shockable rhythm being identified.

Paramedics from NSW Ambulance arrived at the Long Bay Correctional Complex at 3.01pm and made contact with Mr Dungay at 3.07pm. The paramedics continued to attempt to resuscitate Mr Dungay after having him brought out into the corridor for just over half an hour. As there were no signs of life in response to treatment, resuscitative efforts ceased and Mr Dungay was pronounced deceased at 3.42pm.

In that factual context there are a number of key questions that need careful consideration.

1. Was it lawful to use force to move Mr Dungay from cell 71 to cell 77?
2. Was the use of force throughout the proceedings lawful?
3. If unlawful, was the force objectively dangerous? and
4. What caused Mr Dungay's death?

I have concluded that on the evidence that was presented to the Coroner, the answers to these questions are.

1. It was not necessary or appropriate to move Mr Dungay from cell 71 to cell 77 and that, by doing so, Officer F and the various IAT officers acted unlawfully by using force.
2. The IAT members continued to use unlawful force under the direction of Officer F during the time when they restrained Mr Dungay in cell 71, on the way to cell 77 and in cell 77.
3. The force used was objectively dangerous. It carried with it an appreciable risk of serious harm.
4. Mr Dungay's death followed a violent struggle and an extended period of face down restraint. There was some evidence suggesting that a substantial contributing cause of Mr Dungay's death was the excessive force used to restrain him but on the totality of the evidence before the Coroner, there may have been other reasons for his death.

Question 1 - Was it lawful to use force to move Mr Dungay from cell 71 to cell 77?

In relation to this issue, I agree with many of the Coroner's findings.[5] Notably, his Honour said,

> "Ultimately, it was neither necessary nor appropriate for David to be moved. Officer F acknowledged that David was already safely contained within his cell and therefore did not pose a security risk. Similarly, Officer E held no security concerns regarding David's circumstances at the time. From a medical point of view there was no evidence of any acute condition which would warrant a cell transfer and the need for David to be observed in a camera cell."[6]

Officer E wrote an Incident Report on 29 December[7]. The Incident Report suggested that Officer E approached RN Xu who "was concerned about the amount of buy-up" that Mr Dungay had taken into his cell because he was a diabetic who was consuming too much sweet type food. The Incident Report suggests that Officer E went to cell 71 to speak with Mr Dungay to "voice our concerns about the amount of food he was consuming".

[5] Paras 13.16-13.21 of the Coroner's findings
[6] Para 13.19 of the Coroner's findings
[7] Exhibit 1, p.126

Officer F then went to the cell and asked Mr Dungay to hand over the biscuits. He was accompanied by RN Xu, who observed Mr Dungay become highly agitated in response.[8] He was shouting and hitting the door, and RN Xu felt the nursing staff needed to do something to calm him down.[9] However at no stage did RN Xu request that the IAT attend, nor that Mr Dungay be moved between cells.[10] In his evidence RN Xu said,

> "My worry about his – the possibility of him being harming himself that day was based on my observation of him being uncontrollably angry. My worry was that based on he was actually – I, I didn't see it but I was pretty close to the cell door at the time I could, I could sense he was throwing himself to the door."[11]

RN Xu's evidence was that he understood that there was a general practice that inmates could only be medically transferred to a different cell after a doctor completed a certificate. He stated in his evidence that, if he wanted David Dungay moved out of concern for his condition he would have spoken to a doctor who would have then assessed him and, presumably, filled in a certificate.[12] It is fairly clear from the evidence at the Inquest that no one from Justice Health made any of the arrangements to move Mr Dungay from one cell to another. That decision seems to have been made by Officer F. This is so even though in Officer E's Incident Report it states that, "[Officer F], [RN Xu] and I decided it would be safe to move Dungay to a camera cell so he could be observed better".[13]

