CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Dungay
Hearing dates:	16 to 20 July 2018; 23 to 27 July 2018; 4 to 8 March 2019
Date of findings:	22 November 2019
Place of findings:	NSW State Coroner's Court at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause of death, prone restraint, positional asphyxia, Immediate Action Team, Mental Health Unit, Long Bay Hospital, de-escalation techniques, negotiation and persuasion, resuscitation attempts
File number:	2015/381722
Representation:	Mr J Downing, Counsel Assisting, instructed by Mr J Loosley & Ms J Murty (Crown Solicitor's Office) Mr M Windsor SC for Justice Health & Forensic Mental Health Network, instructed by Hicksons Lawyers Mr S Beckett and Ms T Stevens for the Commissioner, Corrective Services New South Wales, instructed by the Office of the General Counsel, Department of Justice. Mr D Evenden for Ms L Dungay Mr R Hewson for Dr T Ma Mr N Dawson for Registered Nurse C Xu, Registered Nurse R Maharjan and Registered Nurse N Thapa Mr P Madden for Officer A, Officer B and Officer C Ms P Robertson for Registered Nurse A Jay and Registered Nurse M Neumann

Findings:

Identity

The person who died was David Dungay.

Date of death

David died on 29 December 2015.

Place of death

David died within the Mental Health Unit at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death

The cause of David's death was cardiac arrhythmia.

Manner of death

David died whilst being restrained in the prone position by Corrective Services New South Wales officers. David's long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint were all contributory factors to David's death.

Recommendations: See Appendix A for Recommendations made pursuant to section 82(1) of the *Coroners Act 2009*.

Non-publication orders: See Appendix B for Orders made pursuant to s. 74(1) of the *Coroners Act 2009*.

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1. Introduction

1.1 On 29 December 2015 David Dungay was housed as an involuntary patient inmate within a mental health unit at Long Bay Hospital in Long Bay Correctional Complex. David was serving a custodial sentence and was due to be considered for parole on 2 February 2016. David had been diagnosed with chronic schizophrenia, was acutely psychotic and had a longstanding history of type I diabetes which was poorly controlled.

1.2 During the afternoon, David retrieved some rice crackers and biscuits from his belongings, returned to his cell, and began to eat them. Nursing and correctional staff within the ward where David was housed expressed some concern about this, given David's elevated blood sugar levels which had been measured earlier that day. Requests were made of David to return his biscuits and crackers. David refused to do so.

1.3 This resulted in David being forcibly moved by correctional officers from his cell to a different cell so that his condition could be observed. Less than 10 minutes after the cell move began David suddenly became unresponsive whilst being restrained in a prone position. Resuscitation efforts were commenced but were unsuccessful. David was pronounced deceased a short time later.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. All reportable deaths must be reported to a Coroner or to a police officer.

2.2 By depriving a person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an objective inquiry, that the State discharges its responsibility appropriately and adequately.

2.3 As David was in lawful custody at the time of his death an inquest into his death is mandatory. Further, the events of 29 December 2015 and the circumstances surrounding David's death raised a number of questions about the manner of his death. The inquest sought to explore key issues related to these questions, and whether any factor contributed to David's death. The purpose in doing so is not to attribute blame to any person or organisation, or to penalise or punish any person or organisation. These are concepts that are incongruous with the purpose and functions of the coronial jurisdiction. Rather, the purpose is to identify deficiencies or shortcomings of a broader, systemic nature so that, with the benefit of hindsight and appropriate reflection, lessons may be learned and opportunities for improvement identified.

2.4 It should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably

expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process is very much a public intrusion into what would otherwise be a very private and personal experience for members of our community.

2.5 However one of the fundamental principles underlying the coronial process is that it is an independent and transparent. Another fundamental principle is that a coronial process seeks to identify in a public forum health and safety issues which may affect the broader community at large.

2.6 It should also be acknowledged that the closing of an inquest represents the end of a legal process where a family of a deceased person has come into contact with the coronial system. The end of that process represents the conclusion of a confronting, arduous, and distressing chapter following the death of a loved one. It should be recognised that long after the conclusion of an inquest, the sorrow and immeasurable loss experienced by families will continue to endure.

2.7 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

3. David's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.3 David was born in Kempsey at Old Burnt Bridge Reserve, the youngest son to his mother, Leetona Dungay and his father, David Hill. David had two older half siblings, Christine and Ernest, and a younger sister, Cynthia. On his father's side, David had five half-siblings: Janeeka, Jakiah, Jivarhn, Janessa and Jehziac. David's mother described him as a proud Dunghutti warrior.

3.4 David enjoyed sports as a child. He played rugby league at a young age for the Sharks club in Port Macquarie, and later continued playing in Kempsey. David initially attended Melville High School in Kempsey before transferring to a vocational college in South Kempsey where he later obtained his Year 10 School Certificate. David's family were extremely proud of his achievement.

3.5 Despite the challenges faced by early school leavers to secure employment in Kempsey, David was determined to do so. After leaving school David successfully found casual work with a government funded program for Aboriginal youth. His mother describes David at this stage in his life as simply a lovely young man growing into his independence.

3.6 David's family knew him to be happy-go-lucky, kind and loving. He had a talent for writing poetry and an ability to convey enormous meaning with his poems. David was extremely loyal and dependable, willing to give up his own time for his siblings, and to always be there for them when they needed him. At the conclusion of the evidence in the inquest it was most distressing to hear the words spoken by some of David's siblings and how his separation from them has caused so much grief and pain.

3.7 David's sense of family, and his bonds with those closest to him, only serves to emphasise how much he is missed and what his heart-rending loss means to those who loved him most. For his family to lose David at a time where, in his mother's words, he was ready to return home and simply be with his family is indeed most tragic.

4. Background to the inquest

4.1 The inquest began on 16 July 2018. There were an initial 10 days of hearing concluding on 27 July 2018. The matter was then adjourned part heard to 4 March 2019, with an additional five days of hearing concluding on 8 March 2019.

4.2 At the conclusion of the evidence the matter was adjourned for findings to be delivered, with a timetable set for the filing of submissions by Counsel Assisting and the various interested parties. A number of applications were made by Counsel Assisting and some of the interested parties for the timetable to be extended. These applications were granted resulting in postponement of the original date for findings to be delivered.

4.3 A total of 31 witnesses were called throughout the course of the inquest, including the following expert witnesses:

(a) Associate Professor Mark Adams, cardiologist;

(b) Dr Kendall Bailey, forensic pathologist;

(c) Professor Anthony Brown, emergency physician;

(d) Dr Thomas Cromer, endocrinologist; and

(e) Mr John Farrar, consultant forensic pharmacologist.

5. David's custodial history

5.1 After leaving high school David began coming under the notice of the local police in Kempsey. David was charged with a serious robbery offence relating to a home invasion that occurred on 23 November 2007. He was also charged with an aggravated attempted sexual assault offence in relation to an incident on 19 January 2008. Further, he was charged with an offence of assault occasioning actual bodily harm in relation to an incident on 21 January 2008. On 22 January 2008 David was received into custody.

5.2 David later pleaded guilty to the robbery in company offence, and was convicted of the sexual assault and assault occasioning actual bodily harm offences. He was sentenced in the District Court on 26 June 2009. David later appealed against his conviction in relation to the aggravated attempted sexual intercourse offence and the Crown appealed against his sentences. On 13 May 2010 the New South Wales Court of Criminal Appeal dismissed the conviction appeal and allowed the sentence appeal. The effect of this was that David received an overall sentence of nine years and six months with a non-parole period of five years and six months. This meant that David was eligible for parole on 20 July 2014.

5.3 During the period from 2008 to 2015, David was housed at a number of different correctional centres across New South Wales. He was initially housed at Mid-North Coast Correctional Centre before later being transferred to Junee Correctional Centre, Parklea Correctional Centre, Lithgow Correctional Centre, the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater, the Metropolitan Special Program Centre at Long Bay Correctional Centre and the Long Bay Hospital at Long Bay Correctional Centre. On 25 November 2015 David was transferred to G Ward in Long Bay Hospital. David was initially housed in a camera cell. However following a recommendation made on 30 November 2015, David was later moved to a non-camera cell.

5.4 On 14 September 2009, following sentencing, David was classified from A2 Maximum Security to C1 Minimum Security. On 14 January 2013 David was reclassified to B medium security following a number of aggressive episodes. On 18 June 2013 David was reclassified as A2 maximum security following an assault of a Correctives Services New South Wales (**CSNSW**) officer at Long Bay Hospital. This classification was subsequently reviewed several times and remained unchanged until David's death.

5.5 On 12 March 2014, David was informed that he was not recommended for parole by Community Corrections because of his failure to engage in programs to address his offending behaviour. On 29 May 2014 the State Parole Authority (**SPA**) refused David's application for parole. David sought a review of that decision but it was confirmed by the SPA on 3 July 2014.

5.6 On 21 May 2015, the SPA deferred consideration of David's parole to 30 July 2015 so that a further Community Corrections report and a psychiatric report could be obtained. On 13 August 2015 the SPA further deferred consideration of parole to 26 November 2015, so that a supplementary Community Corrections report could be obtained.

5.7 On 30 November 2015, the SPA again refused parole on the basis that David needed to complete a program to address his offending behaviour and needed to undergo a psychological assessment. The parole application was due for further consideration on 2 February 2016.

6. David's physical health history[1]

6.1 David had a lengthy history of type I diabetes. It was first diagnosed when David was five or six years old. He required daily injections of insulin as part of his diabetic management. Whilst in custody these daily injections of insulin continued. During the latter part of 2015, he was being treated with three injections per day of Novorapid, a fast-acting insulin, as well as one injection of Lantus, a long acting basal insulin analogue, at night.

6.2 Management of David's diabetes whilst in custody proved to be challenging at times. From 2010 David was known to experience periodic seizures related to episodes of hypoglycaemia which required treatment from Justice Health & Forensic Mental Health Network (**Justice Health**) staff. Some of these seizures resulted in David being transferred to hospital. As a result, by December 2015, alerts within the CSNSW electronic records noted that David had very uncontrolled diabetes, numerous hypoglycaemic episodes, and required strict monitoring.[2] There is also evidence that David experienced hyperglycaemic episodes, albeit on a less frequent basis, although there is no evidence to indicate a David suffered any serious physical effects as a result of these episodes.

6.3 The available records indicate that at times David was non-compliant with treatment for his diabetes. For example records indicate that in September 2013, when David was housed at Lithgow Correctional Centre, there were instances when he did not attend a Justice Health clinic to receive his insulin injections.[3] On one occasion David was questioned by a Justice Health nurse regarding his non-attendance to receive insulin. David indicated that he had difficulty getting out of bed because of low blood sugar.[4]

6.4 The records also indicate that at other times David intentionally circumvented management of his diabetes. It appears that David was motivated by an intention to self-harm when he did so. For example:

(a) On 11 June 2012 David attended the Justice Health clinic at Junee Correctional Centre and drew a large dose of insulin and injected himself with it when he was unobserved by Justice Health staff;[5]

(b) Records from 19 January 2013 indicate that when David was asked about his frequent low blood sugar levels he voiced suicidal ideation and confirm that he was deliberately sabotaging his diabetic management;[6]

(c) On 26 January 2014 David suffered a fall, due to low blood sugar levels, whilst at Lithgow Correctional Centre. David's condition deteriorated into a diabetic coma, requiring the attendance of an ambulance. David subsequently indicated that he had been non-compliant with his insulin regime.[7]

[1] The factual background regarding David's medical history, and the events leading up to, and including, 29 December 2015 have been drawn from the helpful closing submissions of Counsel Assisting.
[2] Exhibit 1, page 560.
[3] Exhibit 1, page 1166.
[4] Exhibit 1, page 1167.
[5] Exhibit 1, page 1124.
[6] Exhibit 1, page 1135.
[7] Exhibit 1, page 1176.

6.5 From 25 November 2015 through to 29 December 2015, David experienced frequent fluctuations in his blood sugar levels. In the period immediately before 29 December 2015, David's blood sugar level remained unstable and was more often elevated.[8]

[8] Exhibit 1, page 1437-1438.

7. David's mental health history

7.1 Available records indicate that David was admitted to Kempsey District Hospital as an involuntary patient on 7 March 2005 after a community diabetes worker expressed concern about his unusual behaviour.[9] During this admission David was described as appearing agitated, confused, aggressive and requiring sedation. It appears that David was diagnosed as suffering from a brief, limited psychotic episode requiring treatment with antipsychotic medication. There is also evidence of David being involuntarily admitted to Taree District Hospital in 2005, however the details of this admission are not known.

7.2 During David's initial period in custody in 2008 and 2009 he was seen by a number of psychiatrists. No diagnosis of a major mental illness or mood disorder was made although David's history of alcohol and cannabis abuse was referred to in the context of emergent antisocial behaviour. Whist in custody it became apparent to David's treating clinicians that he suffered from psychosis. This manifested itself in the form of behavioural issues in David's interactions with CSNSW and Justice Health staff, aggressive confrontations with other inmates. David also exhibited self-harming behaviour.

7.3 In January 2010 it was noted by a psychiatrist, Dr Richard Furst, that David reported previously hearing voices that told him to harm himself. However at the time of Dr Furst's review David denied hearing any voices or having any feelings of paranoia. Dr Furst concluded that David had depression with psychotic features and noted that treatment with the anti-depressant mirtazapine had brought about some improvement. However by mid-2010 David had become non-compliant with the prescribed mirtazapine. Dr Furst considered that it was likely that David had an underlying psychotic disorder and recommended treatment with antipsychotic medication. However David declined such treatment.

7.4 It appears that David's mental health worsened in 2013. In April 2013, whilst housed at Parklea Correctional Centre, David reported to psychologists that he was experiencing non-threatening visual and auditory hallucinations.[10] David was later transferred to Long Bay Correctional Centre. He was observed to be highly irritated, disorganised, and describing persecutory themes after it was found that he had damaged his cell on 15 May 2013. On psychiatric assessment David was diagnosed by Dr Anthony Samuels, a consultant psychiatrist, with schizophrenia. On 17 May 2013 David was assessed as a mentally ill person and transferred to a mental health facility pursuant to section 55 of the *Mental Health* (*Forensic Provisions) Act 1990*. On 5 June 2013 David was reassessed and found to no longer be a mentally ill person. However he remained at Long Bay Hospital until he was transferred to Lithgow Correctional Centre on 29 June 2013.

7.5 There is also evidence that in August 2014 David had reduced a dose of risperidone, after taking it for a period of time, because it made him too drowsy. In October 2014 David ceased taking risperidone completely and because he had no overt psychotic symptoms at the time further medication was not enforced. On 20 November 2014 David was transferred from Lithgow Correctional Centre to the MRRC. An intake mental health assessment was conducted by a psychiatrist, a mental health nurse, and correctional centre staff. David was observed to be withdrawn, despondent and avoiding eye contact. He was guarded and difficult to engage with, and reported ceasing his antipsychotic medication (risperidone) about five weeks earlier. David

[9] Exhibit 2.
[10] Exhibit 1, page 1149.

reported that he felt that the risperidone was "*spinning him out*" and producing suicidal ideation with thoughts of self-harm. David reported that since ceasing the risperidone he had been able to resist the suicidal urges.[11] David also reported hearing the voices of other inmates who were encouraging him to kill himself. During the interview David's demeanour quickly changed and he became emotional, teary and pulled his shirt over his head in order to hide his face. David also apparently continued to respond to internal stimuli and described hearing "*spirits*", and hearing other voices for most of the year. The assessment resulted in an impression that David was acutely psychotic with a schizophrenic relapse.

7.6 Following his admission to the MRRC David continued to be non-compliant with his risperidone. As a result, and because David was found to be highly distressed and agitated, he was commenced on monthly depot injections of paliperidone, an atypical antipsychotic. David agreed to this treatment but the available records indicate that his mother, Leetona, was unhappy that David was receiving the depot injections. She expressed a preference that David be treated with tablets.

7.7 After starting the monthly depot injections David still reported hearing voices. In mid-February 2015, he asked to go back on oral medication due to sexual dysfunction. He was then treated with a combination of oral and depot paliperidone. In June 2015, David had become non-compliant with the anti-psychotic treatment as he stated that it made him sick.

7.8 On 9 November 2015, Dr Gordon Elliott, consultant psychiatrist, wrote to Dr Tobias Mackinnon, Justice Health Statewide Clinical Director seeking David's urgent transfer to the Long Bay Hospital as a mentally ill person.[12] At the time, David was housed at Lithgow Correctional Centre. On 9 November 2015 David's treating psychiatrist, Dr Gordon Elliott, noted that David had a history of recurrent psychosis and had been non-compliant with his antipsychotic medication "*for months*". At the time Dr Elliott noted that David "*has been noted to be increasingly suspicious and uncooperative with nurses attempting to monitor his blood sugar levels*", that he had been "*floridly psychotic*" over the past week, and that "*he suddenly became violent with officers escorting him for a blood sugar level*", resulting in the use of force.[13] Dr Elliott noted that David's "*blood sugar level control is usually poor*" and raised concerns regarding David's "*risk of acute diabetic complications in his current mental state and the safety of nurses attempting to manage his blood sugar level*".[14]

7.9 On 20 November 2015, David was transferred to the MRRC, where he was assessed by the Risk Intervention Team. On 23 November 2015, he was reviewed by Dr Elliott and Dr Smith. They both provided medical certificates describing David as suffering from a mental illness.[15] In particular, Dr Elliott indicated that David was completely uncooperative with the interview and observed to be talking and laughing to himself, as well as shadow boxing and pacing back and forth. Dr Elliott described David as extremely agitated and expressed concern that his behaviour was consistent with auditory hallucinations and formal thought disorder. As a result of this assessment, an order was made on 23 November 2015 for David to be transferred to an in-patient mental health facility pursuant to section 55 of the *Mental Health (Forensic Provisions) Act 1990*.[16]

[11] Exhibit 1, page 1193.
[12] Exhibit 1, page 1336.
[13] Exhibit 1, page 1266.
[14] Exhibit 1, page 1266.
[15] Exhibit 1, pages 1334-1335.
[16] Exhibit 1, page 1331.

8. David's admission to Long Bay Hospital from 25 November 2015

8.1 David was admitted to Long Bay Hospital on 25 November 2015 under the care of Dr Robert Reznik, consultant psychiatrist. On admission to Long Bay a mental state examination was conducted. It noted that David was uncooperative, that his affect was blunted, that it appeared he was responding to internal stimuli (auditory hallucinations) and that his insight and judgment were impaired.

8.2 Dr Sergiu Grama assessed David at 11:00am on 25 November 2015 in G Ward. He found that David was acutely psychotic and at significant risk of violence. Dr Grama discussed his assessment with his supervising psychiatrists, Dr Antonio Simonelli and Dr Matthew Hearps. Dr Grama charted aripiprazole 20mg in the morning, zuclopenthixol 10mg twice daily, lantus insulin 46 units at night, Novorapid insulin as a sliding scale and perindopril 2.5mg in the morning. David was prescribed an injection of zuclopenthixol acetate, a parenteral antipsychotic medication. When told he was to be given this injection, David kicked the cell door and challenged the Immediate Action Team (**IAT**). He was subsequently given Cogentin 2mg (anticholinergic medication to prevent Parkinsonian symptoms), midazolam 10mg (sedative) along with the zuclopenthixol acetate, in the presence of the IAT and with their assistance. Following initial treatment David was observed later that day to remain floridly psychotic but appeared to be more settled and accepting of his prescribed medication.

8.3 Dr Reznik saw David for the first time on 26 November 2015. On examination he found David to be non-cooperative, guarded, displaying poverty of thought and speech and to have poor insight and judgement. Dr Reznik formed the impression that David was acutely psychotic and suffering from chronic schizophrenia. Plans were made for David to be reviewed daily and monitored for management of his diabetes mellitus.

8.4 Dr Trevor Ma, psychiatric registrar, saw David on 27 November 2015. David denied having a diagnosis of schizophrenia but could not explain his previous symptoms. Dr Ma explained the need to re-commence intramuscular objections. David did not oppose this. David also raised no concerns about his diabetic management and said he would accept regular nursing monitoring.

8.5 On 30 November 2015 it was noted that David had been compliant with his medication and had been self-administering insulin and checking his blood sugar levels appropriately. Dr Ma reviewed David again on 4 December 2015. A plan was made to refer David to the general practitioner for medical advice for diabetes management.

8.6 Dr Grama reviewed David at 9:00am on 7 December 2015. David reported auditory hallucinations overnight and feeling unwell, but feeling better in the morning. Dr Grama discussed David's presentation with Dr Hearps who ordered that PRN medication in the form of chlorpromazine 100mg up to three times per day be added to David's charted medication.

8.7 On 7 December 2015 David became verbally abuse during his night time medications. He was given an insulin pen to self-administer but later refused to return it. CSNSW staff eventually persuaded David to return the insulin, but it was unclear if he had used it. Plans were made to monitor David through the night and review his blood sugar level the next morning.

8.8 Dr Grama saw David on the morning of 8 December 2015. David reported hearing voices but said that he was happy taking his oral medication because it relaxed him. David was commenced on oral chlorpromazine 100mg three times a day.

8.9 Dr Mica Spasojevic, a Career Medical Officer, reviewed David on 8 December 2015. She reduced the sliding scale amounts of insulin and ordered Novorapid. Dr Spasojevic also referred David to the Prince of Wales diabetic clinic for follow up.

8.10 Dr Reznik saw David again on 8 December 2015. He formed the impression that David was a chronic schizophrenic, still psychotic but less disturbed and more settled than when David was last reviewed. David's current management plan was continued.

8.11 Dr Reznik reviewed David again on 10 December 2015. David reported that the chlorpromazine had been helpful, and that he felt calmer although was still disturbed by voices. Dr Reznik increased David's chlorpromazine to 200mg three times daily and his clopixol to 300mg fortnightly. Due to the possibility of interaction between the chlorpromazine and perindropil, plans were also made to increase David's blood pressure monitoring.

8.12 Dr Hannon reviewed David on 17 December 2015. David's blood sugar at the time was 23.4. He was noted to be asymptomatic but when reviewed later the same day he was dismissive and guarded. Dr Hannon reviewed David again the following day on 18 December 2015 when he was thought to be guarded with limited rapport and underlying irritability.

8.13 Dr Sharma reviewed David on 19 December 2015 when it was noted that his glucose was high. On review David was noted to be clinically asymptomatic but remained psychotic with grandiose religious delusions.

8.14 On 20 December 2015 David was noted to be compliant with his medications with nil behavioural issues. David reported that he was feeling good, that the voices were down, and that his mental state was fluctuating but improving. It was thought that David was more settled but with ongoing mental illness. Dr Grama reviewed David that day as part of a daily review that had been requested by Dr Reznik and Dr Ma. Dr Grama noted that David remained mentally ill but presented as settled and accepting of his prescribed medications which he tolerated well.

8.15 Dr Reznik reviewed David on 22 December 2015. David reported feeling better with no voices at the time. His blood sugar level was noted to be high. Dr Reznik decided to maintain the existing management regime noting that if David was refusing oral medications and behaviourally disturbed that consultation with a registrar could be considered for administration of intramuscular Acuphase and 10mg midazolam.

8.16 Dr Spasojevic saw David on 22 December 2015 due to his unstable blood sugar level. Dr Spasojevic discussed David's condition with an endocrinology registrar at Prince of Wales Hospital (**POWH**) and arrangements were made for information regarding David's blood sugar level and medication insulin to be sent to the registrar for further review and follow up. Dr Spasojevic reviewed Davis again on 24 December 2015 and arrangements were made for David's blood sugar levels to be sent to the registrar for review.

9. What happened on 29 December 2015?

9.1 A summary of the events of 29 December 2015 is set out below. A number of issues related to these events will be examined in greater detail later in these findings.

9.2 Registered Nurse (**RN**) Charles Xu was the Justice Health nurse assigned to care for David on 29 December 2015. David was housed in cell 71 in G Ward, the Mental Health Unit at Long Bay Hospital. RN Xu checked on David at approximately 8:00am and took his blood sugar level, which was 3.2 mmol/L. RN Xu spoke with Dr Ma and it was decided to withhold David's pre-breakfast Novorapid because of the low blood sugar reading.

9.3 RN Xu took David's blood sugar level again at approximately 10:00am. By this time it was 17.4 mmol/L, which was a high reading.[17] RN Xu attempted to locate Dr Ma to discuss the reading. When he could not do so he spoke to Dr Grama instead. On Dr Grama's advice, no treatment was given pending the next blood sugar level which was to occur just before lunch.

9.4 RN Xu took David's blood sugar level again at approximately midday, noting that it was high (over 25 mmol/L). At that time, David did not agree to having his vital signs taken and informed RN Xu that he felt fine. RN Xu noted that David was asymptomatic, with no signs of being physically unwell, despite having an elevated blood sugar level. RN Xu discussed David's treatment with Dr Ma, who ordered a unit of regular Novorapid, plus 8 units of sliding scale Novorapid.

9.5 At various times during the morning of 29 December 2015, David spent time in the exercise yard of G Ward. He had morning exercise between approximately 8.35 am and 10.43 am, during which time he ate what appeared to be some crackers. David again entered the exercise yard between about 1.10 pm and 2.04 pm.

9.6 At about 2.00 pm, RN Xu re-took David's blood sugar level and found that it was 24.2 mmol/L (slightly reduced from the midday reading). David again refused to have his observations taken, but RN Xu observed that he remained asymptomatic. RN Xu discussed David's treatment again with Dr Ma, who recommended withholding a dose of Novorapid pending an endocrine review.

9.7 Officer D saw David in the smoking yard close to lock in time at 2:30pm. She saw that David was calm and let him out of the yard so that he could return to his cell. Once inside David asked if he could make a phone call. He was still calm and respectful at this time. Officer D said that he could but told him to do so quickly. After the call David asked if he could get something out his buy up. Officer D saw him retrieve a packet of rice crackers and a packet of biscuits. She said to David, "*Remember what the nurse said, you've got to watch what you eat*".[18] According to Officer D's account, this was a reference to her hearing RN Xu telling David sometime that morning whilst in the smoker's yard to "*watch his food intake*".[19]

9.8 After giving this reminder to David, Officer D said that there was a rapid change in David's behaviour and that he "*immediately became very aggressive and abusive*".[20] David reportedly

[17] Exhibit 1 , page 1319.
[18] Exhibit 1, page 122 at [6].
[19] 16/7/18 at T39.39.
[20] Exhibit 1, page 122 at [7].

responded by saying, "*I'm going to go off my fucking cunt if I can't have these biscuits. I fucking paid for them and they're mine*".[21]

9.9 Officer E and then Officer F took turns speaking to David in an unsuccessful attempt to persuade him to return the biscuits.[22] David remained angry and agitated and informed the officers that he would do what he wanted with the biscuits, and continued to eat them. Just before 2:30pm a decision was made that it would be safer to move David to a camera cell, so that he could be better observed. Officer F asked the IAT to facilitate the move.

9.10 As this was occurring RN Xu had a discussion with a medical officer and his nurse colleagues about administering an intramuscular injection of midazolam to address David's agitation and aggression.

9.11 After the IAT was summoned, the six members – Officer A, Officer B, Officer C, Officer M, Officer N and Officer O – all assembled at G Ward at approximately 2.35 pm. After a briefing by Officers A and F, the team proceeded to the door of cell 71. They arrived at just before 2.40 pm. Consistent with procedural requirements that were in place relating to the duties of the IAT, a video recording was commenced using a handheld camera operated by one of the IAT officers (**the IAT footage**).

9.12 Officer A spoke to David through the door of cell 71 and twice asked him to come to the door, place his hands through it so that he could be handcuffed and then moved to another cell. Officer A also indicated that if David did not comply with the direction, force may be used. David continued to eat his biscuits and did not comply with the direction. At one point, he pulled his shirt over his head and appeared to shadow box.

9.13 At 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 David collided with the shield. The IAT members gained control of David and restrained him, pinning him down on the cell bed. It is evident from the IAT footage that David resisted and officers described him clawing at them and attempting to bite.

9.14 In the course of David 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 breathe*". 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.

9.15 The IAT members moved David from the bed onto the floor of cell 71. After the IAT members gained control of David, 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 David continued to spit blood.

9.16 At approximately 2:46 pm, David was led by the IAT from cell 71 into corridor A and then through corridor B to cell 77. David continued to scream that he could not breathe and at one point during the transfer dropped to his knees. The officers remonstrated with David to stand up and to stop spitting blood.

[21] 16/7/18 at T56.9.
[22] For convenience the rice crackers and biscuits which David took from his buy upon his return from the yard will simply be referred to as biscuits for the remainder of these findings.

9.17 David was led into cell 77 at approximately 2:47 pm. He was placed onto the bed face down and again restrained by the IAT officers placing weight onto him. Soon after David's arrival in cell 77, and after being summoned by the IAT, RN Xu entered and administered an intra-muscular injection of midazolam into David's right buttock. David continued to scream that he could not breathe while RN Xu was in the cell.

9.18 RN Xu departed the cell after administering the injection of midazolam. He said that he observed David becoming increasingly aggressive during the midazolam injection and that as a result, he spoke to Dr Ma to report the further escalation of aggression. Dr Ma subsequently provided a verbal order for an intramuscular injection of haloperidol, an anti-psychotic.

9.19 While RN Xu was absent from cell 77, CSNSW officers continued to restrain David, based on their understanding that a second sedative was to be administered. Officer G says that he yelled out to Officer F to say that the IAT members should continue to restrain David 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.

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

9.21 Approximately 60 to 90 seconds after the midazolam injection was administered, David became unresponsive and the CSNSW officers described his body going limp. That seems to have occurred at approximately 2:49 pm. After David became unresponsive, IAT members called for a nurse and began providing cardiopulmonary resuscitation (**CPR**) after moving David to the floor.

9.22 Within roughly 90 seconds of David becoming unresponsive, nurses from Justice Health were on the scene with resuscitation equipment. About 30 seconds later, Dr Ma attended and took over the attempts at resuscitation from the CSNSW officers. A call was made for an ambulance and it was booked at 2.52 pm. 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 David's airway.

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

9.24 Paramedics from NSW Ambulance arrived at the Long Bay Correctional Complex at 3:01 pm and made contact with David at 3:07 pm. The paramedics continued to attempt to resuscitate David, 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 David was pronounced deceased at 3.42 pm.

10. Issues for consideration at inquest

10.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

1. The nature of David's behaviour and in particular, the status of his psychiatric and diabetic conditions in the period leading up to his death.

2. The need for any intervention on 29 December 2015 on the part of CSNSW staff or Justice Health staff in light of issue 1 above.

3. Whether it was necessary and appropriate to move David from cell 71 to cell 77 (a camera cell) on 29 December 2015 in light of issue 1 above.

4. Whether it was necessary and appropriate to utilise the Immediate Action Team (IAT) to facilitate the move between cells on 29 December 2015. What alternatives to using the IAT were available?

5. Whether the IAT team members acted in accordance with CSNSW Policy and Procedures in facilitating the move of David between cells on 29 December 2015.

6. Whether the IAT members acted appropriately in the application of force to David/restraint of David on 29 December 2015.

7. Whether the IAT team members were appropriately trained in respect of the application of force/restraint of inmates, including any risk of positional asphyxia, prior to 29 December 2015.

8. Whether appropriate and timely steps were taken to establish cells 71 and 77 as a crime scene after David was moved between cells on 29 December 2015.

9. Whether video evidence was appropriately collected and retained after David was moved between cells on 29 December 2015.

10. Whether Justice Health staff acted appropriately and in compliance with Justice Health policies and procedures in administering a sedative (Midazolam) to David on 29 December 2015.

10A. Whether Justice Health staff were appropriately trained on the risks and use of restraint?

10B. Was it appropriate to administer a second injection to David, as was planned on 29 December 2012, and who had the responsibility to decide whether such an injection should occur? What effect did the ensuing delay and further restraint have on David?

11. Whether Justice Health staff acted appropriately in providing life support to David between the time he became unresponsive through to the arrival of NSW Ambulance Paramedics on 29 December 2015.

12. The likely cause of David’s death and in particular, which of the following matters caused or contributed to it (whether separately or in combination):

    (i) David's diabetic condition;

    (ii) the manner of David's restraint/positioning;

    (iii) the medications David was on for his diabetes and/or his psychiatric condition as at 29 December 2015;

    (iv) the Midazolam administered to David on 29 December 2015;

    (v) any inadequacies in the life support provided to David.

11. Issue 1: The nature of David's behaviour and in particular, the status of his psychiatric and diabetic conditions in the period leading up to his death

11.1 David suffered from a significant psychiatric condition during the period he was admitted to the Long Bay Hospital from 5 November 2015 to 29 December 2015. Dr Reznik diagnosed David as suffering from chronic schizophrenia, with multiple assessments conducted indicating that David was acutely psychotic, although his psychosis settled to some extent during the course of his admission. During his admission David reported hearing voices that argued with him and told him not to comply with his medication regime.

11.2 Dr Reznik and Dr Ma reviewed David at 9:00am on 29 December 2015. David reported feeling better and was looking forward to calling his mother. He said that the auditory hallucinations were still present but no longer bothering him. On examination David was noted to be settled, polite and cooperative giving rise to an impression that he remained psychotic but was less aggressive, with sudden and dramatic changes in his mental state.

11.3 By 29 December 2015 David's diabetes remained poorly controlled, despite the slow and fast-acting insulin which he had been prescribed. Dr Spasojevic noted that David had experienced recent hypoglycaemic episodes and that his blood sugar levels were unstable. This resulted in adjustment of David's insulin therapy and contact with the endocrinology clinic at POWH for review.

11.4 The solicitor for Ms Leetona Dungay and the Dungay side of David's family (**the Dungay Family**) submitted that there was a failure to provide David with timely access to specialists review regarding his diabetic management, and a failure to act on specialist's advice that was provided. It is also submitted that available medical records indicating wide fluctuations in David's blood sugar levels are consistent with improper management of David's diabetic condition.

11.5 However, the medical records establish that David had a lengthy history of poorly controlled diabetes and that he had been insulin-dependent since the age of six. The records also establish that David's blood sugar levels were regularly monitored. Where appropriate, advice was given to David about food consumption which may impact upon such measurements, in the absence of any ability to directly control his eating habits. It should be noted that there is no evidence to indicate that David had diabetic autonomic neuropathy, which is a complication of long-standing, poorly controlled diabetes.[23] Further, as discussed in more detail below, there is no evidence to indicate that David's diabetes (and consequently the management of it) led to the development of an acute condition proximate to his death, or was contributory to it.

11.6 The solicitor for the Dungay Family also submitted that "*improvements in David's psychiatric condition were compromised by the character of mental health treatment he received in G Ward*".[24] In support of this submission reference was made to the unique position that G Ward occupies as the only mental health facility in New South Wales that sits within a correctional centre, and the necessary consequences which this brings.

11.7 The submissions have been understood to be a re-agitation of what was described as "*the proposed 11A issue*" during the course of the inquest. Broadly put, the proposed 11A issue sought to examine the appropriateness of mental health treatment being provided to involuntary

[23] Exhibit 1, tab 68B at [13].
[24] Submissions on behalf of the Dungay Family at [75].

patients, who are also inmates, in a correctional setting. On several occasions during the inquest it was determined that consideration of this proposed issue falls outside the scope of an inquest, particularly so far as consideration of the manner of death is concerned. On this basis any consideration of the matters submitted by the solicitor for the Dungay Family with respect to broader issues relating to management of David's mental health fall outside the parameters of the inquest.

11.8 Similarly, the solicitor for the Dungay Family submitted that it was necessary or desirable to make a number of recommendations in relation to the "*proposed 11A issue*".[25] As already noted above, it has previously been determined that matters which might give rise to the making of any such recommendations were not examined at the inquest. The inquest did not receive any direct evidence in relation to such matters and any consideration of such matters would have warranted other organisations (such as New South Wales Health) being regarded as having sufficient interest in the proceedings in accordance with section 57 of the Act. Having regard to these factors, it would be inappropriate, and procedurally unfair, to give consideraton to the submissions that have been made on this issue.

[25] Submissions on behalf of the Dungay Family at [396] to [405].

12. Issue 2: The need for an intervention on 29 December 2015 on the part of Corrective Services New South Wales Staff or Justice Health Staff in light of issue 1 above

12.1 Having regard to the nature of David's mental and physical health conditions on 29 December 2015, the question arises as to whether any intervention, either by Justice Health or CSNSW staff, was warranted at the time that David returned to his cell with his buy up of biscuits. Several considerations are relevant to consideration of this question and are set out below.

Blood sugar levels

12.2 The first consideration relates to any impact which consumption of the biscuits might have had on David's blood sugar levels given his history of poorly controlled diabetes. RN Xu measured David's blood sugar levels a number of times over the course of the morning and early afternoon of 29 December 2015. The measurements recorded were:

(a) 3.2mmol/L at about 8:00am, a low reading. RN Xu noted that David was asymptomatic. RN Xu spoke with Dr Ma who ordered that David's pre-breakfast dose of Novorapid should be withheld.

(b) 17.8 mmol/L at about 10:00am, a high reading. RN Xu noted that David remained asymptomatic but attempted to speak to Dr Ma again regarding the elevated blood sugar level. RN Xu could not locate Dr Ma and instead spoke to Dr Grama, suggesting that a stat dose of Novorapid be administered. According to RN Xu, Dr Grama directed that no further action was to be taken until the next blood sugar level measurement which was to occur just before lunch. Although Dr Grama said that he had no recollection of such a discussion taking place, he did not "*strongly disagree*" that it did not take place.[26]

(c) More than 25 mmol/L at about 12:00pm, a high reading. RN Xu noted that David said that he felt fine, and did not show any physical signs of being unwell. RN Xu spoke to Dr Ma who directed that eight units of regular Novorapid and eight units of sliding scale Novorapid be administered.

(d) 24.2 mmol/L at about 2:00pm, another high reading. RN Xu noted that David remained asymptomatic. RN spoke to Dr Ma and suggested another stat dose of Novorapid. However Dr Ma instructed RN Xu not to administer Novorapid as an endocrine review was being undertaken which would result in David's insulin regime being subsequently adjusted by an endocrinologist.

12.3 RN Xu said he was confident that he spoke to Dr Grama after taking David's blood sugar level of 17.8, and being unable to locate Dr Ma.[27] RN Xu said that he recalled trying to call Dr Ma but there was no answer. RN Xu said that Dr Grama was onsite and that he had been the admitting doctor and spoke to him. RN Xu confirmed that at no time did he continue to try to locate Dr Ma and explained that David was very agitated and, as time was a primary concern, he could not wait.

[26] 24/7/18 at T62.47.
[27] 24/7/18 at T85.32.

12.4 **Conclusion:** RN Xu measured David's blood sugar levels four times on 29 December 2015. On each occasion the measurements raised concerns as they were outside acceptable clinical ranges. On each occasion RN Xu appropriately sought advice from a medical officer as to whether to withhold or administer Novorapid in order to normalise David's blood sugar levels. In this regard it is accepted that RN Xu sought appropriate advice from Dr Grama following the 10:00am blood sugar level reading. Although Dr Grama has no specific recollection of discussing David's blood sugar level with RN Xu, he left open the possibility that such a discussion took place. On this basis, it is most likely that RN Xu discussed this issue with Dr Grama.

Removal of the biscuits

12.5 Officer D said that she accompanied RN Xu each time he measured David's blood sugar level at about 8:00am, 10:00am, and 12:00pm.[28] She said that David was compliant on each occasion. At some stage during the morning, whilst David was in the yard, Officer D said that she heard RN Xu tell David to "*just to watch his food intake*".[29] Officer D said that she could not recall the circumstances in which this was said, or whether it was said when RN Xu was measuring David's blood sugar levels. In his statement and in evidence RN Xu made no reference to making such a comment to Officer D. However, it is clear that RN Xu held some concerns about David's blood sugar levels given the measurements he had taken at different times on 29 December 2015. So much is clear from RN Xu's contact with Dr Ma and Dr Grama regarding aspects of David's insulin therapy. The making of the statement which Officer D attributes to RN Xu is consistent with these concerns.

12.6 David was out of his cell and in the yard from between 12:40pm until 2:20pm.[30] He was scheduled to be locked back in his cell at 2:30pm. Shortly before 2:30pm Officer D saw that David was calm and let him out of the yard so that he could return to his cell. Once inside David asked if he could make a phone call. Officer D described David as calm and respectful at this time. Officer D told David that he could make his phone call, but to do so quickly. After the call David asked if he could get something out his buy up. Officer D saw him retrieve a packet of rice crackers and a packet of biscuits. She said to David, "*Remember what the nurse said, you've got to watch what you eat*".[31] Officer D knew nothing about David's medical conditions or the fact that he had diabetes. However, on Officer D's account, her comment to David was a reference to what she heard RN Xu tell David earlier that day regarding his food intake.

12.7 After giving this reminder to David, Officer D said that there was a rapid change in David's behaviour and that he "*immediately became very aggressive and abusive*".[32] In evidence Officer D said that David responded by saying, "*I'm going to go off my fucking cunt if I can't have these biscuits. I fucking paid for them and they're mine*".[33] On hearing this, Officer D formed the view that David was angry and aggressive and wanted to secure him in his cell and then have the biscuits removed.[34]

12.8 Officer D said that she spoke to RN Xu about David's reaction. She said that she was certain that RN Xu told her, "*We have to get the biscuits out of his cell*".[35] Officer D said that Officer E was

[28] 16/7/18 at T55.12-20.
[29] 16/7/18 at T39.39.
[30] Exhibit 1, page 336.
[31] Exhibit 1, page 122 at [6].
[32] Exhibit 1, page 122 at [7].
[33] 16/7/18 at T56.9.
[34] 16/7/18 at T56.18.
[35] 16/7/18 at T42.42.

present at the time. However, she rejected the possibility that another CSNSW officer had said something about removing the biscuits from David's cell. In evidence Officer D initially said that after David reacted aggressively she spoke to RN Xu who suggested that the biscuits needed to be removed. However, later in her evidence Officer D indicated that she had independently formed the view that the biscuits needed to be removed before she spoke to RN Xu.[36]

12.9 RN Xu said that at no point did he say to Officer D or Officer F that the biscuits had to be removed from David's cell.[37] RN Xu said that he had no recollection of saying to David that the biscuits had to be removed. He agreed that whilst it was a concern that he was eating them his focus at that point was on David's mental state.[38] RN Xu maintained that he did not speak to Officer F who was nearby but RN Xu did not engage him in conversation. He said that it was not possible that it was not Officer F, and instead Officer E, who was there.[39] He said that he never spoke to Officer E and that he was positive that he had no discussion regarding any concerns about David's blood sugar level.

12.10 Officer E prepared an incident report on 29 December 2015. In it he wrote: "*At about 14:10hrs I was approached by [RN Xu] whom [sic] indicated to me that he was concerned about the amount of buy-up that [David] had taken into his cell. The reason for this concern was that [David] was a diabetic and that he was consuming too much [sweet] type food*".[40]

12.11 In evidence Officer E said that he was sure that it was RN Xu who expressed concern about David taking his buy up back to his cell.[41] When asked whether it was another officer who might have expressed such concern, Officer E said that he could not recall but relied on the contemporaneous record made at the time in his incident report. He initially said that Officer D told him that David had buy up in his cell and that RN Xu was concerned because of his high blood sugar levels that day. Later he agreed that it was possible that he was confused and that it might have been Officer D who expressed a concern and not RN Xu.[42]

12.12 It is clear that there is a factual dispute on the oral evidence as to who raised the need for the biscuits to be removed. The contemporaneous records provide some assistance in this regard. On the one hand the incident report created by Officer E on 29 December 2015 indicates that it was RN Xu who raised a concern about David eating his biscuits. It is important to note that the incident report attributes only a concern on the behalf of RN Xu, and no reference to any request made by RN Xu regarding removal of the biscuits.

12.13 In his incident report prepared on 29 December 2015, Officer F recorded: "*Officer E informed me that 20 minutes prior to having his rice crackers the nurse informed him that his blood sugar levels were high and that the crackers had to be removed from his cell. This was in case he went into a diabetic coma by eating too many of them which he had bought on buyouts which were delivered today*".[43] Similarly, in his statement of 30 December 2015 Officer F said: "*[Officer E] stated that inmate Dungay did not want to return the crackers that he had taken to his cell and was consuming them. He further told me that he was gorging them into his mouth and that the nurses*

[36] 16/7/18 at T58.25.
[37] 24/7/18 at T93.49.
[38] 26/7/18 at T93.3.
[39] 26/7/18 at T92.37.
[40] Exhibit 1, Tab 15.
[41] 16/7/18 at T68.6.
[42] 17/7/18 at T97.13.
[43] Exhibit 1, page 128.

had informed him [Officer E] that [David's] blood sugar levels were already high prior to him consuming the crackers and that the nurse requested the food be taken from [David]".[44]

12.14 In contrast Officer D, in her very brief incident report of 29 December 2015, makes no mention at all of any conversation with RN Xu. Instead that conversation is raised for the first time in Officer D's statement made on 1 June 2016, some six months after the event.