RN Xu denied even knowing that a cell transfer was to occur until he had attended cell 71, ready to inject with Mr Dungay with the midazolam.[14] The video footage supports this assertion, and shows RN Xu following the IAT down to cell 71 and then being told to go away. As the Coroner pointed out in his judgment, if RN Xu had organised or requested the cell transfer it would have been unlikely that he would have attended David Dungay in cell 71. Rather, it's more likely that RN Xu would have waited until he had been moved to cell 77 to administer the injection. The footage is support for RN Xu's version that the first he became aware of the cell transfer was after the arrival of the IAT on G ward.[15]

In my opinion, the combination of the evidence of the Incident Report provided by Officer E, RN Xu's account of the events, the CCTV footage which corroborates RN Xu and evidence from Officer E is prima facie evidence that Officer F made the decision to move Mr Dungay from cell 71 to cell 77. Dr Cromer the endocrinologist, who gave evidence at the Inquest, is of the opinion that Mr Dungay's sugar levels were not such as that the incident constituted a medical emergency justifying the movement of the

[8] Transcript 24/7/2018 at T92.30
[9] Transcript 24/7/2018 at T94.38
[10] Transcript 26/7/2018 at T10.41
[11] Transcript 26/7/2018 at T11.14
[12] Transcript 26/7/2018 at T12.36
[13] Exhibit 1, p.126
[14] Transcript 26/7/2018 at T15.13
[15] Para 13.13 of the Coroner's findings

patient from one cell to another. He also gave evidence that, whilst it would have been preferable to remove the biscuits from the cell, the incident had not become so pressing as to be considered a medical emergency[16]. Needless to say, no one appears to have considered that the trouble could have been avoided by simply confiscating the biscuits.

I am of the view Officer F acted prematurely and inappropriately in organising Mr Dungay's movement. It is significant that Officer F is a correctional officer and that Mr Dungay was present on the ward as an involuntary mental health patient. Further, there is evidence that shortly before the cell movement RN Maharjan advised Officer F to leave Mr Dungay in a non-camera cell.[17] RN Maharjan was unhappy about the planned move. She advised Dr Ma that Corrective Services' officers were seeking a medical certificate to transfer Mr Dungay to a camera cell. Dr Ma gave instructions to leave him in the non-camera cell and indicated that they would work towards a new joint management plan to manage the situation.[18] RN Maharjan gave evidence at the Inquest that she returned to the ward and advised Officer F and others what Dr Ma had said.[19] Mind you, Dr Ma's evidence was not exactly the same. He denied that there was such a conversation with RN Maharjan.

Nevertheless, it is the case that Officer F made the arrangements for the IAT to facilitate the cell change. There was no request for such a move from Justice Health.

The Coroner rejected the Dungay family's solicitor's submission that Officer F "embarked on a "power play" in response to David's defiant behaviour, which can only be described as repugnant and reprehensible"[20]. His Honour did so because he was of the view that,

> "It could not be said that this is the only reasonable conclusion that can be drawn from Officer F's decision to effect a cell transfer for David. …. The rationale given by Officer F as to his decision-making process was that it was based on medical grounds. Whilst the evidence demonstrates that there was no medical basis to support such a rationale, this was not known to Officer F at the time."[21]

Whether or not Officer F was mistaken about the medical basis to support a move, there was, in fact, no medical basis and no other emergency existed that required moving David Dungay from one cell to another.

As a matter of course, it was the IAT that was called on to effect the move. There was no attempt to deal with the matter through any other form of negotiation and persuasion. As the Coroner found, the IAT training had a "distinct lack of emphasis on de-escalation techniques".[22]

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[16] Transcript 25/7/2018 at T63.46
[17] Transcript 4/3/2019 at T29.38
[18] Transcript 4/3/2019 at T32.10
[19] Transcript 4/3/2019 at T45.16
[20] Para 13.20 of the Coroner's findings
[21] Para 13.20 of the Coroner's findings
[22] Para 15.21 of the Coroner's findings

It was in this background that the IAT arrived at the cell door and made the proclamation that required Mr Dungay to present his arms through the cell door slot to be cuffed in order to give effect to the planned move. By that time, it is apparent from the footage that Mr Dungay was intent on resisting. No effort was made to try and deal with the escalating crisis which was emerging, or to consider non-violent alternatives.

Question 2 – Did the IAT members act appropriately in the application of force to move and/or to restrain David Dungay?

In the context outlined above, where there was no medical emergency and where Officer F decided to enlist the IAT to move Mr Dungay, it is necessary to analyse the way in which he was moved and the application of force throughout the course of his movement. As there was no good reason to move him, his movement was illegal. In that sense, all of the force used during the process of moving him was illegally applied. It was certainly not "appropriate".

The power of Corrective Services officers to use force is provided by legislation. Officers act under the *Crimes (Administration of Sentences) Act 1999* and its regulations. The Act itself does not include any relevant powers concerning the use of force. The *Crimes (Administration of Sentences) Regulation 2014* deals with the maintenance of order and discipline within correctional centres. Clause 129 of the Regulation states that "order and discipline in a correctional centre are to be maintained with firmness, but with no more restriction or force than is required for safe custody and well-ordered community life within the centre."

Clause 131 of the Regulation deals with the use of force in dealing with inmates and indicates that a correctional officer "may use no more force than is reasonably necessary in the circumstances, and the infliction of injury on the inmate is to be avoided if at all possible." The force used must not exceed the force necessary for control and protection.

Mr Dungay was securely housed in his cell. There was no medical or security emergency. As there was no good reason to move him, any force directed at doing so was illegal. The force used was contrary to the relevant Custodial Operations Policy and Procedures (COPPs). It was illegal. Mr Dungay was actually assaulted by all of the custodial officers who effected the move and who applied any force to him. This included Officer F, who directed the move, together with the IAT officers. Those particular officers, whose conduct will be shortly identified, used so much inappropriate force as to be able to conclude clearly and unambiguously that they committed a crime, namely, assault (at least).

As the Coroner pointed out in his findings, s.5 of the *Corrective Services Custodial Operations Policy and Procedures* (COPP) covers the use of force by Corrective Services officers on inmates. It instructs officers: "*You must use alternative methods to resolve*

problematic behaviour whenever possible. A peaceful, injury-free solution is the first objective".[23]

Section 2.1 of the COPP provides,

> "*The type of force you use will depend on the circumstances and what resources are available. It must be reasonable, appropriate for the circumstances, and no more than necessary to manage the risk … you must give the inmate clear instructions about what you want the inmate to do and when you want them to do it. Clearly explain the consequences for failing to comply and give them a reasonable opportunity to comply. When all else has failed, only then instruct personnel to use force".*[24]

Section 2.2 provides,

> *"Once an inmate has been satisfactorily restrained you must not apply additional force. If the force is no longer necessary, you must stop applying it. That includes the use of restraints. Force must be applied in the way that minimises the injury risks to staff and the involved inmate(s). In every case, a Correctional Officer using force must justify the type of force that they use, why they use it, and the duration of its use. This includes the use of security equipment".*[25]

The video footage is by far the best evidence of what force was used. All of the force occurred in circumstances where the movement from one cell to the other was not required. All of the force was used in circumstances where no alternative means to resolve the problem were examined. No one suggested a "peaceful, injury-free solution".

Mr Dungay was warned that he was about to be moved and he was asked to co-operate by placing his hands through the opening of his cell door so he could be handcuffed. He refused to co-operate.

He was given time to consider and, perhaps, reconsider his co-operation but by 2.43pm, the decision was made to use whatever force was necessary so as to move him to cell 77. No IAT officer checked to see if the cell move was medically required. No IAT officer saw a Certificate issued by a doctor or a nurse. There was no such certificate issued. No one thought about alternative ways of dealing with Mr Dungay.

When the door was opened at about 2.43pm, Officer C entered. He was carrying a shield. He came into contact with Mr Dungay and pushed him back into the cell and then used the shield to effect force upon Mr Dungay a second time.[26]

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[23] Exhibit 1, p.782
[24] Exhibit 1, p.783
[25] Exhibit 1, pp.783-784
[26] Transcript 20/7/2018 at T371.5

Thereafter, Officer C used his upper torso to collide with Mr Dungay in a "sort of a rugby style tackle". This forced Mr Dungay backwards onto the mattress of the cell bed.[27]

Officer C then pushed down on Mr Dungay's upper torso and restrained Mr Dungay's left hand with one hand and used his other hand to turn Mr Dungay's face towards the cell wall.