12.15 On the other hand, RN Xu made a retrospective entry in the clinical progress notes at about 7:30pm on 29 December 2015. In that entry no mention is made of any conversation with Officer D regarding removal of the biscuits.[45]

12.16 **Conclusion:** As noted in the submissions by Counsel Assisting, it is acknowledged that there are certain limitations associated with RN Xu's evidence which made it unreliable in some respects. These limitations are discussed further below. The solicitor for RN Xu submits that RN Xu observed that David was asymptomatic each time his blood sugar levels were taken and that on each occasion RN Xu sought instructions from medical officers as to whether any clinical intervention was warranted. On this basis, it is submitted that if RN Xu formed the view that removal of the biscuits was warranted he would have, consistent with his practice earlier that day, sought instructions from a medical officer before actioning such a course. There is some force to this submission given that there is no evidentiary basis to suggest why RN Xu would have departed from the practice that he had followed earlier in the day with respect to the issue of removal of the biscuits.

12.17 This submission is accepted because it is consistent with Officer D's evidence. In re-examination by Counsel Assisting, Officer D clearly acknowledged that she independently formed the view that the biscuits needed to be removed from David *before* she spoke to RN Xu. Further, Officer E's evidence leaves open the possibility that it was indeed Officer D who expressed a concern about David's consumption of the biscuits.

12.18 Of course, the fact that Officer D independently formed the view about removal of the biscuits does not preclude RN Xu from also reaching a similar view, and expressing it to Officers D and E. However, given the contemporaneous incident report prepared by Officer E, and the absence of any similar contemporaneous record created by Officer D, it is most likely that any view which RN Xu might have conveyed was limited to concern about David eating the biscuits, rather than an express request that they be removed. This is consistent with the similar concern attributed to RN Xu in relation to his measurements of David's blood sugar levels earlier in the day.

12.19 On the basis of the above, it is most likely that any concern expressed by RN Xu was conveyed by Officer D, together with her own independently formed view, to Officer E. As Officer E was receiving the information indirectly it seems likely that these two factors led to an understanding in the mind of Officer E that a request had been made by RN Xu for the biscuits to be removed. Officer E in turn conveyed this purported request to Officer F.

[44] Exhibit 1, Tab 16 at [7].
[45] Exhibit 1, page 1307-1310.

Escalation to Officer F

12.20 Officer E said that after RN Xu expressed his concern he (Officer E) approached David in his cell. Officer E told David that "*if he ate all the food he had in his cell he would become sick due to his diabetic condition*".[46] According to Officer E, David said, "*It's my buy up and I'll fucking eat it. Fuck off*".[47] Officer E then saw David start to "*stuff rice crackers into his mouth*".[48]

12.21 Officer E said that he had seen David leave his cell on two occasions earlier in the day and had been calm and cooperative at the time. He said that nothing about David's behaviour prior to about 2:10pm had caused him any concern. Officer E initially said in evidence that he spoke to David on two or three separate occasions in an attempt to negotiate with him.[49] However he agreed that there was no reference to this in his incident report, and later acknowledged that he had only made one visit to David's cell.[50] It was suggested to Officer E that he only spoke to David for between 30 to 60 seconds. Officer E said instead that he possibly spent five to 10 minutes trying to negotiate with David, but acknowledged that it could have been less time than this.

12.22 After unsuccessfully attempting to negotiate with David, Officer E called Officer F, the Acting Assistant Superintendent, to attend G Ward. Officer E said that he did not see David's aggression as a security issue.[51] Officer E said that he did so because he knew that Officer F was the regular senior officer in G Ward. When asked why he didn't choose medical staff to speak about a dietary issue, he said that it was just a decision he made at the time, and thought that Officer F would have more luck communicating with David.[52]

12.23 **Conclusion:** Having been informed of a concern regarding the consumption of his buy up, it was appropriate for Officer E to attempt to negotiate with David to return the biscuits. When this was unsuccessful, it was also appropriate for Officer E to escalate the issue to the most senior officer on the ward, Officer F. Officer E knew that Officer F was also familiar with David and his history, and that Officer F might have had greater success in negotiating with David.

[46] Exhibit 1, Tab 15.
[47] 17/7/18 at T107.41.
[48] Exhibit 1, Tab 15.
[49] 17/7/18 at T93.37.
[50] 17/718 at T94.7.
[51] 17/7/18 at T98.7.
[52] 17/7/18 at T98.15.

13. Issue 3: Whether it was necessary and appropriate to move David from Cell 71 to Cell 77 (a camera cell) on 29 December 2015 in light of issue 1 above

13.1 Following Officer F's unsuccessful negotiations with David, a discussion reportedly took place between himself, Officer E, and RN Xu. There is a dispute on the evidence as to who participated directly in the discussion and as to what precisely was discussed.

13.2 Officer E's evidence was to the effect that in his view RN Xu had already "*made the call*" about what needed to happen,[53] namely that the crackers were to be removed. To this extent, Officer E agreed that RN Xu expressed a concern about David having biscuits, and that eating them could affect his elevated blood sugar level. Officer E agreed that someone had to go into the cell to remove the biscuits, but no one did and instead David was taken from the cell.[54] When asked why RN Xu's concern was not acted upon Officer E said that when David was asked to hand over the biscuits he instead ate them. Because this happened it was decided by RN Xu and Officer F that David should be placed in a camera cell to be observed. He said that Justice Health made the decision to move David and that CSNSW had no reason to move David. However, he agreed that the extent of what he and other CSNSW officers were asked to do (by RN Xu) was to get the biscuits.[55]

13.3 Officer E said that it was for RN Xu and Officer F to decide whether David should be moved to a camera cell. He said that he understood the basis for the decision to move David was so that he could be moved to a camera cell and be monitored in case anything went wrong with the biscuits he was eating. On this basis, he agreed that there was no security issue and that there was no discussion about any security concerns. He agreed that it was a medical issue and needed to be managed as such.[56]

13.4 Officer E said that ultimately a decision was made between Officer F and RN Xu for David to be transferred to a camera cell. Officer E said that he was he was present during the discussion between Officer F and RN Xu when this decision was made. However, he said that he had no active input into the discussion. This is contrary to what is set out in Officer E's incident report which records: "[Officer F]*, [RN Xu] and I decided it would be safer to move DUNGAY to a camera cell so he could be observed better*".[57] In evidence Officer E maintained that he was not part of the decision-making process and he simply heard the decision that had been made by Officer F and RN Xu.[58]

13.5 Officer F maintained that "*the nurses*" had asked for David to be transferred, although he could not identify which nurse or nurses told him that the transfer was required.[59] Officer F said that a nurse had told Officer E that the crackers needed to be removed and that this was not something that Officer E had decided. He said that he was sure Officer E had not expressed concern of his own accord.[60] Officer F said that he was sure he was told that David could go into a diabetic coma[61] and indicated that he had referred to this in his incident report.[62] Officer F said that he

[53] 16/7/18 at T74.8.
[54] 17/7/19 at T103.35-104.5.
[55] 17/7/19 at T105.6.
[56] 16/7/18 at T75.24-36.
[57] Exhibit 1, page 126.
[58] 16/7/18 at T75.11.
[59] 17/7/18 at T160.34.
[60] 17/7/18 at T117.33.
[61] 17/7/18 at T120.32.
[62] Exhibit 1, Tab 16.

was aware that David's diabetes was difficult to manage and that on the basis of a previous alert[63] the significant problem was hyperglycaemic episodes.

13.6 Officer F was asked how a request for biscuits to be removed became a request for the IAT to facilitate a cell transfer. He replied: "*Due to his volatile nature on the day and Justice Health nurse saying to us he needs to be moved to the ob cell for observation and the amount of biscuits he was eating*".[64]

13.7 It was pointed out that neither his incident report nor his statements made any mention of a nurse requesting a cell change. He said that he had no reason to move David and that the only reason for the move was so that he could be moved to a cell where he could be observed for health reasons.[65] He maintained that the CSNSW officers were asked to move him there. He rejected the suggestion that he took the request to remove the biscuits to prompt a response to have him move cells. He explained that David would not be moved because of security concerns because he was already within his cell and secure.[66]

13.8 Officer F said that his best recollection is that he returned from attempting to negotiate with David, spoke to Officer E and then made the decision to call the IAT. When asked whether he agreed that there was no reference in his report to having a conversation with a nurse, he did not answer the question directly. This was indicative of the quality of evidence given by Officer F. Instead he answered obliquely by saying that he was not medically qualified and that if a nurse said that a patient needed to be moved, they would be moved. Later he agreed that he was reaching this conclusion based on his understanding and experience of usual practice and that it was not based on any actual recollection of a conversation.[67]

13.9 Ordinarily, the transfer of an inmate, on medical grounds, required a medical officer or nurse to complete a Justice Health document titled "*Medical Officer/Nursing Certificate*". Such a certificate had previously been completed for David most recently on 30 November 2015 (when he was transferred to a non-camera cell) and on 14 December 2015 (when he was transferred to a different ward). Officer F agreed that if normally seeking a cell move on medical grounds he would seek such a certificate. When it was suggested that "*the nurses*" did not request a cell move he said that he would not move an inmate without a request from a nurse.[68] He agreed that he did not seek a transfer certificate and said that it was because he was told the move was on medical grounds and that the certificate would be done later when the move was completed.

13.10 In his evidence RN Xu said that it was not true when Officer E had said that he and Officer F made the decision together to move David.[69] RN Xu was asked whether he thought David could be safely housed in cell 71. He said that he gave no thought to a cell transfer and said: "*My understanding - 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*".[70]

[63] Exhibit 1, pages 559-560.
[64] 17/7/18 at T123.31.
[65] 17/7/18 at T123.39.
[66] 17/718 at T124.8.
[67] 17/7/18 at T152.47-153.3.
[68] 17/7/18 at T127.23.
[69] 26/7/18 at T14.2.
[70] 26/7/18 at T11.14.

13.11 RN Xu explained that he understood the general practice to be that the decision to medically transfer an inmate can only be made by a doctor by completing a certificate. He agreed that if he wanted David to be moved out of concern for his condition he would have spoken to a doctor who would have then assessed David and completed a certificate.[71]

13.12 Upon the arrival of the IAT in G Ward, RN Xu said that he saw the IAT officers proceed directly to cell 71. Having drawn the midazolam by this stage, RN Xu followed the IAT officers to cell 71 with the understanding that it was to be administered in cell 71.[72] At that point one of the officers told him that the injection would not occur in cell 71. He explained that this was the first time that he became aware that David was to be transferred to a camera cell. He said that the IAT directed him to leave straight away, and he returned to the treatment room.

13.13 RN Xu's account is clearly depicted on the CCTV footage of the corridor leading to cell 71. This footage shows RN Xu following the IAT to cell 71, wearing gloves and carrying a yellow kidney dish. This is the same dish captured on the IAT footage later in cell 77. Therefore if RN Xu had requested the cell transfer it can reasonably be concluded that he would have waited until the cell transfer had been effected, before attending cell 77 (and not cell 71) to administer the injection. The footage of RN Xu following the IAT to cell 71 and then leaving a short time later is consistent with RN Xu's version that he first became aware of a cell transfer *after* the arrival of the IAT on G Ward.

13.14 Dr Cromer expressed the view that in a scenario where David's blood sugar level was initially low but then seemed to increase after breakfast, but that he was observed to be asymptomatic, he would not consider removal of the biscuits from David to be a medical emergency. He further explained that whilst it would be preferable to remove them, it would not be considered to be a pressing matter from a medical perspective.[73]

13.15 In evidence Dr Ma was asked what consideration he would give if he had been asked whether David should be moved to a different cell. He explained: "*But whether [the cell move] needed to be done immediately, given that [David] was quite aggressive at the time, potentially that could have, they could, they, they, they could have waited. There could have been further attempts, potentially of, of de-escalation, or potentially, as I was under the impression, that intramuscular emergency sedation could have been administered, to then safely take him to a camera cell at a point in time where he might have been more settled*".[74] Dr Ma eventually agreed that other options were available which meant that an immediate cell transfer was not required.[75]

[71] 26/7/18 at T12.36.
[72] 26/7/19 at T63.19.
[73] 25/7/18 at T63.46.
[74] 5/3/19 at T11.39.
[75] 5/3/19 at T12.5.

13.16 **Conclusion**: It is most likely that Officer F made the decision that David be moved to a camera cell. The oral evidence of both Officer F and Officer E was inconsistent with aspects of their contemporaneous incident reports. Officer F maintained in evidence that "*the nurses*" had requested the cell move. However, no mention of this was made in Officer F's incident report and in evidence he was unable to identify any nurse who had made such a request. Similarly, in evidence Officer E disavowed any participation in the decision-making process to effect a cell move. However, this was inconsistent with the content of his incident report.

13.17 The evidence establishes that RN Xu was aware that if a cell transfer was to be effected on medical grounds, that was a matter for a medical officer to decide. If such a decision was made it required completion of an appropriate certificate. The absence of such a completed certificate on 29 December 2015 tends to support RN Xu's evidence that he made no request, on medical grounds, for David to be moved. Importantly, the video evidence supports RN Xu's version that he was not aware of any proposed cell transfer until after the IAT arrived in G Ward.

13.18 Therefore it appears that the concern previously expressed by RN Xu, coupled with Officer D's request for the biscuits to be removed, was misinterpreted as a request for David to be moved from a non-camera cell to a camera cell so that he could be observed. It is likely that this misapprehension can be attributed to the nature of the indirect communication between RN Xu and Officer F. This issue is discussed further below.

13.19 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 have warranted a cell transfer and the need for David to be observed in a camera cell. Indeed the evidence points to the contrary in the sense that whilst David's blood sugar level was elevated, and he was consuming biscuits, he had been observed to be asymptomatic. As counsel for CSNSW correctly submitted[76] the appropriate response to the circumstances which confronted Officer F on the afternoon of 29 December 2015 was for advice to be sought from a medical officer as to whether a cell transfer was necessary, and could be effected safely.

13.20 The solicitor for the Dungay Family submitted that Officer F "*embarked on a 'power play' in response to David's defiant behaviour, which can only be described as repugnant and reprehensible*".[77] It could not be said that this is the only reasonable conclusion that could be drawn from Officer F's decision to effect a cell transfer for David. As already noted above, 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.

[76] Submissions on behalf of CSNSW at [75].
[77] Submissions on behalf of the Dungay Family at [132].

13.21 It has already been noted that the quality of Officer F's evidence was deficient in some regards. However an appropriate concession was ultimately made by Officer F that his oral evidence relevant to whether there had been a request for a cell move by RN Xu was based on previous experience rather than actual recollection. Further, given that Officer F was not medically qualified, his belief that David needed to be moved on medical grounds (regardless of how that belief was ultimately formed) is consistent with a misunderstanding that an acute deterioration in David's condition was either imminent or likely. On this basis it could not be reasonably concluded that Officer F's actions were representative of a "*power play*".

14. Issue 4: Whether it was necessary and appropriate to utilise the Immediate Action Team (IAT) to facilitate the move between cells on 29 December 2015. What alternatives to using the IAT were available?

14.1 Section 12.1 of the CSNSW Operations Procedures Manual (**OPM**)[78] was in force as at 29 December 2015. It related to general matters affecting the safety, security, good order and discipline of a correctional centre. Specifically, section 12.1.9.2 of the OPM identified the role of an IAT and set out a bullet point list of responsibilities. Relevantly, section 12.1.9.2 identified that one of the responsibilities of an IAT was to "*respond to security and emergency situations at their respective correctional centres at the direction of the Manager Security*".[79]

14.2 Officer F agreed that it was his decision to call the IAT to facilitate the cell transfer.[80] As noted already above, neither Officer F nor Officer E considered the circumstances of David being in his cell eating his biscuits to be a security issue. Officer F also agreed that there was no emergency situation.[81] The question which therefore arises is whether there was a proper basis for the IAT to be utilised in such circumstances.

14.3 In evidence it was suggested to Officer F that the circumstances of 29 December 2015 did not fall within the scope of section 12.1.9.2 of the OPM. Officer F explained that as long as he had been working in G Ward if an inmate who needed to be moved was being volatile or irate a call would be made to the IAT.[82] However he agreed that none of the criteria set out in section 12.1.9.2 provided that the IAT had a general role to respond to medical issues.

14.4 It was suggested to Officer F that the circumstances of David refusing to hand over his biscuits where his blood sugar level was elevated was not a medical emergency. As already noted, Officer F referred to the fact that "*the nurses*" had made a request for David to be moved, and that he would not have been moved if it was not a medical emergency.[83] When it was suggested that a mentally ill man eating biscuits did not amount to a medical emergency Officer F responded by saying that they had been asked to move David so that he could be in a camera cell. He disagreed with the propositions that he was not asked by a doctor or nurse to move David, that without a doctor's input the reaction was excessive, and that the IAT was not required and that their presence was not a reasonable response to the circumstances.[84]

14.5 Officer F said that Officer E passed on to him a nurse's concern that David was at risk of diabetic coma.[85] When asked what his understanding was of when such an event might occur, he said that it could have been any time after David ate the biscuits.[86] Officer F agreed that he made no reference to this in his incident report. He agreed that if he had been told that David was at risk of falling into a diabetic coma then it would have been included in his second statement.[87] On this basis Officer F appeared to agree with the proposition put to him by the solicitor for the Dungay Family that given there was no reference to risk of diabetic coma in his second

[78] Version 1.32, July 2015.
[79] Exhibit 4.
[80] 17/7/18 at T127.40.
[81] 17/7/18 at T130.5.
[82] 17/7/18 at T130.10.
[83] 17/7/18 at T130.32.
[84] 17/7/18 at T130.50-T131.10.
[85] 17/7/18 at T117.33.
[86] 17/7/18 at T172.24.
[87] 17/7/18 at T151.30.

statement he was never told about it.[88] However during later questioning by counsel for CSNSW, Officer F reverted to his original position and maintained that, based upon what he had been told, he held a concern that David was at risk of a diabetic coma. In re-examination by Counsel Assisting Officer F was questioned about whether or not he considered such a risk to be imminent or whether any potential intervention could be taken later.

14.6 Officer F agreed that what any nurse might have said had been conveyed to him by Officer E. He agreed that he had no face-to-face discussion with any nurse and that one option would have been to speak to a doctor or nurse to determine how imminent any risk might have been.

14.7 Officer F said that he spoke to David three times in an attempt to persuade him to hand over the biscuits. He told David that the IAT were on their way and that they were going to transfer him to cell. Officer F said that David replied, "*Send the squad, I'll fight them all*". Officer F agreed that David's response indicated that it was likely that physical force would be applied.[89] Officer F also agreed that by calling the IAT it meant that force and restraint would be used and that there was a likely risk of injury to David or the IAT officers. In these circumstances it was suggested that it was sensible to see a doctor or nurse to see if the risk of diabetic coma meant others were to be put at risk. In response Officer F said that it had been explained to him that there was a need to move David and the reasons why. He said that he did not think it was appropriate to speak directly to a doctor or nurse because a nurse had already spoken to Officer E about the need to move David.[90]

14.8 Officer E was also asked whether he thought that the situation was so urgent that there was no time to see if a Justice Health staff member could complete a certificate for David to be moved to a different cell. He said that he did not consider the situation to be urgent because David was in his cell, but that his impression of the sense of urgency was conveyed to him by RN Xu.[91] He said there was never any mention about a doctor needing to be consulted. He agreed that this sense of urgency was not conveyed in his incident report.

14.9 Officer E agreed that he did not seek a doctor's view about a diabetic condition because he had been briefed by a nurse on the ward. He said that he did not think to see whether a doctor might de-escalate the situation and said that this was because in his experience doctors and nurses only inflame a situation more than help it.[92] He expressed the view that CSNSW officers were better at de-escalating situations than Justice Health staff, despite being aware there were trained psychiatric nurses experienced in dealing with psychiatric patients on the ward.[93]

14.10 After agreeing that he had no medical training, or training in relation to managing patients with psychiatric or diabetic issues, Officer E said that his opinion about whether he was able to make such an assessment that the involvement of Justice Health staff would be likely to inflame the situation, was based on watching past interactions. Regardless, he said that he gave no thought to calling doctors or nurses in any event.

14.11 Officer E agreed that he knew David suffered from a mental disorder and diabetes, that David could be aggressive, his behaviour could be unpredictable, and that this information apprised him about David's condition and the way he might act on a particular day. He agreed that this

[88] 17/7/18 at T153.34.
[89] 17/7/18 at T135.7.
[90] 17/7/18 at T174.35.
[91] 17/7/18 at T98.47-99.11.
[92] 17/7/18 at T99.40.
[93] 17/7/18 at T100.10.

was information he did not need in writing. In addition he agreed he had access to information written on the patient whiteboard and that he had access to nursing and medical staff who could inform him of changes in a patient's condition that might affect the management of a patient.

14.12 **Conclusion:** The evidence establishes that there was no proper basis for Officer F to request the attendance of the IAT in G Ward on 29 December 2015. None of the criteria set out in section 12.1.9.2 of the OPM relating to the roles and responsibilities of the IAT provided for their involvement in a medical issue, as understood by Officer F. On this basis alone, it can be concluded that it was neither necessary nor appropriate to utilise the IAT to facilitate David's cell transfer.

14.13 Counsel for CSNSW submitted that whether or not Officer F considered that David represented a security threat whilst inside cell 71 is not to the point.[94] Rather, it is submitted, once Officer F made the decision to open the cell door to move David a security situation did arise which required the involvement of the IAT. In support of this submission reference was made to the evidence of Shane Bagley, the senior investigation officer who completed the Death in Custody Report following David's death, who sought to explain that a security situation arises in circumstances where an inmate is unwilling to voluntarily move to another cell and, because of the inmate's demeanour, mechanical restraint is required to effect the cell move. However, the evidence of Officer Bagley does not take into account the fact that the decision made by Officer F to involve the IAT was only made after David had refused to return the biscuits. Therefore, the relevant point for determining whether or not there was a security issue is at the time that Officer F made the decision to request the attendance of the IAT. At that point in time the evidence clearly establishes that David was secured within his cell, with no security issues present.

14.14 Officer F was plainly aware that requesting the involvement of the IAT carried a risk, particularly given his interactions with David and knowledge of his volatile condition, that the use of force would be likely. Officer F was also aware that the likely use of force in turn carried a risk of injury to David and the IAT officers. With this awareness in mind, it would have been appropriate for Officer F to confirm his understanding of the acute nature of David's condition, whether any risk to his health was imminent, and whether any such risk warranted the involvement of the IAT. It should be noted that the incident report prepared by Officer F does not suggest that he considered that urgent intervention was warranted. Officer F's explanation that he had already been provided this confirmation by RN Xu is flawed. The evidence establishes that the purported confirmation was only provided indirectly through Officer E. With this in mind, it was again neither necessary nor appropriate for Officer F to request the attendance of the IAT without conducting proper enquiry as to whether there was a basis to do so.

14.15 Having concluded that it was neither necessary nor appropriate to utilise the IAT, the question that arises is whether there were any alternatives available to Officer F to properly manage the situation he was confronted with.