Officers A, B, M and O entered the cell and assisted Officer C to restrain Mr Dungay on the bed. At this point Mr Dungay's hands were cuffed at the front of his body. Whilst that was happening, pressure was applied to his legs.

Mr Dungay was held on the bed for about 1 minute and 37 seconds before he was moved onto the floor of the cell where he was restrained for a further 1 minute and 25 seconds. He was then stood up and led from cell 71 to cell 77. Mr Dungay's head was kept down to stop him spitting blood. He was walking whilst bent forward and hunched over.

When being moved between the cells Mr Dungay complained about not being able to breath. He collapsed to the ground. He was lifted back up and forced to walk escorted to cell 77.

When he was pushed into cell 77, he was forced onto the cell bed lying down with his head at one end of the mattress. He was still handcuffed. Officer O used the "Figure 4 technique", applying pressure to Mr Dungay's legs whilst Officer C used a "knee ride" to prevent Mr Dungay moving his hips. The "knee ride" involved the officer pushing down on Mr Dungay's shoulders between his shoulder blades, with one foot on the ground and with his knee being forced into Mr Dungay's lower back.

Mr Dungay was held in this position until he became unresponsive 8 minutes and 16 seconds after the commencement of the IAT footage. The amount of force exerted on Mr Dungay by Officer C's knee is apparent from the footage. When the pressure of the knee ride was finally removed, Mr Dungay's lower back rebounded from the mattress.

Mr Dungay complained on many occasions that he could not breath. His first complaint was made whilst he was still on the bed inside cell 71. He also complained when he was being held on the floor of cell 71, whilst being escorted from one cell to the other and whilst he was on the bed inside cell 77. Indeed, his complaints about not being to breath continued even after he was well under control in cell 77.

Mr Dungay also appeared to experience breathing difficulties. Laboured breathing and gasping are apparent in the IAT footage from early on within cell 71 through to cell 77. Officer F was present throughout the incident.

[27] Transcript 22/7/2018 at T371.11

The footage makes it clear that at least some of the IAT officers regarded Mr Dungay's complaints that he could not breath to be a ruse or, as it was explained in evidence at the Inquest, a "diversionary tactic" so that the officers would "loosen the restraint".[28]

It may be true that the IAT officers thought that Mr Dungay was trying to divert them from their task by his complaints but, the continuation of the force in the face of these complaints was not justified. The test for whether or not Mr Dungay was able to breath or not would have been to ease up on the force, even momentarily, to see whether or not he was able to respond.

As the Coroner commented, "Notwithstanding this acknowledged possibility that David's complaints were in fact genuine, no enquiry was made with any available Justice Health staff so that a proper determination could be made. Instead, several of the officers relied upon their own personal experiences or personally acquired understanding which were inherently flawed."[29]

I agree with the Coroner's finding at 16.10 that "David's persistent complaints of being unable to breath, together with his audible gasping respirations should have prompted action in the form of a request for nursing or medical assessments. Instead, David's complaints were ignored, and his gasping was incorrectly attributed to exertion".

By at least the time that Mr Dungay was restrained on the bed in cell 77, the application of additional force by Officer C using the knee ride was not warranted. The circumstances were such that satisfactory restraint had been achieved.[30]

Hence, at the very latest, the officers were applying inappropriate and unnecessary force contrary to the Regulations and to their own COPP. They were assaulting him. All of these actions were undertaken in the presence of Officer F, and under his direction, in circumstances where he had ordered the cell move. The application of force was illegal. It carried with it grave risks of serious harm.

<u>Question 3 – If unlawful, was the force objectively dangerous?</u>

As I have already made plain, there were grave risks in the application of the force that was used.