[94] Submissions on behalf of CSNSW at [79].

Alternative: use of Aboriginal inmate delegates and welfare officers

14.16 Officer F was asked whether he considered seeking the assistance of a doctor, an Aboriginal inmate delegate, or an Aboriginal welfare officer to de-escalate the situation. Officer F said that the Justice Health nurses had already spoken to David unsuccessfully, and that he did not consider seeking the assistance of an Aboriginal delegate or welfare officer.[95] Officer F agreed that Aboriginal welfare officers and delegates were available to be used. However, he said that he did not give any thought to such alternatives because he had already tried to reason with David three times and he remained unreasonable, and that he had known David for a number of years.[96] He also said that unlike other wards, he had never taken an Aboriginal delegate or welfare officer into G Ward. However, when taken in evidence to certain CSNSW records, Officer F agreed that an Aboriginal delegate was previously used in another volatile situation involving David on 22 August 2012.[97]

14.17 Officer F explained that the process involved for calling Aboriginal welfare officers to attend G Ward meant that he had to ring up or do a referral in an electronic casenote for a welfare officer to attend when available. If called, it was likely that they would attend later that day, or the next day. He said that in his experience it was unlikely welfare officers would have attended at short notice due to officer shortage.[98] However, notwithstanding, Officer F said that he gave no consideration at all to this process.

Alternative: removal of the biscuits

14.18 Officer F was asked whether he considered that a way of dealing with the situation was to ask the IAT to simply remove the biscuits. He said that David would not return them to him or the IAT. When it was suggested that he could not know what David might do he said that he knew David better than the IAT, that he had attempted to negotiate with David three times, and there was nothing that made him think that David would give the biscuits to the IAT.[99] When it was suggested that the difference was that the IAT could forcibly remove them from him, Officer F said that it was still the case that the nurses had asked that David be moved to a camera cell.

Alternative: allow David to remain in his cell

14.19 Officer F agreed that by calling the IAT and having what could be a violent confrontation that there was a risk of serious harm to David and the CSNSW officers. Officer F agreed that any proper risk assessment had to take into account such risk, but disagreed that he failed to appropriately conduct such an assessment.[100] When asked what risk there was if nothing was done, he said that there was a risk to David's health and that he was not qualified to answer what might happen if no action were taken.[101]

14.20 Officer F agreed that he was bound to consider alternatives to the use of force and indicated that in this sense he went three times to see David and at no time was he compliant. Officer F said that to him de-escalation meant leaving the inmate in his cell where he was contained with no

[95] 17/7/18 at T135.12.
[96] 17/7/18 at T121.44.
[97] Exhibit 1, page 1128.
[98] 17/7/18 at T169.4-14.
[99] 17/7/18 at T133.13.
[100] 17/7/18 at T154.43.
[101] 17/7/18 at T155.1.

risk to any officer.[102] He was asked whether he considered an option of tactically disengaging. He said that if there was no need to move on non-medical grounds then this would have been considered.[103]

14.21 **Conclusion:** Regrettably, alternatives to involvement of the IAT on 29 December 2015 were not considered. Seeking the involvement of an Aboriginal inmate delegate or welfare officer, requesting the IAT to simply remove the biscuits from David (rather than effect cell transfer), and simply allowing David to remain in his cell (with appropriate observations to be performed) were options that were potentially all available to Officer F. However, the evidence established that either no enquiries were made by Officer F regarding utilising these options, or that Officer F predetermined that the options were unavailable to him.

14.22 In circumstances where Officer F appropriately acknowledged that involvement of the IAT carried with it the likely use of force and consequent risk of injury, it was appropriate for at least some enquiry to be made as to whether any alternatives were available. Even allowing for the fact that Officer F believed that a cell transfer was warranted on medical grounds, he acknowledged that no proper enquiry was conducted to allow for a determination to be made as to whether the risks associated with a likely use of force were outweighed by any risks associated with David's medical condition.

14.23 Although Officer F indicated that he gave no consideration to possibly seeking the assistance of an Aboriginal inmate delegate or welfare officer, his evidence also demonstrated a lack of awareness of such personnel as an available alternative. Further, even if Officer F had sought to utilise such an alternative, the evidence suggests that possible utilisation would likely have been constrained by resource limitations.

14.24 **Recommendation:** I recommend to the Commissioner for Corrective Services New South Wales that all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.

[102] 17/7/18 at T153.42.
[103] 17/7/18 at T153.37.

15. Issue 5: Whether the IAT team members acted in accordance with Corrective Services NSW policy and procedures in facilitating the move of David between cells on 29 December 2015

15.1 As already noted above section 12.1.9.2 of the OPM provided the basis for an IAT to respond to a security or emergency situation. In evidence Officer A, the IAT Team Leader, accepted that this formed part of the core duties of the IAT. Officer A said he was not told directly who had requested the cell move. However he said that based on his experience it involved a consultation between Justice Health and CSNSW. He said that after being told that David had been non-compliant with directions and that negotiation had failed he formed the view that there was a proper basis for the IAT to attend.[104]

15.2 On this basis Officer A said that he regarded the incident as a security situation. He said that the fact David had been non-compliant with staff directions made it a security issue. Officer A said that based on being told that David was "*messing*" with his blood sugar level, he considered there to be an element of self-harm in relation to the request.[105] He said it affected the overall security of the centre as he considered David's continued eating of food to be an attempt at self-harm and that he needed to be placed in a camera cell. He explained:

> "*The overall security of the centre [was at risk], for the fact that…Mr Dungay was eating copious amounts of food in what was explained to me as an attempt of self-harm, that I took as an attempt of self-harm, and that he needed to be placed into a camera cell due to that risk of self-harm and non-compliance*".[106]

15.3 Officer A agreed that self-harm in relation to diabetes was a medical issue but said that he also considered it to be a security issue.

15.4 Officer O also considered the matter to be a security situation. He explained that it related to the security of the staff in G Ward because of David's behaviour.[107] He said that Officer A briefed him that David was an enforced medication inmate who refused to be medicated, was highly aggressive, and needed to be moved to a camera cell.

Negotiation and persuasion

15.5 The policy statement in the CSNSW use of force policy provides that persuasion and negotiation is a strategy to minimise risk when managing non-compliant behaviour by inmates.[108] Further, section 2.1.1 provides: "*A planned use of force is one with prior indication that it **may** be necessary and there is time to prepare for its use - for example, an inmate refuses to come out of their cell, to get into a vehicle or refuses to be searched. These situations and others like them do not necessarily require the immediate use of force*" (original emphasis).[109]

15.6 Officer A agreed that he approached the job with the view of avoiding the use of force if possible. He explained that the inmate dictates the terms, but agreed that by removing the biscuits it would have changed the approach taken by the IAT.[110] He agreed that it would have been

[104] 19/7/18 at T279.9.
[105] 19/7/18 at T274.26.
[106] 19/7/18 at T278.3.
[107] 18/7/18 at T217.9.
[108] Exhibit 1, page 782.
[109] Exhibit 1, page 783.
[110] 19/7/18 at T280.18.

valuable information to him to have known if the nurse had only asked for the biscuits to be removed. He said he approached the cell with the assumption that whoever was in charge had already tried and exhausted other options. Officer A explained: "*…that would just be an assumption that the staff working in that area on the day, or the assistant superintendent, or management on that day working down in that area would have already [tried other options], hence the reason they've called us in as a last resort*".[111]

15.7 Officer A was asked about using strategies in order to minimise risk in accordance with the OPM. He said the proclamation given to David by the IAT to comply with their directions within one minute, prior to entering the David's cell, amounted to negotiation and a risk mitigation strategy. He explained:

> "*I'm not saying that I never go into any negotiation with an inmate. In the brief we were informed that negotiations had failed, which indicated to me that negotiations had took place. The way that I negotiate in a situation where negotiations have failed, the way that I've been trained to do that, is by providing an initial proclamation, and it clearly states and outlines what is required of the inmate, what is being directed of the inmate*".[112]

15.8 Officer A said that the proclamation was the only negotiation skill that he had ever been taught, apart from referring to a specific training module for IAT members in relation to hostage response. He said that he had never received any training in relation to mental health issues. He agreed that avoiding the use of force would be a good outcome for all concerned.[113]

15.9 The OPM provided the basis for the proclamations issued by Officer A:

> "*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*".[114]

15.10 Consistent with his training, Officer A issued the following proclamation to David:

> *"We need to do a cell move on you right now. What I want you to do is come to the door and place your hands through the door, you're going to be handcuffed and moved to another cell. Fail to comply with any of my directions, it may result in the use of force. Do you understand? I'll give you one minute to comply with my directions".*[115]

15.11 When David did not comply Officer A issued the proclamation for a second time. David again did not comply and the IAT entered cell 71 approximately 90 seconds after arriving at the cell door.

15.12 The view taken by Officer A regarding the proclamation given to an inmate relevant to the issue of possible negotiation was shared by some of the other IAT officers. Officer C was asked whether it was standard practice for the IAT to not be involved in negotiations. He said the only negotiation is the presence of the IAT or the proclamation.[116] Officer O was asked whether the

[111] 19/7/18 at T281.33.
[112] 19/7/18 at T321.37.
[113] 19/7/18 at T326.6.
[114] Exhibit 1, page 783.
[115] Exhibit 1, page 357.
[116] 20/7/18 at T396.7.

IAT discussed alternatives to the use of force. He referred to the first proclamation, explained that David was given the opportunity to comply, and that this amounted to use of persuasion and negotiation. He said that there was no discussion within the IAT about seeing whether someone else might be able to reason with David. Officer O said that he was not aware of any attempt to de-escalate the situation in the one minute between proclamation and entry. It was suggested that the extra information that David wanted to take on the IAT was a perfect chance to employ de-escalation techniques. Officer O said that the presence of the IAT is a form of de-escalation and that if the inmate chose to continue on a path that was a matter for them.[117]

15.13 It was suggested that David's indication that he was going to take the IAT on was important information and that it was important not to proceed in a rigid manner until all other options had been exhausted. Officer A referred to a previous training scenario where non-compliance had been indicated after a proclamation but when the cell door was opened the inmate complied. He said that he had never not entered a cell after a proclamation had been given.

15.14 Officer O did not agree that it was unreasonable that an involuntary patient had only been given one minute for de-escalation.[118] When taken to the fact that David was becoming more aggressive he said that it was the job of the IAT to deal with non-compliant inmates. Officer C similarly said that he considered it reasonable to ask a mentally ill person to comply within one minute.[119] Officer C agreed that there was nothing physically preventing Officer A from spending 10 minutes at the cell door (attempting to negotiate with David) but expressed some reservations as to whether that would be in accordance with the policies and procedures specific to the IAT.[120]

15.15 Officer A said that if appropriate training was provided he might be able to agree that an inmate might not be able to respond rationally, and that therefore there was a need to deal with them in a different way. He said that he understood that perhaps there was a need for a different approach when dealing with mentally ill patients who are not rational.[121]

15.16 However Officer A's view was not shared by some of the other IAT officers. It was suggested that if the IAT was given further training then it could play a role in further negotiation or attempts to de-escalate the situation upon their arrival. Officer C disagreed with this proposition and said: "*Our name stipulates that immediate action needs to take place, sir. All four points of the de-escalation strategies were met by IAT. The persuasion and negotiation - persuasion, in itself, is our presence. Actually having us arrive is the persuasion tactic. The negotiation is the proclamation that we deliver and the minutes they have to think about it. The presence of senior officers, there's always a senior officer-in-charge of IAT. We always video record events and we are the IAT which is the fourth point of the list*".[122]

Chemical aids

15.17 Section 2.3.1 of the OPM provides for the use of chemical aids in the use of force. Officer A was asked about using gas in G Ward. He said that he had always been informed by management that in a cell or interior environment gas was not to be deployed because of the air conditioning

[117] 18/7/18 at T261.48.
[118] 18/7/18 at T262.32.
[119] 20/7/18 at T427.48.
[120] 20/7/18 at T428.36-50.
[121] 19/7/18 at T328.24-35.
[122] 20/7/18 at T427.7.

system. He said that the only time he had seen it deployed was 18 months ago in a training exercise outside G Ward.

15.18 Officer O agreed there was an option to use capsicum gas but said that it was only used in situations where an inmate was armed or if there were multiple inmates and said he was not aware of it ever having been used in G Ward.

15.19 **Conclusion:** CSNSW policy identified that negotiation and persuasion is a risk minimisation strategy when dealing with non-compliant inmates. Notwithstanding, no actual active negotiation or persuasion was conducted by Officer A, or any other member of the IAT, upon their arrival at cell 71. Rather, the IAT considered that the proclamation issued to David, and the mere presence of the IAT, amounted to negotiation.

15.20 Officer A explained that in David's case he understood that any attempt at negotiation had already failed, thus necessitating the involvement of the IAT as a measure of last resort. However, even with this understanding, it did not abrogate the responsibility of the IAT to actively negotiate with David in order to avoid the use of force, and its associated risks, if at all possible. So much is made clear by the provisions of the OPM which applied at the time.

15.21 The evidence given by Officer A that, in his experience, he had never not effected a cell entry after giving a proclamation clearly indicates that the same unreasonably rigid adherence to past practice was followed on 29 December 2015. It is accepted that the rigidity of the approach by the IAT was to a large degree dictated by training which had been provided to them and the distinct lack of emphasis on de-escalation techniques in CSNSW policies which applied at the time. Even so, it was acknowledged by Officer C that there was nothing to prevent Officer A spending considerably more time outside cell 71 attempting to negotiate with David. Adopting, or at least contemplating, such a course would have given appropriate effect to the OPM requirements that force was to be used when all else has failed, and that the situation which confronted the IAT on 29 December 2015 did not necessarily require the immediate use of force.

15.22 It was submitted by the solicitor for the Dungay Family that the use of the proclamation process, when used in Long Bay Hospital, should be reviewed on the basis that inmates suffering from a mental illness may not be able to respond rationally. Counsel for CSNSW submitted that such a review was not warranted on the basis that the proclamation process serves a different purpose to de-escalation techniques which are addressed in new Local Operating Procedures at Long Bay Hospital (discussed further below) introduced since David's death. Whilst this is so, it is evident that the proclamation is regarded as the final attempt at negotiation before use of force is imminent. Further, it was recognised by Officer U that taking a more considered position regarding a proclamation issued to a mentally ill inmate patient was warranted.[123]

15.23 **Recommendation:** I recommend that Corrective Services New South Wales review the use of the proclamation process by the Immediate Action Teams in Long Bay Hospital to ensure that appropriate consideration is given, at the time the proclamation issued, to the possibility that a mentally ill inmate patient may not be in a position to comply or respond to the proclamation in a rational manner.

[123] 8/3/19 at T22.5.

15.24 It can be accepted that the use of chemical aids, as an alternative to the use of force, was not available on 29 December 2015. However, there is no evidence that any other alternative was considered, let alone explored, by the IAT members.

16. Issue 6: Whether the IAT members acted appropriately in the application of force to David/restraint of David on 29 December 2015

16.1 Section 5 of the CSNSW Custodial Operations Policy and Procedures (**COPP**) relates to using force on inmates. The policy statement provides the following instruction: "*You must use alternative methods to resolve problematic behaviour whenever possible. A peaceful, injury-free solution is the first objective*".[124]

16.2 Section 2.1 relevantly 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*".[125]

16.3 Section 2.2 relevantly further 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 a 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 they used, why they use it, and the duration of its use. This includes the use of security equipment*".[126]

16.4 Officer A indicated that he understood these limitations on the use of force, and that these limitations applied not only to the IAT officers, but to all CSNSW officers.[127]

16.5 A summary of the force applied by the IAT officers on 29 December 2015 follows:

(a) The door to cell 71 was opened at approximately 2:43pm. Officer C was the first IAT officer to enter cell 71 carrying a shield, which David immediately collided into. Officer C used the shield to push David back in the cell, and used the shield to make contact with David for a second time.[128]

(b) Officer C released the shield and used his upper torso in a "*sort of a rugby style tackle*" to collide into David and force him backwards and onto the mattress of the cell bed.[129] This caused David to land in a partially sitting position on the bed.

(c) Officer C pushed down on David's upper torso, and then used his left hand to restrain David's left hand whilst using his other hand to turn David's face towards the cell wall to gain control.[130]

(d) Officers A, B, M and O entered the cell and assisted Officer C in restraining David on the bed. David was positioned in a partially sitting, partially supine position on the bed.[131] Officer B and Officer O controlled David's arms and his hands were eventually cuffed at the front of his

[124] Exhibit 1, page 782.
[125] Exhibit 1, page 783.
[126] Exhibit 1, pages 783-784.
[127] 19/7/18 at T283.24-33.
[128] 20/7/18 at T371.5.
[129] 20/7/18 at T371.11.
[130] 20/7/18 at T371.27-50.
[131] 19/7/18 at T344.44.

body. Officer M applied downward pressure onto David's legs. Some of the officers reported that David had been spitting blood.

(e) David was restrained on the bed for approximately 1 minute and 37 seconds before being moved off the bed and onto the floor.

(f) David was restrained for a further 1 minute and 25 seconds on the floor by Officers A, B, C M and O.

(g) David was stood up and led from cell 71 to cell 77. Officer A directed the other IAT officers to control David's neck so that he could not spit blood at any of the officers.[132] This resulted in David walked whilst bent forward and hunched over.

(h) Whilst being escorted along the corridor between the cells, David said that he could not breathe and suddenly collapsed to the ground. He was lifted back to his feet by the IAT officers and continued to be escorted to cell 77.

(i) Inside cell 77 David was placed onto the cell bed in a prone position with his head near the end of the mattress, whilst remaining handcuffed. Officer O used the Figure 4 technique to apply pressure to David's legs in order to restrain them. Meanwhile Officer C employed a technique known as a knee ride as a control measure to prevent David from moving his hips in order to avoid restraint. This involved Officer C placing his hands on David's shoulders, between his shoulder blades, with one foot on the ground and his knee against David's lower back. Officer B maintained handcuff control.

(j) David remained restrained in this position in cell 77 up until the point that he became unresponsive, at approximately 8 minutes and 16 seconds after the IAT footage commenced.

David's inability to breathe

16.6 David first complained that he could not breathe whilst being restrained on the bed inside cell 71 (at approximately 2 minutes and 24 seconds into the IAT footage). He repeated his complaints of being unable to breathe on multiple occasions whilst restrained on the floor of cell 71, whilst being escorted from cell 71 to cell 77, and whilst on the bed inside cell 77.

16.7 In evidence, a number of the IAT officers were asked about what consideration they gave, if any, to David's complaints that he could not breathe:

(a) **Officer A** said that he considered David's complaints to be "*a diversionary tactic employed by Mr Dungay so that we would loosen the restraint*".[133] He explained that he considered this to be the case because although he thought David was exerted he could still hear his breathing.[134] Officer A was asked, even accepting that it was his experience that past inmates had used a complaint of not being able to breathe as a tactic to loosen a restraint, whether he considered it was also possible that the complaint was genuine. Officer A said that he did not think that this was the case in David situation. Officer A explained that David followed instructions from the IAT, and the fact that David continued to talk to the IAT officers made him think that the complaints were not genuine.

[132] 19/7/18 at T291.31.
[133] 19/7/18 at T294.34.
[134] 19/7/18 at T294.42.

Officer A agreed that he thought because David could talk he could breathe. He said that this was based on his own experience as a child when he experienced panic attacks and hyperventilated. He said that he recalled his father used to calm him down by telling him that because he could talk he could breathe and this always stuck with him: "*And my father used to always, in a way to calm me and reassure me, would say, "If you're talking, you can breathe. Just talk to me. Talk to me. If you're talking, you can breathe". That's something that always stuck with me*".[135] Officer A agreed that he was not taught this as part of any training that he had received.

Officer A said that he had no concern regarding the amount of weight on David's back in terms of whether it would restrict his ability to breathe.[136] Officer A said that the amount of pressure applied was dictated by an inmate. He was asked whether increased struggling meant more pressure. He said that it would not necessarily mean more pressure but instead more coverage of an area, particularly to stop an inmate rolling their hips and rising up.

When asked if he heard David gasping Officer A said that David sounded physically exerted and not like he was gasping. He disagreed that he could hear David struggling to breathe and instead said he sounded like "*someone that was short of breath from resisting restraint from officers*".[137] He was asked whether he thought he had a responsibility to ensure that David was completely well when he said he could not breathe. Officer A replied, "*I agree that I had a duty of care to make sure he was okay, yes*".[138]

(b) **Officer O** was asked what his understanding was of the force permitted to be used. Similar to Officer A, he said that it was dictated by the inmate in the sense that if the inmate was compliant minimal force was used.[139] However, if there was resistance shown by the inmate then only enough force would be used in order to gain control.

When the IAT footage was played to Officer O he disagreed that David could be heard gasping and instead described the sounds as heavy breathing. He said that at no point did he form the view that David's complaints about being unable to breathe were genuine.[140] He said that he did not see anything from his observations to think that the complaints were genuine. When asked whether he considered the heavy breathing to be a sign of breathing difficulty, he said that everyone in the cell had been involved in the use of force and that it had been a physical interaction and that everyone was breathing heavily.

(c) **Officer B** said that his view about the genuineness of the complaint only changed within seconds after the first injection. He said that this was because David's breathing appeared more laboured and that he was trying to take in more air and agreed that it could be described as David gasping. Officer B said that he asked Officer C to turn David's head in his direction. Officer B said that he then monitored David airway and could see him breathing and his chest expanding.[141]
Officer B described David's breathing as him being out of puff from taking on the IAT. He said that he gave no thought at that time to the fact that David might have been struggling to get

[135] 19/7/18 at T297.10.
[136] 19/7/18 at T301.15.
[137] 19/7/18 at T293.18.
[138] 19/7/18 at T333.31.
[139] 18/7/18 at T221.3.
[140] 18/7/18 at T231.46.
[141] 19/7/18 at T348.38.

air in. He was asked whether he thought the complaints were genuine and said that he thought it was a bluff or tactic used to relax the restraint as it had been used in the past.[142] However he acknowledged that he had to try to assess what was in front of him.

Officer B said that he had watched a video in his own time – he believed it was an instructional type video in relation to a US prison – in which he had heard someone telling an inmate that if they could talk they could breathe.[143] He said that that he also recalled reading some literature that his partner had regarding first aid which indicated that for a person who was choking if they could talk it only indicated a partial lodgement and that the airway was still open.[144] He said that what he saw in the video informed his thinking on 29 December 2015. He said that he now understood what he had previously seen and read to be a "*total myth*".[145]

(d) **Officer C** was asked about David's breathing. He said that he noticed David was breathing heavily and puffing from exertion. He said he would not use the term gasping. He was asked whether he thought the complaints were genuine. He said that he thought David was puffed from exertion. He said that he did not see how David could not breathe as no one was compressing his chest.[146]

Officer C was asked whether it appeared that David was trying to take deep breaths. He said that it sounded like deep puffs and that he did not consider that David was gasping. He agreed that if there were no physical exertion that would be gasping and compared it to a panic attack.[147] Officer C was asked about his understanding of the repeated statements made to David that if he could talk he could breathe. He said that he considered it to be a "*calming measure*", to remind a person that if they are speaking they are actually breathing.[148]

Officer C agreed that David was not struggling in the same way during the transfer but said this did not cause him to become concerned that David's complaints might be more than merely exertion. He was asked if it was fair to say that no consideration was given to David's breathing at this time. Officer C said that he was always conscious of David's breathing and that he heard he was breathing deeply and often.