Positional asphyxia is a fairly well understood mechanism that puts a subject at high risk of suffocation. It was best described in the evidence at the Inquest by Professor Anthony Brown, an Emergency Physician. He testified that placing a subject in a prone position and applying force to their chest or back prevents the chest from fully expanding which, in turn, causes congestion and prevents blood from returning to the chest. The

[28] Transcript 19/7/2018 at T294.42
[29] Para 16.9 of the Coroner's findings
[30] Para 16.18 of the Coroner's findings

compressed chest obviously restricts ventilation. Hence, oxygen levels in the blood are reduced.[31] Sudden death may result.

This phenomenon and the risk of sudden death is well recognised in law enforcement and Corrective Services circles. In the UK, their Prison Service has a policy which emphasises the need to avoid high risk restraint techniques and which provides comprehensive guidance on managing the control of restraint incidents to minimise risks. Similarly, the UK Metropolitan Police Service publishes an officer safety manual that states that officers should avoid applying pressure across a person's back and shoulders and that the subject must be repositioned from the face down position at the earliest opportunity.

Findings in Inquests in Australia have made similar conclusions.[32]

It follows, therefore, that there was an appreciable risk, ie, an objectively recognisable risk, of serious harm as a result of the application of the force that was, in fact, used on this particular occasion to Mr Dungay.

If someone applies unlawful force to a person and in doing so exposes that person to an appreciable risk of serious harm and the forceful act causes the person's death, then the offence of manslaughter is established. Manslaughter by way of unlawful and dangerous act occurs in exactly these circumstances. So then, the evidence in this case establishes that the IAT officers used unlawful force on Mr Dungay and that by their acts exposed him to a serious risk of harm. They did so under the direction of Officer F, who was present during Mr Dungay's restraint. Mr Dungay died in the course of this event. All elements to establish the offence of manslaughter are made out on the evidence if the unlawful forceful acts caused Mr Dungay to die.

<u>Question 4 – what caused Mr Dungay's death?</u>

The legal question as to whether an act "causes" a result is well established. The act causing death must be "a substantial or significant cause of death" or a "sufficiently substantial" cause. See *Royall v The Queen* (1991) 172 CLR 378 at 411-412; see also at 398, 423 and 442; also see *Osland v The Queen* (1998) 197 CLR 316 at [16]; *Patel v The Queen* [2012] 247 CLR 531 at [75]; *Gillard v the Queen* [2014] 88 ALJR 606 at [24]; and *Swan v The Queen* (2020) 94 ALJR 385 at [24].

In *Swan* the High Court said, at [25],

> "It was also recognised in *Royall v The Queen* that there are some cases where an accused will be legally responsible for a death even if the act of the accused was not, by itself, necessary for the victim's death but was instead "one of the

[31] Transcript 25/7/2018 at T26.0.

[32] Inquest into the death of Tofia Mataia, Queensland State Coroner, 2010; Inquest into the death of Shaun Coolwell, Queensland State Coroner 2019; Inquest into the death of Tristan Naudi, NSW State Coroner 2020.

> conditions which were jointly necessary to produce the event". An exceptional example where an accused might be held legally responsible for the death of another even if the act of the accused was not by itself necessary for the victim's death is where a victim "dies from the combined effects of … two wounds, either of which would have been sufficient for death but only one of which was inflicted by the accused."

So, causation does not require an act to be the only cause of death. There may be multiple causes. But the act causing death must be at least "a substantial cause" of the death. It must have some substance and be more than minimally involved in the mechanism of death.

As the High Court made plain in various judgments, substantial cause is sometimes equated with "significant cause". But, the preponderance of authorities seems to suggest that the real test is "substantial cause".

The post mortem revealed that Mr Dungay had petechial haemorrhages which occur when there is impaired blood drainage from the head through force of pressure on the neck or torso. There was evidence about the risks associated with compression of the torso in the prone position. This type of force may reduce the entry of air into the lungs and ultimately lead to hypoxia/cardiac arrest.

The post mortem also provided evidence that there was possibly aspirated foreign material in Mr Dungay's lungs. The post mortem also suggested that Mr Dungay could have been suffering from early dehydration due to high blood glucose levels. Then, another complicating factor was whether or not the administration of midazolam might have led to cardiac arrest.