(e) **Officer F** agreed that he possibly thought David saying he could not breathe was a tactic to get out from his restraint. He said that he did not take it seriously and did not think to call a doctor.[149] He agreed he heard David scream a number of times that he could not breathe and saw him collapse to his knees at one point. He said that despite officers being around David and David's head turned towards the wall he believed David was breathing because he could hear his breath and see the rise and fall of his chest, even though he was face down on his stomach with one officer's knee on his back.[150] It was suggested to Officer F that he could hear David gasping and that David was audibly having difficulty with his air intake. Officer F rejected this suggestion and said that he could only hear David taking "*deep breaths*".[151]

[142] 19/7/18 at T348.38.
[143] 19/7/18 at T353.19.
[144] 19/7/18 at T353.30.
[145] 19/7/18 at T354.8.
[146] 20/7/18 at T374.39.
[147] 20/7/18 at T388.40.
[148] 20/7/18 at T412.5.
[149] 17/7/18 at T136.20.
[150] 17/7/18 at T138.32.
[151] 17/7/18 at T139.18-22.

Officer F was asked whether he thought the laboured breathing meant that David could not get any air. He said that was possible but that it also might have meant that David was attempting to rest in order to fight again. He said that from hearing David say he couldn't breathe he thought that due to the number of people in the cell, and the increased temperature, David may have found it hard to get air.[152]

Officer F said that he thought David was faking difficulty breathing in cell 71, but not during the move, and initially said that in cell 77 he thought David was taking deep breaths but with no trouble breathing. Eventually he accepted that David was having trouble breathing when he was in cell 77.

Officer F said it didn't occur to him to call for medical help because he was waiting the nurse to return and he didn't feel any concern as David was lying on the bed with his arms out and breathing. It was indicated that the nurse was returning to give an injection not check David's breathing. He was asked whether he thought he should indicate that David's breathing should be checked and said no.

Officer F agreed that if he was not happy with the actions of the IAT that he had the authority, as the senior officer on scene, to order them to stop.[153] When asked what dangers there were to David as a result of the position he was in, he said that there was no danger and that whilst he had difficulty breathing, he was still breathing.[154] He said that the fact that David was face down and the length of time under restraint caused him no concern. He said that the further wait for a second injection to be given also caused him no concern.

16.8 **Conclusion:** It is evident that most of the IAT officers considered David's complaints of being unable to breathe as being disingenuous, and amounting to an attempt to avoid further restraint. However some officers, such as Officers B, C and F, indicated that their concerns about the genuineness of David's complaints lessened as David was escorted from cell 71 to cell 77 (during which time he collapsed to his knees), and once he had been placed on the bed in cell 77.

16.9 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.

[152] 17/7/18 at T145.5.
[153] 17/7/18 at T143.6.
[154] 17/7/18 at T143.23.

16.10 It is acknowledged that all but one of the IAT officers were, to a significant degree, constrained by the limitations of training which had not been provided to them prior to 29 December 2015. This issue will be considered in more detail below in the context of risk factors associated with positional asphyxia. However, even leaving aside any gap in training, David's persistent complaints of being unable to breathe, together with his audible gasping respirations should have prompted action in the form of a request for nursing or medical assessment. Instead, David's complaints were ignored and his gasping was incorrectly attributed to exertion.

Restraint on the floor

16.11 As noted above, David was moved from the bed to the floor of his cell and restrained for a period of almost 90 seconds. As this occurred he continued to complain of difficulty breathing. Several of the IAT officers provided explanations regarding the need to move David to the floor under continued restraint:

(a) Officer A said David was placed on the floor because it allowed for more room, compared to the awkward positioning on the bed. He agreed that David had been handcuffed on the bed but disagreed with the suggestion that David was under control. He said that he was more satisfied that David was under control when he was placed on the floor.

(b) In contrast, Officer B disagreed with the suggestion that it was possible David was taken to the floor in order to gain control.[155] He said that once David had been cuffed on the bed he was under control. Instead, Officer B said that David was placed on the ground because he was spitting.[156]

(c) Officer C said that he understood the need to move David to the floor was because the IAT needed to prepare him to get him to his feet to walk by himself to cell 77.[157]

16.12 **Conclusion:** The conflicting accounts given by the IAT officers regarding the need to move David to the floor suggest that there was confusion amongst the IAT as to whether the move, and David's continued restraint on the floor was warranted. It is accepted that there was a basis for the IAT to use continued mechanical restraints to restrain David until the cell transfer could be effected. However, the evidence of Officer B raises the possibility that, in accordance with the OPM, David had already been satisfactorily restrained on the bed prior to being moved to the floor. If this was the case then the application of additional force whilst David was on the floor would not have been warranted and David could have been walked to cell 77 at an earlier stage.

Escort from cell 71 to cell 77

16.13 During the escort from cell 71 to cell 77 the IAT officers maintained David in a hunched over and bent forward position. This was to prevent David from spitting blood which had occurred whilst in cell 71. Officer A was asked whether as at 29 December 2015 the IAT officers had available to them equipment to deal with an inmate spitting. He indicated that the officers had access to a riot helmet provided by CSNSW, and an elasticised spit mask which could be provided by Justice Health. Officer A said a spit hood was not available on hand but was available in the IAT office, although it was not taken to incidents to which the IAT were called as a matter of course. He

[155] 19/7/18 at T345.27.
[156] Exhibit 1, page 226.
[157] 20/7/18 at T404.2.

explained that it was his understanding that use of the spit hood needed to be approved by the Commissioner.[158]

16.14 Training provided to IAT officers established that they were to always wear riot helmets with visors when assigned to attend incidents.[159] However in practice this did not always occur. Officer C expressed certain difficulties associated with wearing a riot helmet. He described them as ill-fitting, uncomfortable and cumbersome.[160] He explained that because the helmets were designed to allow a gas mask to be worn underneath it, they sit further out rendering them ineffective.

16.15 **Conclusion:** The absence of an approved spit hood on 29 December 2015 and difficulties associated with the functionality of riot helmets which were available to the IAT meant that alternative measures had to be adopted during David's transfer between cells. This had the consequence of additional force being applied to maintain David in a bent forward position to reduce the possibility of spitting towards the IAT officers. Given David's continued complaints about difficulty with breathing during the transfer, and the fact that he collapsed to his knees during it, the maintenance of David in this position was undesirable.

Use of the knee ride in cell 77

16.16 Once David had been placed on the bed in cell 77, Officer C was asked whether it was possible to restrain David adequately just by Officer B maintaining control of David's arms and Officer O using a Figure 4 leglock to restrain David's legs. Officer C said that David still had the opportunity to roll his hips and make the Figure 4 leglock useless. Therefore, there was a need to use his shin to prevent rolling of David's torso.

16.17 Officer C agreed that he had applied what he described as "*very minute*" pressure to David's shoulder blades and legs. When the IAT footage was played to Officer C in evidence he agreed that his knee was in David's lower back and towards his upper back. He also agreed that David was adequately restrained by this point.[161] This continued in circumstances where David continued to complain of difficulty breathing.

16.18 **Conclusion:** By Officer C's own acknowledgment, David was adequately restrained on the bed in cell 77 when the knee ride continued to be applied. Consistent with the provisions of the OPM, the application of such additional force was not warranted in circumstances where satisfactory restraint had been achieved.

16.19 Overall, counsel for Officers A, B and C submitted that any criticism of the actions of these officers is not warranted on the basis that their actions were a reasonable response to David's actions and aggression. In support of this submission counsel referred to two authorities which refer to an objective test in determining the question of reasonableness. However the submission made by counsel for Officers A, B, and C incorrectly applies a subjective test.[162] On this basis alone, the submissions cannot be accepted although it is noted, for clarity, that objective consideration has been given to the conduct of all of the IAT and CSNSW officers.

[158] 19/7/18 at T330.37.
[159] 23/7/18 at T515.21.
[160] 20/7/18 at T401.29.
[161] 20/7/18 at T408.50.
[162] Submissions on behalf of Officer A, Officer B and Officer C.

Other considerations

16.20 The solicitor for the Dungay Family submitted that a referral ought to be made to the NSW Director of Public Prosecutions pursuant to section 78(4) of the Act with respect to the conduct of Officer A and Officer F. On this basis it was submitted that the evidence in the inquest enlivened section 78(1)(b) of the Act. That section does not provide the basis for a sufficiently interested party to make an application for a referral pursuant to 78(4) of the Act. Rather, section 78(1)(b) provides the basis for certain procedural steps to be taken in relation to the conduct of an inquest if a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with. Its purpose in doing so is to preserve the rights of any such person of interest and the integrity of any consequent criminal proceedings, and to separate the role and functions of the coronial and criminal jurisdictions.

16.21 If an issue had arisen during the course of the inquest as to the possible enlivenment of section 78(1)(b) then, as a matter of procedural fairness, the opportunity to make submissions regarding this issue would only have been extended to any interested party in potential jeopardy, and to Counsel Assisting. The opportunity would not have been extended for submissions to be made on behalf of the Dungay Family, or any other party with sufficient interest in the inquest but that was not in jeopardy. This is on the basis that any party's right to be afforded procedural fairness could in no way be effected by whether section 78(1)(b) was enlivened or not.

16.22 On this basis, upon receipt of the written submissions by the solicitor for the Dungay Family, the legal representatives for each of the interested parties were advised in writing of the above on 8 August 2019. The legal representatives were also advised that there was no requirement for any interested party, or for Counsel Assisting, to provide submissions on this issue. Accordingly, it is not proposed to give consideration to the submissions made by the solicitor for the Dungay Family.

16.23 However, for avoidance of doubt, it can be indicated that even if there was a proper basis to consider these submissions, they are constrained by the operation of section 61 of the Act. During the course of the inquest, counsel for Officers A and F raised an objection pursuant to section 61(1)(b) of the Act to those officers giving evidence. It was indicated on behalf of the officers that their evidence would be given willingly if they were issued with a certificate pursuant to section 61(5) preventing their evidence from being used against them (except in relation to criminal proceedings in relation to the falsity of their evidence). Certificates pursuant to section 61(5) were subsequently given to both officers.

16.24 Had Officers A and F (and other officers who were also given section 61(5) certificates) been placed on notice of a real possibility that section 78(1)(b) would be enlivened, then it is likely that that they would not have given their evidence willingly. This eventuality would have required consideration of section 61(4) of the Act. It would be procedurally unfair to now consider the submissions made by the solicitor for the Dungay Family regarding the potential operation of section 78(1)(b) having regard to the history which has just been outlined. Further, by virtue of the protection provided by the 61(5) certificates themselves, the evidence given by Officer A and Officer F raise clear admissibility issues in any prospective criminal proceedings and therefore cannot be taken into account when considering the matters set out in sections 78(1)(b)(i) and 78(1)(b)(ii). These same considerations also apply in relation to further

submissions made by the solicitor for the Dungay Family regarding potential work, health and safety prosecution. Having regard to each of these matters, the submissions cannot be accepted.

17. Issue 7: Whether the IAT members were appropriately trained in respect of the application of force/restraint of inmates, including any risk of positional asphyxia, prior to 29 December 2015

17.1 CSNSW officers are trained in the use of force as part of the Weapons and Officer Safety Training (**WOST**) component of their primary training. Additionally, officers are required to complete the Emergency Response Operators Course (**EROC**) to be eligible to perform IAT duties. The EROC replaced the former Security and Emergency Procedures Training Course (**SEPTC**) in around 2012 to 2013.

17.2 Instruction regarding positional asphyxia has been included in the WOST Participation Guide since at least January 2013. The January 2015 version of the WOST Participation Guide relevantly provided:

> "*Any, [sic] body position that interferes with a muscular or mechanical components of respiration, or that obstruct the airway, may result in positional asphyxia. There is an even greater risk where the person is unable to move in order to breath [sic]. This inability may be as a result of the effects of drugs or exhaustion or they may be restrained so they cannot move. Death can occur rapidly. Depending on the individual circumstances, death may occur unexpectedly and within a very short period of time*".[163]

17.3 The WOST Participation Guide identified obesity, psychosis, pre-existing physical conditions, respiratory multiple fatigue, multiple officers holding an inmate in the prone position, and chemical agents as all being risk factors for positional asphyxia death.[164] The WOST Participation Guide goes on to provide that "*operational recognition of risk factors is the first step in [positional asphyxia death] prevention… Close attention should be given when the correctional officers recognise the following signs or symptoms, taking immediate action to remedy the problem:*

- *Telling you that they cannot breath [sic]*
- *Gurgling gasping sounds*
- *Cyanosis (face is discoloured blue due to lack of oxygen)*
- *Panic, prolonged resistance*
- *Sudden tranquillity - an active offender suddenly becomes passive*."[165]

17.4 The EROC Manual[166] relevantly provides: "*<u>Positional Asphyxia</u> is most simply defined as when the position of the persons [sic] body interferes with respiration, resulting in death from asphyxia or suffocation [original emphasis]*".[167] It goes on to identify the same risk factors, and signs and symptoms, for positional asphyxia as contained in the WOST Participation Guide.

17.5 Training records of the six IAT officers revealed that officers A, B, C, M and N all completed their WOST and SEPTC training prior to September 2011. This meant that none of these five officers had, prior to 29 December 2015, received any training or instruction regarding the risk of positional asphyxia generally in relation to restraint, particular risk factors, or its signs and symptoms. Officer O completed his WOST training in March 2014 and his EROC training in July

[163] Exhibit 1, page 495.
[164] Exhibit 1, page 496-497.
[165] Exhibit 1, page 497.
[166] Version 1.2, 2013.
[167] Exhibit 1, page 501.

2015. This meant that he was the only officer in the IAT on 29 December 2015 that had received any training or instruction regarding the risks associated with positional asphyxia.

17.6 Even so, the Death in Custody Report prepared by Officer Bagley identified that insufficient emphasis was given to positional asphyxia risk in EROC training. Specifically it was identified that instructions regarding positional asphyxia risk in the EROC Manual was effectively an abridged version of the same information contained in the WOST Participation Guide; the risk of positional asphyxia was limited to classroom instruction without any inclusion of practical or scenario-based training, and the risk of positional asphyxia was not a distinct part of the situational assessment for planning of cell extractions.[168]

17.7 The Death in Custody Report (dated 21 September 2016) made a recommendation "*that CSNSW immediately advise all correctional officers of positional asphyxia risk, particularly the dangers of prone restraint, prolonged restraint, and placing of any pressure on a person's torso or neck while under restraint*".[169] The first response to this recommendation appears to have been a memorandum issued by the Security Operations Group - Training dated 3 July 2017 (**the July 2017 memorandum**). The July 2017 memorandum notes that "*there is a need to highlight the implications of positional asphyxia*".[170] It goes on to define positional asphyxia "*as when the position of a person's body interferes with their breathing, resulting in death from asphyxia or suffocation*".[171] It also advises that the EROC Manual and WOST Participation Guide have been updated to include information about what positional asphyxia is, its risk factors, and the signs and symptoms of positional asphyxia. It also requests recipients of the memorandum to ensure that staff read the relevant updated section of the EROC Manual, and includes an intranet link to the document.

17.8 The evidence established the specific understanding of the IAT and other CSNSW officers as at 29 December 2015 with respect to positional asphyxia, its risk factors, and signs and symptoms as follows:

(a) Officer A said that he did not learn about positional asphyxia in training and did not know what the term meant as at 29 December 2015.[172] He said that he had not received any refresher training between 2009 and 2015 in relation to the use of force. He said that he had received ongoing training more recently, but not up to 29 December 2015.[173] He said that the only refresher training he had received regarding use of force was in relation to the use of equipment such as batons and chemical munitions. He said that he had not been told of changes to the EROC prior to the July 2017 memorandum but said that it would have been useful if he had been told.[174]

Officer A was taken to the July 2017 memorandum in evidence and said that this was the first time he had received any information regarding positional asphyxia. He agreed that all the risk factors identified were present on 29 December 2015. He agreed that it was valuable to have this information on 29 December 2015 and accepted that without this information he was not in a proper position to minimise risk to the IAT members and inmates.[175] He also

[168] Exhibit 1, page 536.
[169] Exhibit 1, page 539.
[170] Exhibit 1, page 1248.176.
[171] Exhibit 1, page 1248.176.
[172] 19/7/18 at T283.46-50.
[173] 19/7/18 at T284.42.
[174] 19/7/18 at T339.27.
[175] 19/7/18 at T308.15.

accepted that if he had information regarding positional asphyxia it would have made a significant difference to his assessment of whether David genuinely could not breathe, and that it made it more likely for him to consider that the complaint was genuine.[176] Officer A was asked if the information regarding positional asphyxia had been provided to him whether it would have made it more likely that he would have treated it as a medical problem that needed medical attention. He said: "*Not so much medical attention the first instance, but it would have provided me the tools I needed to possibly change the position so that I could take the complaint as serious, and then if it further developed I could definitely seek medical attention immediately*".[177] He agreed that if confronted with the same situation now and it looked like the complaint was genuine he would take rapid action to seek medical assistance.

Officer A agreed that he had not been asked to repeat EROC training since 2015. When asked if he thought it was beneficial for the IAT to receive additional training about restraint and how to identify positional asphyxia he said that the information he had been given was a start but that training would be beneficial. He agreed that training should be face-to-face and involve roleplay and health professionals. He said that it would be beneficial for all CSNSW officers, not only IAT officers.[178]

(b) Officer B said that from the time of his primary training up to 29 December 2015 he had never received any training in positional asphyxia in relation to the use of force and restraint. He said: "*All training I received up until that time, zero reference*".[179] Officer B said that the July 2017 memorandum was handed to him by another IAT member. He said that since 29 December 2015 he had not received any refresher training in relation to restraint or positional asphyxia, and that it had all been literature-based. He agreed that face to face training would not only be beneficial to IAT members but all CSNSW officers, and agreed it would have been valuable to have known about in on 29 December 2015.

(c) Officer C said that he had not received any training in relation to positional asphyxia prior to 29 December 2015. He said that the only refresher training he had received since had been in relation to equipment use. He agreed that the last training he had received in relation to restraint was the SEPTC course in 2011. He said that it absolutely would have been valuable for him to have known information regarding signs and symptoms of positional asphyxia on 29 December 2015. He was asked whether he felt handicapped in carrying out his duties by not knowing this. He said that he would not use the term handicapped but said that he felt more equipped with the benefit of this knowledge.[180]

Officer C was asked if he thought whether the information should have been passed on by CSNSW if they had it in their possession. He said that was a question for the executive but said that he thought all information should be shared in order to meet the duty of care to inmates.[181] He said that if the organisation had information regarding risks it was important to pass that on so that he could carry out his job. He agreed that it would have been useful to know all the information about positional asphyxia, however he said that it would have made no difference to the restraint and cell extraction on 29 December 2015. He said that if

[176] 19/7/18 at T308.41.
[177] 19/7/18 at T308.50.
[178] 19/7/18 at T314.44.
[179] 19/7/18 at T352.8.
[180] 20/7/18 at T388.7-11.
[181] 20/7/18 at T389.20.

David needed to be moved and restrained for medication that the cell entry would remain the same but that the restraint would change. He said that a spit hood would be used so that David could walk upright. He also said that if they knew there would be a long period between the first and second injection that David would be placed in the recovery position, that he would be reassured, and that a nurse would possibly be requested to monitor his breathing.

(d) Officer F said at the time of restraint he had no idea that a warning sign of positional asphyxia was a person struggling to breathe and complaining of it. He said he assumed that by a person talking meant that they could breathe but agreed that this assumption could be challenged by medical evidence.[182] He said that he had no awareness of positional asphyxia until reading it in the COPP in 2018. He agreed that apart from the OPM, which governs the use of force, there was no other CSNSW policy applicable at the time which covered the restraint of patients in Long Bay Hospital. He agreed that the OPM contains nothing about the techniques for restraint or the dangers of prone restraint.

(e) Officer O described the risk of positional asphyxia when someone is placed in the prone position as being "*quite rare*".[183] He said that on 29 December 2015 the prospect that David might have been at the risk of positional asphyxia did not enter his thinking at all.[184] Officer O said that he thought the way that David was restrained best minimised the risk to David and to CSNSW staff. When asked if he thought there was increased risk with the weight of an officer on David's back he said that there was an officer continually checking his breathing so he was unconcerned. He was asked whether he gave thought to restraining David on his side. He said that it was standard practice for an inmate to be restrained in that way so that an injection could be given in the buttocks.[185] Officer O said that he was unaware why psychosis was a risk factor for positional asphyxia and said that he had received no training on this issue. He agreed that other than the July 2017 memorandum he had received no remedial training in relation to the IAT actions on 29 December 2015. He agreed that even though attempts had been made to check David's breathing the fact that David became unresponsive despite this suggested that something needed to be done earlier.

Officer O was asked what he would do differently now. He said that after an injection a patient would be rolled to their side whilst waiting for any subsequent injection. He said that this was based on his own experience of the events of 29 December 2015 rather than any training he had received.[186] When asked whether he would normally restrain a person in the prone or another position he said that it would depend on the job. He was asked whether he would do anything in relation to a patient with known risk factors in the prone position. He said that he would move the inmate to the side and continually check their airway. Officer O said that he would avoid having persons on the inmate's back and said he would call a doctor or nurse if the inmate was having trouble breathing. When asked what was needed to satisfy him that an inmate was having trouble breathing he said that he would need to hear choking or wheezing and see that the inmate's chest was not moving.

[182] 17/7/18 at T148.13.
[183] 18/7/18 at T234.9.
[184] 18/7/18 at T239.41.
[185] 18/7/18 at T240.10.
[186] 18/7/18 at T243.30.

CSNSW systems as at 29 December 2015

17.9 In evidence Officer Bagley made a number of concessions relevant to the lack of appropriate training provided to the IAT officers on 29 December 2015 including:

(a) It was fair to say that if the information contained in the WOST had been given to the IAT on 29 December 2015 they could have applied force in a different manner, and they should have done so.[187] If the IAT had knowledge of the signs and symptoms of positional asphyxia "*they would be far more alert to the situation*".[188]

(b) It was a significant failing if only the most junior members of an IAT had any training in relation to the risks of positional asphyxia[189], and that it was the IAT leader more than anyone who needed to be made aware of such risks. Officer Bagley said that he had no idea why the training for an IAT member via the EROC was less fulsome than the training provided by the WOST, but agreed that as a matter of logic the IAT should receive the more detailed training.[190]

(c) It would be helpful for the IAT to have a ready reckoner of information relevant to a patient[191] and said that it would be helpful for an Assistant Superintendent to provide a briefing about this.[192] Officer Bagley agreed that information contained in an inmate profile was very helpful as part of the situational awareness process. He also agreed that a reference to David being acutely psychotic was also useful for any situational assessment, and that it would be useful to have a proforma document to guide the IAT and help them go about their duties in a way which minimised risk to inmates and officers.

17.10 Steve Davis, the General Manager of the Security Operations Group (**SOG**), also made a number of similar concessions including:

(a) When the risks of positional asphyxia were introduced to WOST training in 2013 no advice was given to existing officers who had already undertaken the training.[193]

(b) Knowing not to use more force than necessary in accordance with the training provided to IAT and other CSNSW officers is different to knowing about positional asphyxia and its risk factors.[194]

(c) It was a significant failure in training that existing officers were left ignorant until 2017.[195]

(d) IAT officers need to be aware more than others of the dangers of restraint.[196]

(e) The same information as contained in the WOST should be in the EROC, or even further information contained in the EROC.

[187] 20/7/18 at T441.47-442.3.
[188] 20/7/18 at T442.8.
[189] 20/7/18 at T451.44.
[190] 20/7/18 at T452.49-453.3.
[191] Exhibit 1, page 538.
[192] 20/7/18 at T453.32.
[193] 23/7/18 at T499.12.
[194] 23/7/18 at T500.1.
[195] 23/7/18 at T500.12.
[196] 23/7/18 at T501.40.

(f) It was a significant failure in training for existing officers to not be told of the EROC changes.[197]

CSNSW systems after 29 December 2015

17.11 Officer Bagley was asked to assume that the July 2017 memorandum was the first response in relation to the Death in Custody recommendations from September 2016. He said that he did not regard this as a sufficiently urgent response and agreed that something should have been disseminated within weeks.[198] He expressed the view that it would also be preferable for a document-based response to also be coupled with face-to-face training, particularly for IAT members.

17.12 Officer Bagley said that he was not aware whether the IAT were advised about the updated EROC. He agreed that the July 2017 memorandum did not contain strong advice about the dangers of prone restraint relative to the contents of the Death in Custody report. Officer Bagley said that he was confident that the dangers identified in his report had been covered thoroughly in the COPP.[199] However, he agreed that the July 2017 memorandum did not warn against the use of prone restraint, and that just by reading the memorandum, and not accessing the COPP, a reader would not know about the dangers of prone restraint.[200]

17.13 Mr Davis said that he did not receive a copy of the recommendations arising from the Death in Custody report until February 2017. He was asked about any urgent advice that might have been provided by the SOG in response to the Report's recommendations relating to the risks of positional asphyxia. He indicated that an IAT conference was conducted on 8 March 2017 which brought together IAT officers and team leaders from across the state so that awareness could be raised regarding positional asphyxia and its risk factors. When it was suggested that the response should have occurred earlier Mr Davis referred to the fact that the Death in Custody Report recommendations were only received in February 2017. Mr Davis agreed that in order for him to do his job properly, the recommendations should have been received earlier.[201]

17.14 Mr Davis agreed that one of the outcomes of the 8 March 2017 conference was that it was still necessary to restrain people in the prone position. He agreed that this was in complete opposition to recommendations arising from the Death in Custody Report but said that consideration needed to be given to the fact that in most uses of force the person restrained will end up on the floor the majority of the time. He agreed that no decision was made by CSNSW as an organisation regarding any amendment to the WOST or EROC because the prone position was regarded as the most effective way to restrain a person for the safety of the inmate and staff.[202] He agreed that no expert medical advice was received at the conference. Mr Davis was asked whether his view (as at July 2018) was that prone restraint was a safe technique for CSNSW officers to undertake. He replied: "*Providing - absolutely in the circumstances and providing that the restraint is not held for any long periods of time. In some circumstances it is the safest of means and that's from all, in our specialised areas it would be their view*".[203]

[197] 23/7/18 at T502.39.
[198] 20/7/18 at T454.41-50.
[199] 23/7/18 at T488.17.
[200] 23/7/18 at T486.35, T487.17.
[201] 23/7/18 at T509.2.
[202] 23/7/18 at T522.42.
[203] 23/7/18 at T523.22.

17.15 Mr Davis disagreed with the suggestion that no IAT members had been retrained since receiving notification of the Death in Custody Report recommendations in February 2017. Instead, Mr Davis repeatedly referred to the fact that there was now an awareness of positional asphyxia and its signs and symptoms. He referred to the COPP and the fact that there had been follow-up with an online training module to reach officers in the most timely manner. Mr Davis sought to explain: "*All I can say is we have addressed the awareness of position asphyxia [sic] in relation to the conference, in relation to our memo with the information on position asphyxia [sic] and also in relation to the new custodial operations policies and procedures which clearly outlines the signs, the symptoms and what to do in relation should - should position asphyxia [sic] become an issue*".[204]

17.16 Later in evidence Mr Davis was asked whether he thought there was any benefit to having officers practically trained rather than having them read documentary updates. He replied, "*I think it's an awareness. I think the information needs to get out there as quickly as possible in relation to position asphyxia [sic] and I think the quickest way to do that is through the Learning Management System where all staff could have access to it, know the symptoms. Know the signs, know what they need to do and at the same time this can also be used as a management training so it can be done every two years as opposed to a face to face training which would be nothing more than a theory based session as well*".[205]

17.17 Mr Davis repeatedly stated this position even when it was pointed out to him that the IAT were paying close to David's breathing and he still collapsed. It was suggested that this highlighted the need for training. He said that instead there was a need to identify the symptoms and respond to the issue. It was suggested that it would be useful to use roleplay scenarios. However he referred to the Learning Management System and indicated that it was interactive and able to reach officers in the shortest time possible.

17.18 The matters raised with Officer T and Mr Davis were also raised with Assistant Commissioner Kevin Corcoran. He agreed that more urgent action could have been taken in relation to making officers aware of the dangers of positional asphyxia.[206] He also expressed concern that junior officers had this awareness but that senior officers did not.[207]

17.19 Assistant Commissioner Corcoran agreed that in hindsight it would have been a good thing for CSNSW as an organisation to have issued a memorandum around the time of David's death expressing the need for caution with prone restraint, and agreed that doing so would not have been an onerous task for CSNSW. He acknowledged that the first communication to the IAT being in the July 2017 memorandum was too slow of a response.[208]

17.20 Assistant Commissioner Corcoran was asked about his view of the use of prone restraint generally in correctional centres. He replied: "*Look the view I have I think is shared by other senior people in the agency is that we need to use that prone restraint for as short a time as possible to gain control of a situation and hopefully you wouldn't have to use that. But every situation is different and you know there is still a time that that may need to be used but for as short a period as possible*".[209]

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[204] 23/7/18 at T529.25.
[205] 23/7/18 at T535.27.
[206] 23/7/18 at T538.35.
[207] 23/7/18 at T539.8.
[208] 23/7/18 at T540.8.
[209] 23/7/18 at T540.36.

17.21 Assistant Commissioner Corcoran agreed that the possibility of death occurring suddenly from positional asphyxia highlighted the need to call for medical advice when a planned use of force was to occur. He agreed that G Ward was unique, as was Long Bay Hospital as a whole. He agreed that it would "*be a good thing*" to require a doctor or nurse to be present in the case of a planned use of force to assist in identifying risk factors and the possibility of positional asphyxia.[210] He agreed that CSNSW needed to look at G Ward closely and see what practices were occurring there in relation to enforced medication.

17.22 Assistant Commissioner Corcoran said that it would have been appropriate to retrain all officers who had received their WOST training prior to 2013.[211] To address this issue Assistant Commissioner Corcoran indicated that a training course would be rolled out to all correctional centres with an IAT and would involve theory, case studies and practical application. He said that field training officers would also take this training to other correctional centres without an IAT.

17.23 Assistant Commissioner Corcoran said that he was aware that Officer E expressed the view that he would still restrain an inmate in the same manner. On this basis Assistant Commissioner Corcoran said that there was a need to treat G Ward differently and referred to the intention by CSNSW to form a Working Group with Justice Health to consider such issues.[212]

17.24 **Conclusions:** The evidence given by the various IAT officers, and the appropriate concessions made by Assistant Commissioner Corcoran, Officer Bagley and Mr Davis clearly establishes that there was a significant insufficiency in the training provided to IAT officers as at 29 December 2015. In circumstances where IAT officers are more likely to be involved in the use of force than other CSNSW officers, it was incumbent to provide them with sufficient training regarding positional asphyxia, its risk factors, and its signs and symptoms. This plainly did not occur, leading to a situation on 29 December 2015 where David's individual risk factors were unknown to the IAT officers, and his symptoms either inappropriately minimised or ignored entirely.

17.25 It was also appropriately conceded by Assistant Commissioner Corcoran that the organisational response by CSNSW following David's death, and in particular following the Death in Custody Report recommendations relating to positional asphyxia, was not timely. It was readily acknowledged that dissemination of information to CSNSW officers regarding the risk of positional asphyxia could have occurred in the immediate period following David's death. Instead, a period of 18 months elapsed before the issuing of a memorandum which itself was not entirely sufficient in the sense that, read on its own, it provided no explicit warning regarding the dangers of positional asphyxia.

[210] 23/7/18 at T541.40.
[211] 24/7/18 at T2.30.
[212] 24/7/18 at T4.12.

17.26 Further, the July 2017 memorandum was not accompanied by any practical retraining for CSNSW Officers in relation to positional asphyxia and its warning signs. Nor was any re-training provided to CSNSW officers who had completed their WOST Participation Guide prior to 2013. The absence of such training is reflected in the intransigent nature of Mr Davis's evidence. He repeatedly, and inappropriately, maintained that the documentary-based awareness of positional asphyxia provided to CSNSW officers was sufficient, and that scenario-based practical training was seemingly, and incorrectly, without merit.

Remedial action taken since 29 December 2015

17.27 In July 2018 CSNSW introduced an online training package titled *Positional Asphyxia Awareness*, which had been developed by the SOG (and an external organisation), that could be accessed via the CSNSW Learning Management System. The training was mandated for all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent and was to be completed by 1 October 2018. Further, the training was required to be undertaken every two years. In evidence Officer U (the Acting General Manager of the Special Operations Group between December 2018 and February 2019) indicated that as at 22 January 2019 approximately 10 percent (or approximately 500 officers) of applicable CSNSW officers were yet to complete the *Positional Asphyxia Awareness* online training.[213] Officer U indicated that there is a means by which completion of training by all applicable offices can be verified.

17.28 **Recommendation:** I recommend that Corrective Services New South Wales continue to provide *Positional Asphyxia Awareness* online training to all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent, and audit completion rates annually to identify correctional staff who have not yet completed such training.

17.29 In August 2018 CSNSW also introduced a four hour training module on positional asphyxia available to SOG officers who have undertaken Learning Management System training and are qualified, and regularly rostered, to perform IAT duties. The training module includes a theory revision component, a practical teaching component, and two assessment-based practical scenarios. Between 24 August 2018 and 23 October 2018 327 IAT and SOG officers completed the training module at 18 correctional centres across New South Wales. However not all officers qualified to undertake IAT duties completed the training module due to roster and leave constraints.[214] As at 8 March 2019 Officer U was unable to provide a more up-to-date and precise indication as to how many IAT and SOG officers had completed the training module, but agreed that it was important to have as many applicable offices complete the training as possible.[215]

17.30 Further, the training module only targets CSNSW officers regularly rostered to perform IAT duties. It is evident that there are other officers working in the Mental Health Unit, not performing IAT duties, who have not received the benefit of such specialist training.[216]

[213] 8/3/19 at T5.28.
[214] Exhibit 1, Tab 77 at [11].
[215] 8/3/19 at T14.41.
[216] 8/3/19 at T10.16.

17.31 **Recommendation:** I recommend that Corrective Services New South Wales continue to provide specialist practical training on positional asphyxia to Immediate Action Team and Special Operations Group officers, and audit completion rates annually to identify officers who have not yet completed such training.

17.32 **Recommendation:** I recommend that Corrective Services New South Wales provide training to all Corrective Services Officers working in the Mental Health Unit in restraint techniques, positional asphyxia and the risks of sudden death from restraint.

17.33 Section 13.7.8 of the COPP provides for restraint for medical treatment and Section 13.7.9 provides for medical considerations in the context of force. Relevantly (as noted above), section 13.7.8.3 provides that correctional officers should follow directions from Justice Health medical personnel regarding the positioning of a patient during enforced medication procedures. Equally relevantly, section 13.7.9.2 sets out a list of warning signs of positional asphyxia and notes the following: "*attention must be given to a person's claims that they cannot breathe. All reasonable efforts must be made to ensure the person has unrestricted breathing. It is a common misunderstanding that a person who can talk must be able to breathe… A person under restraint who is asphyxiating may resist restraint in an attempt to breathe which can be easily mistaken as non-compliance or violence towards officers it can be hard for correctional officers to distinguish between violent resistance and a struggle to breathe. Therefore ensuring unrestricted breathing and close monitoring for warning signs is extremely important*".[217]

17.34 In evidence Officer U indicated that it would be possible to review the video footage commonly recorded by IAT teams in the use of force to identify whether the training provided by CSNSW regarding positional asphyxia and prone restraint was being put into practice.[218] However, Officer U indicated that such a review process had not been discussed or considered because every use of force in a correctional centre is already reviewed by the manager of security or functional manager at a centre, as well as the general manager of the centre.[219]

17.35 **Recommendation:** I recommend that Corrective Services New South Wales audit at least one-third of all video recordings, as a representative sample, of uses of force by Immediate Action Teams in order to verify that sections 13.7.8 and 13.7.9 of the Custodial Operations Policy and Procedures have been complied with, with consideration to be given to additional auditing if the nominated representative sample does not allow for such verification.

17.36 As part of the Working Group meeting that took place on 29 December 2018 a number of recommendations arose.[220] The first recommendation was for CSNSW to source a suitable soft-restraint system for the mental health unit as an alternative to the use of metal handcuffs where appropriate. It was noted that such a system should be designed in a way that permits reasonable freedom of movement patients while protecting persons from harm. The second recommendation was for the SOG to adopt a revised use of force training package for mental health unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

[217] Exhibit 1, pages 1248-35 to 1248.36.
[218] 8/3/19 at T16.44.
[219] 8/3/19 at T16.47.
[220] Exhibit 1, Tab 75 at [11].

17.37 In December 2018 a number of different soft restraints, including the ones used at the Forensic Hospital, were reviewed to identify a suitable soft restraint to conduct a trial. In evidence Officer U indicated that a decision had been made to trial the soft restraint used at the Forensic Hospital, with plans to provide relevant training to staff from the court escort and the SOG, with a view to extending back training to correctional staff in G Ward.[221]

17.38 In relation to the second recommendation Officer U indicated that as at 8 March 2019 a working group within the training arm of the SOG have been tasked with the creation of such a training package.[222]

17.39 **Recommendation:** I recommend that Corrective Services New South Wales complete the trial of a suitable soft restraint system for use in the Mental Health Unit as an alternative to the use of handcuffs, with the relevant training to be provided to applicable staff including staff in G Ward.

17.40 **Recommendation:** I recommend that Corrective Services New South Wales, through the Special Operations Group, create and implement a revised use of force training package for Mental Health Unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

[221] 8/3/19 at T18.28-19.10.
[222] 8/3/19 at T18.36.

18. Issue 8: Whether appropriate and timely steps were taken to establish cells 71 and 77 as a crime scene after David was moved between cells on 29 December 2015

18.1 The evidence establishes that following David's transfer from cell 71 Officer E instructed RN Amanda Jay to clean cell 71. The motivation in doing so was because bodily fluids, including blood, had been identified within cell 71.

18.2 This cleaning was done so that another inmate, who had been housed in cell 77 prior to David's transfer, could be moved into cell 71. When asked whether he thought it was appropriate to order the cell to be cleaned whilst an IAT operation was underway Officer E sought to explain that he was unable to house an inmate in a cell with bodily fluids in it, and that there was no other housing option for the inmate.[223] He agreed that if the order was made after learning of David's collapse it would be inconsistent with the OPM requirements for crime scene management.

18.3 Officer E also agreed that it was important to preserve cell 71 after learning of David's collapse and agreed that cleaning the cell would affect the integrity of the scene. On this basis he was asked whether he directed that the cleaning be stopped when he learned of David's collapse. He agreed though that he was aware that force had been applied in the cell move. However, Officer E said that the cleaning had already been completed, and the inmate who had previously been housed in cell 77 had been locked in cell 71 by the time he learnt of David's collapse.[224] Officer E said that he was positive that the order to clean cell 71 was not made after David's collapse.

18.4 Notwithstanding, Officer E agreed that it was possible to keep the inmate from cell 77 in one of the two yards in G Ward, in circumstances where all the cells were full that day.[225] At the same time he acknowledged that force had been used at the scene and that mandatory reporting was required afterwards. When asked why the inmate from cell 77 was not placed in the yard when it was apparent that there was blood within cell 71 Officer E said that he did not know the cell had blood until the transferred inmate picked up a biscuit with blood on it in cell 71.

18.5 Officer F said he saw David bleeding in cell 71 and saw blood in the cell. He said he did not see blood coming from David during the transfer or in cell 77. He said he did not hear Officer E order an inmate to be put in cell 71, or order that the cell be cleaned. He said that although he was aware that force had been applied and David had become unconscious he did not think that there might be a subsequent police investigation. He said that in such a case there would be an obligation to preserve the scene but did not think there was a need in this particular case. If there was, he said the obligation rested with Officer A, the head of the IAT, to preserve the scene.[226] He said that it did not occur to him that there was a need to preserve it (despite force having been used and David had become unconscious) because he said he did not know the outcome of subsequent events.

18.6 The CCTV and IAT footage indicates that David became unresponsive shortly before 2:50pm. In her clinical note entry, RN Jay indicated that she arrived in G Ward at approximately 2:50pm.[227] However, in her statement, RN Jay placed her arrival in G Ward at about 2:53pm.[228]

[223] 17/7/18 at T81.42-45.
[224] 17/7/18 at T80.30.
[225] Exhibit 1, page 366.
[226] 17/7/18 at T142.17.
[227] Exhibit 1, page 1311.
[228] Exhibit 1, page 1260.

18.7 **Conclusion:** Examination of the CCTV and IAT footage as to the timing of when David became unresponsive and RN Jay's arrival in G Ward is not inconsistent with Officer E's assertion that he only ordered that cell 71 be cleaned *before* he became aware of David's collapse.

18.8 However, even accepting Officer E's version as to the timing of events, it would have been prudent for any further cleaning to have stopped once it was identified that there was blood in cell 71. This is because of Officer E's acknowledged awareness that force had been used. It would therefore have been logical to assume that the blood found in cell 71 might be attributable to the use of force. Further, being aware that force had been used meant that a mandatory report was required. Even though all the cells in G Ward were full, it would have been possible to place the inmate from cell 77 in the yard until enquiries could be made regarding the origin of the blood and the circumstances in which it came to be deposited within cell 71.

18.9 The solicitor for the Dungay Family submitted that consideration should be given to the referral of Officers A, C, E and F for disciplinary proceedings. On this issue it should be noted that counsel for Officer A and Officer C submitted (not in response to the submissions made by the solicitor for the Dungay Family, but instead to Counsel Assisting's submissions) that the Act contains no provision which allows for the referral of information to a disciplinary body, and that the referral of an individual for disciplinary action would be ultra vires.[229] This submission is rejected. It ignores section 3(e) of the Act which provides that one of the objects of the Act is "*to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies*)".

18.10 Further, it is noted that section 151A of the *Health Practitioner Regulation National Law (NSW) No 86a* provides: "*If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession*". Whilst section 151A obviously has no application in relation to any CSNSW officer, it demonstrates that, even in the absence of section 3(e) of the Act, a referral of an individual for disciplinary proceedings is not precluded.

18.11 Returning to the submissions made on behalf of the Dungay Family, it is submitted that Officer A failed to cease restraint and address David's complaints of difficulty breathing, that Officer C used excessive force in maintaining restraint, that Officer E failed to preserve evidence in cell 71, and that Officer F acted beyond power in deciding to move David from cell 71 to cell 77.

18.12 It has already been noted above that the conduct of the IAT officers was limited by systemic deficiencies in training which had been provided to them. It has also been noted that the available evidence does not rise so high as to suggest that the actions of the CSNSW officers in moving David between cells, and in cleaning cell 71, were motivated by malicious intent, but rather a product of their misunderstanding of information that was conveyed at the time. On this basis, the submission is not accepted.

[229] Submissions of behalf of Officer A, Officer B and Officer C at [55].

19. Issue 9: Whether video evidence was appropriately collected and retained after Mr Dungay was moved between cells on 29 December 2015

19.1 Detective Sergeant Damien Babb, the police officer in charge of the coronial investigation, and Inspector Garry James arrived at Long Bay Hospital at 4:47pm on 29 December 2015. Detective Sergeant Babb attended the office of the manager of security and watched some of the IAT footage at about 5:30pm. Detective Sergeant Babb requested the footage from the IAT handheld camera as well as footage from the cameras within Long Bay Hospital "*relating to the incident*", meaning the incident leading to David's death.[230] In response to his request Detective Sergeant Babb said that he was told that the footage would be obtained. He understood that this process would be facilitated by an external service provider which managed the relevant footage.[231]

19.2 Detective Sergeant Babb explained that after the initial period of investigation (and the subsequent Christmas holiday period), he next returned to his office on 4 January 2016. By that stage he had been sent a copy of some CCTV footage. Upon viewing it Detective Sergeant Babb discovered that it only captured events from which David was being escorted between cell 71 and cell 77. Detective Sergeant Babb said that he wanted more footage specifically from 2:30pm onwards on 29 December 2015 including when David retrieved the crackers from his buy up. Detective Sergeant Babb explained: "*…I would have just wanted footage for the whole day, of [David's] movements for the whole day, everywhere he went during the day*".[232] Detective Sergeant Babb said that he contacted the CSNSW officer responsible for all correctional centre footage state-wide and was informed, sometime around mid-January 2016 that the footage had already been written over.