The forensic pathologist who conducted the post mortem, Dr Bailey, was unable to ascertain to her satisfaction the cause of death. As the Coroner pointed out at finding 24.2, Dr Bailey's evidence was, "*I could not identify a pathology that was incompatible with life and therefore accounting for his sudden death. Having said that, there are many physiological causes of death that cannot be identified at autopsy, but in – my inability to scientifically demonstrate one, I can't give you a cause of death".*[33]

Dr Cromer, an endocrinologist, gave evidence that Mr Dungay had hypoglycaemia. He was, though, of the opinion that the elevated glucose levels would not have contributed to Mr Dungay's sudden death.[34] Dr Cromer was also of the view that, although hypoglycaemia can lead to a loss of consciousness and then ultimately to death, that is a slow process and that there would be evidence of other symptoms prior to loss of consciousness. Essentially, this ruled out the hypoglycaemia as a cause of death.

Professor Brown, an emergency physician, effectively ruled out the midazolam as a cause of death. He said that there was only a short time (2 minutes and 7 seconds) from the

[33] Transcript 7/3/2019 at T48.47
[34] Exhibit 1, p.1547

injection to the cardiorespiratory arrest which was insufficient time for midazolam to have been absorbed such as to contribute to the heart attack. Indeed, Professor Brown said, "*Midazolam played no part at all in the cause of David's death".*[35]

Associate Professor Adams, a cardiologist, gave evidence that it was likely that Mr Dungay had fatal cardiac arrhythmia and pointed to three indicators for this. First, there was no other obvious cause of death at all at autopsy. Second, the IAT footage is consistent with arrhythmia and then a deterioration into a fatal arrhythmia. Third, Mr Dungay had other factors that would have assisted with the development of arrhythmia including, taking antipsychotic medication, type 1 diabetes, hypoglycaemia and possible evidence of hypoxaemia and its introduction during a situation of extreme stress and emotional upsets.

Associate Professor Adams was of the view that the arrhythmia possibly commenced whilst Mr Dungay was in cell 71 and that, by the time he left cell 71 he was already in ventricular fibrillation and, if so, any further exertion or struggle "*could have made the ventricular tachycardia faster and less effective at providing a cardiac output and increasing the degree of failure*".[36]

Professor Adams also suggested that the restraint "*could cause a degree of hypoxia which would further accentuate any sort of arrhythmias which would have occurred or may have occurred*". But, Professor Adams doubted that the restraint was a significant cause of death. He said, *"Whether that is significant, its probably a little doubtful in that I suspect he probably already had the arrhythmia before any restraint might have caused, caused hypoxia".*[37]

The pathologist, Dr Bailey, accepted that the exact mechanism of death was likely to be cardiac arrhythmia but that she didn't know what the underlying reason for it was.[38] Yet, Dr Bailey described the overall position in a manner which suggests that the restraint mechanisms used were a real and contributing factor to the arrhythmia developing. She said, "*So you have somebody who is agitated, whose metabolic demands are very high, who also already has a little bit of metabolic derangement, because of the diabetes, they're put face down, they have a little bit of hypoxia from being placed face down, he may or may not have aspirated. All of this could precipitate potentially fatal cardia dysrhythmia. That is an absolutely hypothetical scenario, but these are all of the contributing factors that I think have come together in this case. I think he is also starting to get a little bit dehydrated, if you look at his biochemical testing, which again a little bit of dehydration on the background of his diabetes and his obesity and his agitation, all of the tiny little things, whilst in isolation are not a problem in total create the possibility for a sudden cardiac death".*[39]

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[35] Exhibit 1, Tab 69
[36] Transcript 7/3/2019 at T11.7
[37] Transcript 7/3/2019 at T8.35
[38] Transcript 7/3/2019 at T61.2
[39] Transcript 25/7/2018 at T47.50