19.3 Officer Bagley agreed that it would have been appropriate for all CCTV footage from 29 December 2015 to have been collected. He agreed, for example, that there was no footage showing the attempts at negotiation before the arrival of the IAT.[233] He indicated that there was no written protocol at the time regarding how to carry out an internal investigation.[234] He agreed that as much footage as possible needed to be provided, that it would be of crucial importance in relation to a death in custody matter, and that it would have been beneficial to have all of the CCTV footage from cameras within G Ward for the entirety of 29 December 2015.[235]

19.4 **Conclusion:** The subsequent coronial investigation following David's death was deprived of relevant footage showing key events in the timeline of events, namely David's retrieval of biscuits from his buy up and attempts to negotiate with David to return the crackers prior to the arrival of the IAT officers in G Ward.

[230] 16/7/18 at T24.1-5.
[231] 16/7/18 at T23.47.
[232] 16/7/18 at T25.1
[233] 23/7/18 at T472.48.
[234] 23/7/18 at T471.45.
[235] 23/7/18 at T472.20-40.

19.5 Given that by the time of Detective Sergeant Babb's attendance at Long Bay Hospital it was apparent that force had been used in the context of a death in custody, and that this fact alone made it mandatory for an inquest to be eventually held, there was clearly a missed opportunity to retain all footage from 29 December 2015 so that it could have been made available to police investigators. It is clear that the unavailability of the footage has had profound and distressing consequences for David's family. It has only added to their sense of uncertainty about aspects of David's death in circumstances where objective footage might have possibly allayed some of their concerns. Whilst it is not possible to understand precisely why the entirety of the relevant footage was not retained it is evident that there is scope for improvements in processes.

19.6 **Recommendation:** I recommend that Corrective Services New South Wales review the current version of the Custodial Operations Policy and Procedure to ensure that clear instructions are provided requiring the retention of all potentially relevant video footage, including CCTV footage, in the event of a death in custody.

20. Issue 10: Whether Justice Health staff acted appropriately and in compliance with Justice Health policies and procedures in administering a sedative (Midazolam) to David on 29 December 2015

20.1 As at 29 December 2015 the *Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit (Policy Number 1.180)* (**the Enforced Medication Policy**) governed the responsibilities and obligations of clinical staff relating to the administration of rapid tranquilisation and enforced medication to involuntary patients. Section 5.3 of the Enforced Medication Policy provided for the following in relation to administering rapid tranquilisation:

(a) An emergency assessment of the patient's airway breathing and circulation must take place concurrently with the restraint and tranquilisation process;

(b) Observation and monitoring of vital functions and supplementary observations must be commenced as soon as it is safe to do so;

(c) Emergency resuscitation equipment, benztropine and flumazenil injection must be immediately available before proceeding to administer rapid tranquilisation.[236]

20.2 Section 5.2 of the Enforced Medication Policy also provided that:

(a) The patient must be given every opportunity to accept prescribed treatment voluntarily;

(b) A nurse must consult a nurse unit manager, nurse in charge, a consultant psychiatrist or psychiatry registrar before medication is administered without a patient's consent;

(c) The patient must be given information about any medication prescribed to them, including the reasons for the prescription, the effects of the medication, the side effects and risks of the medication, and the likely effects on the patient's health in not taking the medication.[237]

Assessment of airway, breathing, circulation

20.3 RN Xu said that he was unaware of the Enforced Medication Policy as at 29 December 2015, and that it was never brought to his attention during induction, and that he was never told anything about it.[238] He agreed that if he had known the requirements contained in the Enforced Medication Policy he should have observed David's vital signs concurrently with the injection procedure.[239]

20.4 In contrast, RN Michelle Neumann said that she had seen the Enforced Medication Policy prior to 29 December 2015 (having been first made aware of it sometime in 2012). When asked how she had become aware of it, RN Neumann explained, "*Because being a Justice - being employed by Justice Health, it is my responsibility to be aware of the policies and procedures and the guidelines that I work under*".[240]

[236] Exhibit 1, page 1287-126.
[237] Exhibit 1, page 1287-126.
[238] 26/7/18 at T36.46-50.
[239] 26/7/18 at T38.37.
[240] 27/7/18 at T18.25.

20.5 RN Xu said that during induction training run by both Justice Health and CSNSW he received advice that all restraint was the responsibility of CSNSW officers, as was the responsibility for checking airway and monitoring a patient after an injection. He said he was told: "*I was aware the first time I was told, 'Okay, it's a, this is gaol, not hospital. You guys, nursing staff, are not allowed to touch the patient in the restraint. We do the job'. We monitor his airway for which we received mandatory training for which we were accredited*".[241]

20.6 RN Xu referred to an induction conducted sometime in 2014 by three IAT officers and said that he was surprised by this and raised it with the CSNSW staff member conducting the training and was told that if he was needed he would be called and that he was otherwise to stay away. He explained: "*So I was told, 'Look', we were specifically training first aiders and we, we were, it's our role to observe the patient's airway during the, during the restraint of the enforced medication. 'If we need you we call you otherwise keep away.' That's so clear it was given*".[242] He was asked whether he sought clarification from any Justice Health staff member and said: "*I did not clarify that question with anybody else because I, at the time I did not have a reason to, to have it out in that because I thought, "That's just a unique environment of the gaol*".[243] He said that in seven months he had worked within Long Bay Hospital not once did he observe a nurse monitor a patient's airway.[244] He said that he never saw a nurse stay in a cell before or after a sedation.

20.7 In this regard section 5.2 of the Enforced Medication Policy provided: "*Justice Health staff should maintain their presence during the administration of enforced treatment process but remove themselves from the immediate vicinity of the restraint. [Justice Health] staff must follow reasonable security direction from CSNSW*".[245]

20.8 RN Xu said that his previous experience, whilst working at POWH, was for a person to be restrained in the prone positon with their head over the end of the bed, but for a nurse to position the patient's head on their chest with hands on their chin and forehead. He was asked whether, because his prior experience had been so different, whether he sought to clarify this with anyone in the Justice Health hierarchy. He said that he did during induction and thought it was clarified by CSNSW staff.

20.9 It was suggested to RN Xu that, even if he was not aware of the Enforced Medication Policy, at the time he was administering the injection and he heard David screaming that he could not breathe, there was a powerful clinical basis to make proper observations of David's breathing and airway. RN Xu replied: "*If under normal circumstance, yes, but as I said there was a terrifying moment that was - my role was so clear - to inject him, to retreat. That would - never crossed my mind. That would be my focus and that would be against my behavioural pattern through the eight-year period so it never crossed my mind I would be doing that. That would be also against the DCS direction. From my understanding I believe I was given that direction*".[246]

20.10 RN Xu agreed that he still had an obligation to his patient but said that he knew that midazolam took about 15 minutes to take effect. He said that he became concerned when he heard David say that he could not breathe but did not believe that he was in any immediate danger. He

[241] 26/7/18 at T25.10.
[242] 26/7/18 at T27.11.
[243] 26/7/18 at T27.29.
[244] 26/7/18 at T28.22.
[245] Exhibit 1, page 1287-126.
[246] 26/7/18 at T39.17.

indicated that it was his experience that half of the patients in POWH made a similar statement and that there clear indication in all such cases it related to pressure and exertion.[247]

20.11 RN Xu said that he was aware of the risks of prone restraint, and that he was concerned that David was restrained in the position whilst being given an injection and screaming that he could not breathe. RN Xu said that his first thought was that best practice would have been to release the restraint and retreat immediately. However he did not do so because: "*Again, that's, that was not my jurisdiction of how to restrain a patient. I did not suggest because in my mind any - that's like to order the officer to, "Leave him. Leave him alone," and that was unthinkable to me at the time*".[248] RN Xu was asked whether he kept the thought to himself that David needed to be released immediately. He said he went to the cell with the expectation that the officers would release David immediately after the injection and then retreat. He explained that his had been his experience in previous enforced medications.

20.12 RN Neumann said that if a restraint was occurring and she noticed that someone was experiencing a problem that she would speak up and advise the CSNSW officers of any concerns in relation to the patient's breathing or airway. She said that she had not received any training from Justice Health in relation to the dangers of restraint because they were not involved in it.[249] She was asked whether she felt the same as RN Xu in relation to having no jurisdiction over such an issue. She replied by saying that she had a duty of care to a patient and if she felt that a patient was at risk she would definitely speak up on that patient's behalf.[250] She said that she was unaware of any policy that allowed a nurse to direct a CSNSW officer to stop doing something however she said that she took it on herself to communicate with officers if she felt the need to do so. She said that she did not believe that the current policy allowed a nurse to direct a CSNSW officer to stop restraining a patient if there was a medical issue; rather, she believed it allowed a nurse to request a CSNSW officer to hold so that an assessment could be performed.[251]

20.13 In contrast to RN Xu's evidence, RN Neumann agreed that section 5.3 of the Enforced Medication Policy was the practice she had adopted. She said that she was never told that it was the responsibility of CSNSW officers to check a patient's airway.[252] She said that it was general practice for two nurses to be present when conducting a tranquilisation, with the non-injecting nurse to assist with the sharps bin and observe the patient during restraint. She said that was a seldom occurrence for only one nurse to perform the enforced medication injection of a patient themselves.

[247] 26/7/18 at T39.40.
[248] 26/7/18 at T40.40.
[249] 27/7/18 at T60.11.
[250] 27/7/18 at T60.26.
[251] 27/7/18 at T62.20.
[252] 27/7/18 at T17.50.

20.14 **Conclusion:** RN Xu's asserted that he was told during an induction process that responsibility for assessing patient's breathing and circulation during a tranquilisation process that involved restraint rested with a non-medically trained CSNSW officer, rather than a health care professional. RN Xu also asserted that he had never previously seen a nurse within Long Bay Hospital monitor a patient's airway in such circumstances. These assertions simply defy logic and common sense, are inconsistent with the evidence of RN Neumann, and are not accepted. Even if it were accepted that RN Xu was never made aware of the Enforced Medication Policy and, in particular, the application of Section 5.3, it remained incumbent on him to make himself aware of the Justice Health policies that applied to his functions.

20.15 Notwithstanding RN Xu's assertions, the evidence establishes that he clearly recognised that there was a clinical basis to make an appropriate assessment of David's breathing and circulation when he heard David complaining of difficulty breathing. Consistent with the practice described by RN Neumann, RN Xu ought to have brought the issue to the attention of the CSNSW officers, including the IAT, in cell 77 so that a proper assessment of David could be conducted.

Observations

20.16 RN Xu said that he was instructed to enter the cell to administer the midazolam injection. He saw that David was "*struggling pretty hard*".[253] He administered the injection and then one of the IAT officers immediately directed, possibly with a gesture, for him to leave the cell.

20.17 The IAT footage was played to RN Xu and he was asked whether he heard David screaming that he could not breathe, both before he entered the cell and whilst he was in the cell. As to the former, RN Xu said: "*I did not recall any of that. I - the moment I stepped in the cell I was like, basically just committed to that, you know, five seconds. Physically step in, we step out. That usually takes me five seconds, less than ten seconds*".[254] As to the latter, RN Xu said: "*It sounds to me as that was once I could hear clearly he said that from the footage. It appears to me when the second time he yelled out he can't breathe the injection was already, yeah. But at the time I was, I was quite frightened and I was - just tried to be collected to complete the injection and my focus for that couple of seconds was 100% on the injection alone, that job. I could not recall I hear anything at that moment when, when a needle was still inside the body just there is no way - sorry, I just, I, I was very sure I did not hear him making that, you know, complaint*".[255]

20.18 RN Xu said that he did not agree that David was screaming that he couldn't breathe before the injection was given, only during when it was given, and after. On playback of the footage he expressed the view that by the time of David's second scream the injection had already been given. He said that he did not notice David's breathing but on playback of the video agreed that it was loud and laboured.

20.19 Following playback of the video RN Xu maintained that he was directed to leave the cell at the time the needle was removed. He said that the word "*go*" might have been said, accompanied by a gesture from one of the officers. He said that he was positive he was given a direction.[256] The video appears to show a CSNSW officer tapping him on his left shoulder following the injection.

[253] 26/7/18 at T19.4.
[254] 26/7/18 at T21.4.
[255] 26/7/18 at T20.42.
[256] 26/7/18 at T23.42.

20.20 RN Neumann said it was part of training she was given, and also routinely voiced by officers, to enter a cell, sedate a patient and then leave ASAP.[257] She said that informal observations would only be performed if a patient was cooperative. She said if there were no concerns then the nurses would return to the cell as soon as possible and offer a debrief. However if the patient was not agreeable or uncooperative then no observations would be performed following an injection.[258] If a patient was agitated she said she would dispose of any sharps, document the medication given, then return to the cell within five minutes and make observations through the cell door and ask if they had any injuries, attempt to engage them and offer a debrief.

20.21 RN Neumann said that she understood the requirement under section 5.3 in practice to mean that there was a requirement to vacate a cell as soon as the injection was given but to return as soon as possible so that observations could be performed.[259]

20.22 **Conclusions:** It can be accepted that RN Xu found the situation within cell 77 to be a confronting one, and that he felt obliged to leave cell 77 at the implicit direction of one of the CSNSW officers. However, RN Xu allowed the clinical need to perform proper observations of David to be inappropriately overborne by these considerations. As already noted above RN Xu ought to have familiarised himself with the terms of the Enforced Medication Policy. In doing so he would have recognised that Section 5.2 did not prevent compliance with Section 5.3. Even absent any awareness of the Enforced Medication Policy, on the basis that RN Xu heard David scream at least once that he could not breathe and that he saw David struggling to resist the restraint, there was a clinical basis for RN Xu to return to the cell as soon possible to perform appropriate observations.

20.23 Counsel Assisting submitted that, on this basis, the conduct of RN Xu in failing to make any relevant observations of David warranted referral for review of his professional conduct. Senior counsel for Justice Health and the solicitor for RN Xu resisted the submission effectively on the basis that RN Xu was confronted with a difficult and complex situation in cell 77, that he has since undertaken further appropriate training, and that, on this basis, there is no possibility that RN Xu remains a danger to the public.

20.24 It does not appear to the case that the only determinant as to whether the professional conduct of an individual should be the subject of formal review is to be determined by whether or not sufficient remedial action has been taken. Such factors may be more relevant to the issue of mitigation of any ultimate outcome. Rather, it is objective examination of the conduct itself which grounds consideration of whether review is warranted. In the present case, the evidence establishes that RN Xu recognised that there was clinical need in general, and having particular regard to David's repeated complaints of being unable to breathe, to assess David's breathing and perform observations. Notwithstanding the complexity of the situation which RN Xu was in, which has already been acknowledged, it remains the case that the review of RN Xu's professional conduct at the time that midazolam was administered to David is warranted for the reasons set above.

[257] 27/7/18 at T14.21.
[258] 27/7/18 at T16.45.
[259] 27/7/18 at T21.14.

20.25 **Recommendation:** I recommend that, pursuant to section 151A of the *Health Practitioner Regulation National Law (NSW) No 86a*, the transcript of the evidence of Registered Nurse Charles Xu be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Registered Nurse Xu on 29 December 2015 should be the subject of review.

Resuscitation equipment

20.26 Section 5.3 of the Enforced Medication policy required that emergency resuscitation equipment, and benztropine and flumazenil injections to be available before rapid tranquilisation was administered.

20.27 RN Xu said that he was unaware of this requirement, having not seen the Enforced Medication policy as at 29 December 2015. In evidence it was suggested to RN Xu that, notwithstanding his assertion, he should have known that there was a need to take emergency resuscitation with him in circumstances where he knew that an intramuscular injection was about to be given. RN Xu disagreed and claimed that it was never the practice to do so.[260] RN Xu was asked whether he considered it good nursing practice to do so. RN Xu agreed that it was but referred to the policy directive requiring that the equipment be kept close by. In this context, RN Xu pointed to the fact that the equipment was never brought in a trolley to a cell but kept some 15 or 20 metres away (at the nurses' station).[261] He said that it was never his experience that the equipment was taken to the site (either at Long Bay Hospital or at POWH) where the injection was to be given.[262]

20.28 RN Xu said that he had never heard of flumazenil and that "*it was a non-existence [sic] in either Prince of Wales or Long Bay*"[263], although he agreed that benztropine was available at Long Bay Hospital.[264] This was supported by RN Neumann who also indicated that flumazenil was not available. She explained: *"…flumazenil is not a medication that we use in - on the mental health unit…It's an IV medication and we do not do intravenous medications in the mental health unit*".[265] However, RN Neumann said that she believed that other medication to reverse the effects of sedatives was contained in the emergency resuscitation bag. RN Neumann agreed with RN Xu that benztropine (known as Cogentin) was kept in the emergency resuscitation bag. However, she explained that the bag itself was kept in the treatment room and the practice was not to take it the cell. RN Neumann explained that usual practice was to take only the injection itself and a sharps disposal unit.[266]

20.29 Dr Ma said that he was also aware that flumazenil was not available. However, he said that he understood that this was because it could induce cardiac arrhythmias and seizures, and so the benefit of using it was outweighed by the risk.[267]

[260] 26/7/18 at T46.31.
[261] 26/7/18 at T47.16.
[262] 26/7/18 at T47.24.
[263] 26/7/18 at T47.31.
[264] 26/7/18 at T74.32.
[265] 27/718 at T21.19.
[266] 27/7/18 at T22.36-41.
[267] 4/3/19 at T70.8.

20.30 **Conclusions:** Whilst flumanzil was not available within G Ward as at 29 December 2015, other medication capable of reversing the effects of sedatives was contained within the emergency resuscitation equipment. Section 5.3 required this and other emergency resuscitation equipment to be available in proximity to where the enforced medication was administered. Given that, by its very name, the use of emergency resuscitation equipment is often time-critical, it cannot be accepted that the location of the emergency resuscitation equipment within the nurses' station was clinically appropriate.

20.31 Further, even although RN Xu was unaware of the provisions of Section 5.3 of the Enforced Medication Policy, his understanding of good nursing practice alone suggested that the emergency resuscitation equipment ought to have been taken to cell 77.

Remedial action taken since 29 December 2015

20.32 RN Xu was asked about current practices regarding emergency equipment for enforced procedures. He said that there are now six nurses and all practice is conducted in accordance with new procedures. He said that all equipment is brought to outside the cell and nurses are allocated roles to maintain the resuscitation bag, the timer, the sharps bin, the syringe, with one nurse to monitor observations and time the duration of the prone position.

20.33 RN Neumann was asked about the differences now for enforced medication and where CSNSW officers were required to restrain a patient. She said that there was now more effective planning and nurses take verbal and documented observations as required. She was asked whether any changes have been made regarding situations where a patient remains agitated and observations cannot be performed. She said that an oximeter is placed on a patient, otherwise no injection occurs.[268] She said that an inservice was provided a few weeks ago but that the policy changes regarding enforced medication had not yet been put into practice yet, although other strategies had been implemented. She said that there had been a lot less enforced medication since the policy change, but there had been no change to the positioning of patients, who were still placed in the prone position. She said that there have been changes in terms of how long a patient is restrained in the prone position (no longer than three minutes) and that an emergency bag is now always available. She said that it still remained the case that if a patient was agitated the nursing staff would remove themselves, but return to take observations when it is safe to do so.[269]

[268] 27/7/18 at T45.49.
[269] 27/7/18 at T48.2.

21. Issue 10A: Whether Justice Health staff were appropriately trained about the risks and use of restraint?

21.1 Section 4 of the Enforced Medication Policy defined enforced medication as: "*Medication given to a patient without consent and with the use of force to restrain the patient in order to administer the medication*".[270] In this regard it is plainly evident that the Enforced Medication Policy contemplated the use of restraint during administration. However the Enforced Medication Policy did not otherwise make mention of restraint other than to note that only CSNSW staff may restrain a patient in the Long Bay Hospital Mental Health Unit, and that CSNSW have their own protocols and procedures in relation to restraint of a patient.[271] Section 5.3.2 of the Enforced Medication Policy identified the need for special care to be taken in a number of specific circumstances. However the use of restraint, and its associated risks, is not mentioned in Section 5.3.2.

21.2 The New South Wales Health Policy Directive, *Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales* (PD2012_035) published on 26 June 2012 (**the Restraint Policy Directive**), provided the following: "*It is the position of NSW Health that clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint. When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not place themselves, their colleagues or mental health consumers at unnecessary risk*".[272] The Restraint Policy Directive applied to, among other things, Specialty Network Governed Statutory Health Corporations such as Justice Health, a fact acknowledged by Therese Sheehan, the Deputy Director of Nursing and Midwifery Services Custodial Health.[273]

21.3 Section 4.1 of the Restraint Policy Directive provided that: "*Physical/manual restraint should be an option of last resort to manage the risk of serious imminent harm because it involves a risk to the physical and psychological health of both staff and consumers*".[274] Further, section 4.1.1 noted that "*there have been instances both in Australia and internationally in which young apparently healthy people have died suddenly while being held in a physical/manual restraint… The mechanism of death is unclear, but most deaths have been attributed to positional asphyxia or cardiac arrest*".[275] Section 4.1.1 goes on to identify a number of factors that appear to be involved with sudden deaths in restraint including prone positioning, a period of combative struggle of more than two minutes, obesity, underlying physical condition, acute mental disturbance, and prescribed medication. It also stipulates the following: "*In view of the possible connection between facedown restraint and sudden death, Local Health Districts should provide appropriate training to staff on the use of restraint*".[276]

21.4 RN Neumann said that coming from a public hospital background she was at first taken aback by the fact that Justice Health staff did not perform restraint and that instead it was performed by CSNSW staff. RN Neumann said that she had not seen the Restraint Policy Directive prior to 29 December 2015.[277] Ms Sheehan acknowledged that no training had been provided to clinical

[270] Exhibit 1, page 1287-125.
[271] Exhibit 1, page 1287-126.
[272] Exhibit 1, page 1789.
[273] 6/3/19 at T4.41.
[274] Exhibit 1, page 1802.
[275] Exhibit 1, page 1802.
[276] Exhibit 1, page 1803.
[277] 27/7/18 at T23.31.

staff in G Ward regarding the policy directive and that this represented a deficiency in training staff as to the dangers of prone restraint.[278]

21.5 **Conclusions:** Given the acknowledgement made by Ms Sheehan, it is abundantly clear that no training was provided to Justice Health staff in relation to the Restraint Policy Directive. As a result Justice Health staff were plainly not appropriately trained in the use of prone restraint and its associated risks.

21.6 **Recommendation:** I recommend that Justice Health implement training for all clinical staff working at Long Bay Hospital Mental Health Unit, including medical officers, in relation to the NSW Heath Policy Directive *Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales* (PD2012_035).

Remedial action taken since 29 December 2015

21.7 Consistent with the evidence given by Assistant Commissioner Corcoran, a Working Group consisting of Justice Health and CSNSW staff, was developed to review the procedures and processes surrounding the treatment of mentally ill patients within G Ward and Long Bay Hospital. The Working Group initially met on 20 August 2018, and again on 29 November 2018 during which a number of recommendations were made. The meetings resulted in the development of draft Local Operating Procedures for Long Bay Hospital related to enforced medication and Joint Planned Interventions by Justice Health and CSNSW: *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) (**the Joint Planned Interventions LOP**) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) (**the Enforced Medications LOP**). These Local Operating Procedures were approved by the Chief Executive of Justice Health on 31 January 2019. On 1 February 2019 the Commissioner of CSNSW endorsed the two Local Operating Procedures.