Professor Brown, the emergency physician, was of the view that Mr Dungay had experienced significant hypoxia by the time he became unresponsive.[40] He explained that prone positioning prevents the chest from expanding fully, which causes congestion and prevents blood returning to the chest. It also restricts ventilation, resulting in reduced oxygen being absorbed into the blood.[41] Multiple petechial haemorrhages around David's eyes, together with a markedly congested scalp, were post-mortem findings which Professor Brown found consistent with impaired blood drainage from David's head, and indicative of positional asphyxia.[42]

Professor Brown expressed the view that the failure to cease restraint was a contributing cause of death. He said, "*I think it was contributory. I can't tell you at which point ceasing it was important. It's an impossible situation where you have an agitated person and a danger to others, a danger to themselves, it's a no win situation. I think, I can't tell you at what point restraint sorry – at what point ceasing any sort of hands on would have made a big difference".*[43]

When asked whether the positional asphyxia was a substantial cause of the cardiac arrest he said, "*I put in my report it was contributory, with a combination of prone positioning and restraints. I haven't been able to say it was substantial and I don't say that now. I don't know what ultimately causes the cardiac arrest. A different arrhythmia is possible but I don't believe that, but I have said that both prone positioning and restraint were contributory".*[44]

Taking all of these matters into account it is my view that there is evidence that there were a number of different contributory factors that led to Mr Dungay's death. One of them was the fact that he was being held down and restrained so forcefully in a manner which was likely to restrict blood supply to and from his heart and restrict his ability to breath. These effects of the forceful restraint are likely to have contributed to the cardiac arrest.

Importantly, if Mr Dungay had not been restrained, he would not have died. Professor Adams expressed the view that despite pre-existing factors such as diabetes and medication, it was more likely that hypoxia during restraint and stress due to the struggle were triggers for the cardiac arrhythmia.[45] Professor Brown indicated that even if all other factors were present (such as Mr Dungay's psychosis, obesity, and agitation), if he had not been restrained, it is likely he would not have suffered a cardiac arrest.[46]

The Coroner made the following conclusion about cause of death,

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[40] Transcript 25/7/18 at T50.40
[41] Transcript 25/7/18 T26.0
[42] Transcript 25/7/18 at T26.42
[43] Transcript 25/7/2018 at T53.44
[44] Transcript 25/7/18 at T53.23
[45] Transcript 7/3/19 at T18.18
[46] Transcript 25/7/18 at T60.45

"Having regard to the opinions expressed by Associate Professor Adams and Dr Bailey it is most likely that the cause of death was cardiac arrhythmia. It is noted that David had a number of comorbidities, both acute and chronic, which predisposed him to the risk of cardiac arrhythmia such as a long standing poorly controlled type 1 diabetes, hypo glycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, a degree of likely hypoxemia caused by prone restraint and extreme stress and agitation as a result of the events of 29 December 2015. The expert evidence established that the administration of midazolam was not contributory to David's death. However, the expert evidence also established that prone restraint, and any consequent hypoxemia was a contributory factor although it is not possible to quantify the extent or significance of its contribution".

With all due respects I cannot agree. It is true that the deceased, Mr Dungay, had comorbidities both acute and chronic disposing him to cardiac arrhythmia. His diabetes, the emerging hypo glycaemia, the effects of his antipsychotic medication and his body mass index were all in existence at the time that he was the subject of the forceful restraint. But the authorities make it plain that, even though all of those comorbidities might have existed, and without them existing death may not have resulted, the application of the force with the mechanisms described above can still be regarded as a significant or substantial cause of death.

As counsel for Mr Dungay's family submitted at the Inquest,

"*It is self-evident that if David had been left in his cell, and there had been no cell move, he would be alive today. The medical evidence demonstrates that absent the restraint occurring at all, David would not have suffered a cardiac arrest. The fact that he was on medication that could cause QT prolongation, together with having poorly controlled diabetes and high blood sugar levels, are matters that can be set aside for the purposes of considering whether the restraints substantially or significantly contributed to David's death. None of David's pre-existing medical conditions that may have increased his risk of sudden death prevent a finding restraint remained an operating and substantial cause of his death*".[47]

I agree with that submission.

In my opinion, not only would Mr Dungay's death not have occurred "but for" the unlawful restraint, the unlawful restraint was necessarily a central component in the mix of factors that led to death. It is mere speculation to ponder the extremely unlikely possibility that death would have occurred that day at that time if Mr Dungay had not been treated in the way that he was treated by the prison officers.

[47] Closing submissions on behalf of Leetona Dungay, para 348

The offence of manslaughter is demonstrated

For all of the above reasons, I am of the view that the evidence before the Coroner allows a conclusion that the prison officers involved in the incident caused Mr Dungay's death and did so whilst they were applying unlawful force to him. Their acts were both unlawful and dangerous. Any reasonable person would have appreciated that the unlawful force exposed Mr Dungay to a risk of serious injury.

The likelihood of a conviction for manslaughter

Viewing all of the medical evidence critically, there are potential defences to the charge. At any trial, it is highly likely that the accused would suggest that the medical evidence left open reasonable possibilities consistent with innocence, namely, that Mr Dungay died of the other "comorbidities" and that the restraint played no significant or substantial role in the mechanism of death. But, the mere fact that the defence might be able to point towards other hypothesis does not mean that the Crown cannot exclude them as being reasonably applicable in the circumstances.

I would, though, recommend that all of the medical evidence be made available to an undoubted expert in the field such as Professor Cordner of the Victorian Institute of Forensic Medicine. A proper, independent review of the evidence is, in my opinion, likely to lead to further and better evidence that the restraint played a significant or substantial role in the death.

Were other crimes committed?

As I have pointed out, even if the cause of death cannot be proved beyond reasonable doubt, there is ample evidence that the prison officers were acting unlawfully in applying unlawful force to a psychiatric patient who was distressed. This evidence proves that he was assaulted. Officer F was instrumental in this assault, despite having not physically participated. There is no good reason why prison officers guilty of this offence should not be prosecuted.

Other considerations

In his judgment, the Coroner rejected the Dungay family's submissions that a referral ought to be made to the NSW DPP pursuant to s.78(4) with respect of the conduct of officers A and F. In rejecting that submission, his Honour spoke about the constraints that he faced by reason of the operation of s.61 of the Act. As he pointed out, during the course of the Inquest those officers objected to giving evidence under s.61(1)(b). After objecting, it was indicated that their evidence would be given willingly if they were issued with a certificate pursuant to s.61(5) which would prevent their evidence from being used against them except in relation to criminal proceedings concerning the falsity of their testimonies. Accordingly, certificates were issued.

His Honour was, of course, correct to have regard to s.61 in those circumstances but, in my opinion there is ample evidence in the material that was presented at the Inquest

that would allow a criminal prosecution to proceed without using any of the testimony of Officers A and F or, for that matter, any of the other officers. The evidence of the Justice Health nurses and, most importantly, the evidence of the video footage when considered with the other contemporary records that were made in the prison and the medical evidence would be sufficient for the prosecution of all relevant people.

If it was thought necessary to strengthen any prosecution case with further evidence, the DPP would, in those circumstances, be required to give consideration to whether or not to prosecute a lesser number than the totality of the IAT officers. Some of the participants were more centrally involved than others. It seems to me, with respect, that the DPP are in a position to be able to determine who is most culpable and, therefore, who should be prosecuted. People who are not prosecuted but who are otherwise participants in the events of the day, are then all compellable witnesses irrespective of whether or not they have received a certificate under s.61(5).

There is, in my humble opinion, a very real public interest in this matter being carefully considered by the Director of Public Prosecutions. Simply because the Coroner decided not to refer the case for consideration for a homicide offence, does not relieve the DPP of giving independent consideration to all relevant issues once they are drawn to the Director's attention. As has been pointed out by many in recent times, the number of Aboriginal and Torres Strait Islander people who have died in custody continues to grow unacceptably. No one has ever been prosecuted for anything that led to the death of an Aboriginal or Torres Strait Island person whilst they were in custody.

This particular death shocked the New South Wales public. It continues to do so.

In these circumstances, it is only right and just that the circumstances of this case be considered with the utmost seriousness and gravity.

Yours faithfully

Phillip Boulten SC