21.8 Shaun Connolly, the Justice Health Nurse Manager Operations, Access and Demand Management, and the legal representative for Justice Health on the Working Group explained that a training calendar had been developed for joint ongoing training between Justice Health and CSNSW staff working in the Long Bay Mental Health Unit. Whilst the training calendar was still in development as at the date of Mr Connolly's evidence (6 March 2019) he indicated that proposed dates for the training had been identified[279], with the first training to occur on 3 April 2019, and an audit to be conducted by the Nurse Unit Manager at the Mental Health Unit.[280]

21.9 **Recommendation:** I recommend that training on the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be provided to all CSNSW and Justice Health staff working at Long Bay Hospital, including theory, practical training and assessment.

21.10 **Recommendation:** I recommend that CSNSW and Justice Health audit compliance with the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* and *Enforced Medications - Long Bay Hospital Mental Health Unit* Local Operating Procedures.

[278] 6/3/19 at T8.5.
[279] 6/3/19 at T25.45.
[280] 6/3/19 at T36.29-42.

21.11 Section 4.6 of the Joint Planned Interventions LOP provides for the roles and responsibilities of psychiatrists and medical officers, stipulating that "*the psychiatrist/medical officer must attend the ward and assess the patient and need for Joint Planned Intervention*".[281] A similar provision is contained also within section 4.6 of the Enforced Medications LOP. However, it stipulates that "*the psychiatrist/medical officer must attend the ward and assess the patient and need for Joint Planned Intervention – if possible".*[282] Mr Connolly accepted that the Joint Planned Interventions LOP would apply to an enforced medication event. On that basis he accepted that there is inconsistency between the equivalent provisions of the two Local Operating Procedures.[283] Mr Connolly attributed this inconsistency to the absence of an on-site medical officer after hours in the Mental Health Unit. However, he explained that whilst enforced medication primarily occurs during business hours in the event that it occurred after hours recommendation would be made for a psychiatrist or psychiatry registrar (who would be on call) to attend Long Bay Hospital so that the enforced medication procedure could occur.[284]

21.12 **Recommendation:** I recommend that Section 4.6 of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to mandate the attendance of a psychiatrist/medical officer to assess a patient in the event of administration of enforced medication.

21.13 Section 6.4 of the Enforced Medications LOP provides for a number of procedural steps to be followed for the administration of enforced medications. One step is the completion of a Joint Planned Medication Checklist (**the Checklist**) indicating proposed roles and the procedure to be taken. The Checklist (identified in the Appendix to the Enforced Medications LOP) includes information such as whether a de-escalation plan was attempted, and a patient's medical alerts. In evidence Mr Connolly was asked if there was a reason why the Checklist does not include information relating to risk factors associated with restraint and positional asphyxia. Mr Connolly indicated that he did not know of any reason why this was the case, and acknowledged that such information would be relevant particularly if Justice Health staff had not received training in relation to the Restraint Policy Directive.[285]

21.14 **Recommendation:** I recommend that the Joint Planned Medication Checklist of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to include information indicating that risk factors for restraint and positional asphyxia have been considered by Justice Health and CSNSW staff prior to the administration of enforced medications.

21.15 Section 8.3 of the COPP relates to enforced medication in mental health facilities. It provides that: "*Correctional officers should follow directions from JH&FMHN medical personnel regarding the positioning of a patient for the administration of injections*".[286] In evidence Mr Connolly agreed that medical advice from Justice Health staff is to be followed when it comes to making decisions about the safety of a patient being restrained, and agreed that this should be clearly set out in the Local Operating Procedures.[287]

[281] Exhibit 1, page 1902.
[282] Exhibit 1, page 1915.
[283] 6/3/19 at T36.4.
[284] 6/3/19 at T35.39.
[285] 6/3/19 at T53.22-28.
[286] Exhibit 1, page 1248.34.
[287] 6/3/19 at T65.4-8.

21.16 **Recommendation:** I recommend that the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to provide that Justice Health medical personnel are able to give directions to CSNSW correctional officers regarding the positioning of a patient for the administration of injections.

21.17 In evidence Professor Brown was asked whether he had any personal experience, in the hospital where he works, of prone restraint being used for the purposes of administering enforced medication to patients. Professor Brown indicated that he cares for many agitated patients and that his hospital uses an equivalent security response team. However he explained: "*what we do is we give an injection with them lying flat. We always, always keep the patients lying flat face up, always, and then the injection goes into the upper outer thigh and we do it through clothing, so we never, ever roll a patient over to use the buttock. It's not necessary. You've got a perfectly good muscle at the front. It also means you can watch the patient, watch the airway and see everything happening*".[288]

21.18 Prior to the 29 November 2018 Working Group meeting Mr Connolly and CSNSW staff attended mental health units at POWH and St Vincent's Hospital. Mr Connolly was asked whether during either visit specific advice was sought regarding the use of prone restraint for enforced medication or emergency sedation. Mr Connolly indicated that although specific advice is not sought, the issue of patient positioning during medication administration was discussed. Mr Connolly indicated that the information obtained was that the prone position was the most commonly used position for the administration of medication.[289] Mr Connolly indicated that within the Working Group there had been some discussion about use of the supine position and whether it would be discussed at a risk briefing as part of risk management.[290]

21.19 It is noted that, contrary to submissions made by the solicitor for the Dungay Family regarding extension of the recommendation below to CSNSW, the positioning of a patient for the purposes of enforced medication within a mental health facility is a matter for Justice Health.

21.20 **Recommendation:** I recommend that Justice Health give consideration to whether a position other than the prone position should be utilised for enforced medication to be administered under the *Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.180) and emergency sedation to be administered under the *Emergency Sedation – Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.441).

21.21 It was submitted by the solicitor for the Dungay Family that :

(a) Justice Health staff working in the Mental Health Unit should attend mandatory violence prevention and management training undertaken by Justice Health staff at the Forensic Hospital. However, the operation of the Forensic Hospital, and training provided to staff within it, did not form part of the issues considered at inquest. Accordingly there is no evidentiary basis upon which the submission could be accepted.

[288] 25/7/18 at T43.50.
[289] 6/3/19 at T23.38.
[290] 6/3/19 at T24.14-19.

(b) Input should be sought by Justice Health from family members of involuntary mental health patients and, where possible, involve such family members in the patient's treatment. The submission acknowledges that the inquest did not receive any evidence on this issue. On that basis alone the submission cannot be accepted. It is acknowledged that the submission arises from concerns expressed by David's family (following the conclusion of evidence in the inquest) as to why there was not an opportunity for them to be more involved in David's care. Non-acceptance of the submission is not intended to minimise such concerns. However, the exercise of the power afforded by section 82 of the Act must be evidence-based and within scope.

(c) Steps be taken by Justice Health to make an Aboriginal Health Worker available to assist with de-escalation and discussion of treatment options involving an Aboriginal or a Torres Strait Islander patient in the Mental Health Unit. The submission acknowledges that progress has already been made in the form of the Enforced Medication LOP, with recruitment action underway, and that the purpose of any recommendation in this regard would be to emphasise its importance. Given the acknowledgement, and the absence of evidence to suggest that repeat emphasis is necessary, this submission cannot be accepted.

22. Issue 10B: Was it appropriate to administer a second injection to David, as was planned on 29 December 2015, and who had the responsibility to decide whether such an injection should occur? What effect did the ensuing delay and further restraint have on David?

22.1 Officer G said that he raised the topic of additional sedation with RN Xu.[291] He said that he did not think sedation for one hour was enough and raised the possibility of additional sedation on the basis of an earlier incident some two or three years earlier which involved David acting aggressively. He was asked to describe this earlier incident and referred to a situation where David became aggressive and shattered some glass which caused an opening in his cell, which in turn resulted in his extraction from the cell. On this basis Officer G maintained that he had safety concerns even after David woke up from sedation, and that he had concerns for the security of the centre even beyond the cell.[292]

22.2 Officer G said that he could not recall at what point he yelled down the corridor to Officer F for continued restraint of David in cell 77, whether it was before or after RN Xu came out of the cell. However Officer G said at the time he yelled out to Officer F he had not received confirmation that a second injection would be given.[293] Officer G said that he had no specific recollection of any conversation with RN Neumann, and that he did not recall being told by her to have the officers continuing to restrain David. However, he agreed that he thought David needed to be restrained until there was confirmation about whether there would be a second injection or not. He denied asking RN Neumann to make a phone call so that a second injection could be given.[294]

22.3 RN Neumann was asked whether her recollection accorded with Officer G's account. She said that at the time she was in the nurse's station calling Dr Ma and she did not know what was occurring in cell 77. She said that she recalled a conversation with Officer G (but did not recall RN Xu being present) where he asked whether it was a good idea to give David an extra sedative. She agreed that it fit with her recollection that after Officer G spoke to her she called Dr Ma.[295]

22.4 RN Neumann said that whilst on the phone to Dr Ma she said that she knew the midazolam was being given and her concern was that due to the rapid escalation and agitation she did not feel that the midazolam would achieve the desired outcome and she wanted further medication to calm David down. She agreed that it was Dr Ma who suggested the haloperidol, explaining that it would not have been up to her.[296]

22.5 Dr Ma confirmed that he had a discussion with RN Neumann and indicated that haloperidol could be administered. Dr Ma was asked whether it was possible that he was told that midazolam had already been administered and that there was some desire to administer additional medication, namely haloperidol. He replied: "*No, my impression was that they were planning to give the midazolam and they wondered whether it would be clinically indicated as to whether they also give haloperidol and [RN Neumann] was asking for my advice*".[297]

22.6 Dr Ma indicated that he considered that administration of both midazolam and haloperidol was clinically indicated based on the level of aggression described by RN Neumann to him, which

[291] 17/7/18 at T181.9.
[292] 17/7/18 at T184.8.
[293] 18/7/18 at T191.12.
[294] 18/7/18 at T191.40.
[295] 27/7/18 at T35.3.
[296] 27/7/18 at T37.50.
[297] 4/3/19 at T66.1.

was considered to be high. Dr Ma said that, although it would vary between individuals, he understood the midazolam in David's case would be effective from between 15 to 20 minutes, and up to one hour. He explained that the "*haloperidol in addition to providing an extra sedative effect, which would have worked synergistically with midazolam to heighten the level of sedation, it would also reduce psychotic symptoms, such as delusions and hallucinations*".[298]

22.7 Dr Ma was asked why he settled on haloperidol. He explained that David had been given it previously with no acute side effects, and that it can take effect within 15 minutes and last up to 12 hours. On this basis Dr Ma explained: "*I felt that given the level of aggression that Nurse Neumann had described that adding the haloperidol would be a more effective means in reducing Mr Dungay's distress more immediately and also ensuring that the staff were safe*".[299]

22.8 Dr Ma said that it was his practice at the time to examine a patient before ordering enforced medication "*if the situation and time allowed*".[300] He said that there would have been a need on 29 December 2015 to review David. However he said: "*I was satisfied that based on what Nurse Neumann had conveyed to me in the handover, and, you know, my knowledge of her experience, was that I was happy for her administer, or the team to administer those medications and I would review as soon as practical*".[301]

22.9 RN Xu said that he had no understanding that there was an intention to give David a second injection. He said he only learned about this intention after the incident when he sat down with the other nurses at about 7:30pm to write up the retrospective progress notes. He said that at the time he did not hear anyone say anything about "*one more needle"* when the IAT footage was played back to him. However he said that if had heard this he would clarify with the officer what he meant.

22.10 Officer G said that he saw no barrier in making a suggestion to RN Neumann that a second sedative be considered. He said he felt free making a suggestion of a medical nature which he thought might calm David down. He said that one of the reasons for this was because it would make David easier to manage.[302] He said that he could not recall whether he had done this before; that is, speak to a nurse to make sure that an inmate was easier to manage because of their aggression.

22.11 Officer G agreed that at the time he yelled for continued restraint RN Neumann was picking up the phone and that at that time there was no order for extra medication and no guarantee that such an order would be given. He agreed that RN Neumann didn't ask for continued restraint and that that was his decision.

22.12 Counsel Assisting suggested to Officer G that even allowing for the earlier 2013 incident, seeking some consideration for a second injection was excessive. Officer G disagreed. He also disagreed with Counsel Assisting's suggestion that there was no good reason to call for a second injection if David was going to be secured in his cell. When asked what he expected to happen after one hour, Officer G replied:

[298] 4/3/19 at T66.24.
[299] 4/3/19 at T73.19.
[300] 4/3/19 at T66.45.
[301] 4/3/19 at T66.50.
[302] 18/7/18 at T202.29-38.

"*Based on previous experience with Mr Dungay…my concern was that Mr Dungay had effectively breached a cell on a prior occasion, and, taking into consideration the level of aggression that Mr Dungay was displaying at the time, I believe I had good cause to be concerned about potential breach of the cell that he was being moved to…the day shift, including the IAT, would have ceased duty upon the finalisation of managing Mr Dungay, leaving me in charge of the correctional centre, with a skeleton staff, which is not enough staff to respond to - effectively respond to an aggressive inmate who has breached their cell*".[303]

22.13 Officer G confirmed that in 2013 David did not exit his cell but said that if the entire glass had been removed he could have easily done so.

22.14 **Conclusions:** The prospect of sedation in addition to the injection of midazolam was first raised by Officer G. It was raised on the basis of Officer G's concerns in relation to a previous incident in 2013 in which David had acted aggressively and damaged his cell. On that occasion David did not breach his cell. There was no reasonable basis to believe that this would occur either on 29 December 2015 given that, following the cell transfer, it was intended for David to be left alone in cell 77 with the midazolam to take effect. In this regard, Officer G unreasonably allowed a perceived security issue to dictate management of a medical issue which did not fall within his remit.

22.15 The responsibility for deciding whether additional sedation was appropriate rested with Dr Ma. In describing David's level of aggression to Dr Ma, RN Neumann sought advice in relation to the possible administration of haloperidol only. It can be inferred from this that there was no basis for Dr Ma to consider that his advice was being sought about both midazolam and haloperidol. In these circumstances, the administration of an additional sedative was not warranted. Firstly, there was no sound reason to consider additional sedation when the effects of the midazolam had not been allowed to take effect, and in circumstances where David was to be secured in cell 77. Secondly, consideration of whether additional sedation was warranted could have been deferred until an assessment could be performed after the midazolam had taken effect. Indeed, Dr Ma, in accordance with his usual practice, considered that there was a need to review David.

22.16 Had advice and authorisation for the additional sedative not been sought, it is most likely that David would have been released from restraint following the administration of midazolam. Observations in accordance with the Enforced Medication Policy should have then been performed. Instead, the consequence of authorising additional sedation was that David was subjected to additional prone restraint which was not warranted in the circumstances.

[303] 18/7/18 at T209.29-48.

23. Issue 11: Whether Justice Health staff acted appropriately in providing life support to David between the time he became unresponsive through to the arrive of NSW Ambulance paramedics on 29 December 2015?

23.1 Dr Ma, RN Thapa and RN Maharjan had not previously been involved in a real life resuscitation attempt prior to 29 December 2015.

23.2 Professor Brown described the inherent challenges with resuscitation attempts in this way: "*…the commonest reason of a suboptimal or a challenging resuscitation is just literally the confronting nature. This is a very frightening situation for medical staff. It's quite possible that the medical and nursing staff may not have had experience in real life of a cardiac arrest. It's very, very different performing a cardiac arrest, basic life procedure, in real life where you've got a patient who…is not breathing*".[304] Nonetheless, Professor Brown explained that in making his criticisms he was conscious of the fact that the clinicians involved were likely confronted with a stressful and confronting situation.[305]

23.3 In evidence the IAT footage was played to Professor Brown. He identified the following deficiencies with the resuscitation attempt:

(a) At 10:11, Professor Brown did not support a CSNSW officer being in charge of the airway. He described it as a technically difficult procedure. He said what was required was a jaw thrust or chin lift to achieve a patent airway. He said that he would have preferred a nurse to manage the airway, with a jaw thrust or chin left, and then a CSNSW officer would be able to provide ventilation. He explained that the necessary skill was not ventilation, but the proper application of the bag valve mask (**BVM**) with an airtight seal, which requires training.[306]

(b) At 10:20, cardiac massage had ceased and there was no evidence of rise in the chest which suggested that the airway was not open optimally.

(c) At 11:50, the defibrillator pads should have been put on in seconds and there was "*a little bit of a lack of urgency*".[307] Once the defibrillator identified no shock rhythm external cardiac massage should have been immediately restarted.

(d) At 12:25, even though there was a suggestion of a weak pulse external cardiac massage should have continued to augment resuscitation attempts until return of signs of life.

(e) At 13:36, at Dr Ma's direction, David was moved from a supine position to the recovery position. Professor Brown accepted that the purpose of the manoeuvre was to ensure that there was no fluid or obstruction in the airway. However he explained that cardiac massage can only be performed when a person is in the supine position, and that suction devices should be used to remove fluid or obstruction from the airway. He explained: "*You don't normally put someone in the recovery position in the middle of a cardiac arrest. It's just not, not helpful*".[308]

[304] 25/7/18 at T33.25.
[305] 25/7/18 at T61.19.
[306] 25/7/18 at T33.41-T34.10.
[307] 25/7/18 at T35.30.
[308] 25/7/18 at T37.6.

(f) At 14:50, external cardiac massage should have continued irrespective of any airway concerns. Airway management required a nurse to be at the patient's head rather than attempting to do so from the side, because it makes "*the technical aspect of this much more challenging*".[309]

(g) At 16:10, again external cardiac massage should have continued in conjunction with airway management. There was no need to place David in the recovery position.

(h) At 17:31, assessment of a possible airway obstruction was being performed in the recovery, rather than the supine, position. Professor Brown explained: "*I believe the reason possibly that it's perceived there's an airway obstruction is simply the tongue has fallen back, which is a common problem when you have an unconscious person that the tongue drops into the back of the mouth and literally obstructs the airway. That's why one of the manoeuvres you do is called a jaw thrust or you can put in an airway, but I think again, the sentiment is correct, the process is not*".[310]

(i) At 18:29, there was no indication to perform a Heimlich manoeuvre middle of basic life support, with the manoeuvre usually only performed in the event of a person choking.

(j) At 19:40, there was an "*enormously prolonged gap in any basic life support*".[311] Professor Brown expressed the view that "*what's happened is that the struggle to work out why has Mr Dungay stopped breathing has taken over from the process of resuscitation*".[312] Professor Brown indicated that this was followed by an approximately eight minute hiatus where no cardiac massage was performed apart from two compressions.

23.4 In summary, Professor Brown noted that the medical treatment provided by Justice Health staff overall "*was of a low standard*" and "*lacking in essential aspects*"[313], and that the lack of provision of continuous basic life support "*rendered the resuscitation attempts by Justice Health doctors and nurses effectively without value, and was incompatible with survival*".[314]

23.5 Professor Brown was asked what should have occurred at the point of injection when David screamed he could not breathe. He said that the injection should be forgotten and attention given to deal with the perceived or actual problem concerning the airway. He said that the nurse should look at the airway, see the colour of the face, and see whether the chest was expanding. David could be placed on his side or back. Although this might have created a risk of spitting a mask could have been placed over his mouth. Professor Brown opined: "*I think to give an intramuscular injection when a patient is complaining they can't breathe is not the right priority*".[315]

23.6 Professor Brown was taken to the IAT footage at 3:09. He said that the breathing sounded laboured and said that it suggested that David was having difficulty expanding his chest, although he said that he understood that an inmate may be saying that they could not breathe in order to release the restraint. He said that the heavy breathing was not consistent with asthma

[309] 25/7/18 at T37.29.
[310] 25/7/18 at T38.8.
[311] 25/7/18 at T39.9.
[312] 25/7/18 at T39.13.
[313] Exhibit 1, Tab 69 at [4/a].
[314] Exhibit 1, Tab 69 at [4/p].
[315] 25/7/18 at T42.24.

as that specifically involves difficulty breathing out and is an expiratory wheeze. In contrast, he explained that difficulty breathing in is an inspiratory noise which is more of a gasping sound which sometimes involves a whistle called a stridor.[316] He said that from what he heard he did not think that Mr Dungay was experiencing an issue with asthma.

23.7 Professor Brown was asked about what recommendations might be possible having regard to the clinicians having no real life experience of dealing with a cardiac arrest. He highlighted the importance of having a team leader who can stand back and direct things and maintain team cohesion, and the use of simulated training.[317]

23.8 RN Xu agreed that the initial step in providing ventilation involves proper positioning of the airway but said that he could not recall whether he did it.[318] He said: "*At the time I was - sorry, I was in a mess I guess. I was very shaken and terrified with disbelief and I knew the, the process is - there are strict guideline for first, for basic life support…I noticed from very beginning it's already went to the fifth step which is, "Compression."…so I just assumed everything was done already before this compression, you know, was started so I don't - I think I didn't specifically check the airway but I did look through the clear mask. At the time I was sure there was nothing there*".[319]

23.9 RN Xu was asked about Professor Brown's criticisms regarding the consistency of ventilation. He said that he only used the BVM briefly and that another nurse then took over. He said that he vaguely recalled seeing David's chest rise and fall.[320] He said that he did not pay attention to whether there were big gaps in the ventilation.[321]

23.10 When asked about differences in practices now RN Xu said that there would be someone designated as team leader. He said that person could be a doctor or nurse, and would be responsible for supervising the process in a hands-off but organised way. He said that the resuscitation would be more role focused, involve simulation-type training, and that a Medical Emergency Response Team Leader (**MERTL**) would assist in responding in a more team-oriented way.

23.11 RN Neumann explained that this was the first emergency resuscitation that she had been involved in. She said that she had received previous training but to the extent that she had been trained after David's death. She said that she was not trained at all in relation to taking a team approach to the resuscitation.[322]

23.12 Prior to 29 December 2015 Dr Ma had never performed resuscitation on a real person, and had not been given training in relation to assigning roles for the purposes of resuscitation. He acknowledged, "*unfortunately and regrettably*", that he had no discussion with the nursing staff about their roles in the resuscitative effort.[323] Dr Ma said that he was aware of Professor Brown's criticisms regarding the absence of continuous external cardiac massage and consistency of cycles and said that he "*definitely*" accepted that these critical aspects of the resuscitation effort could have been done better and more consistently.[324]

[316] 25/7/18 at T46.41.
[317] 25/7/18 at T58.19.
[318] 26/7/18 at T54.5.
[319] 26/7/18 at T54.5.
[320] 26/7/18 at T56.45.
[321] 26/7/18 at T57.20.
[322] 27/7/18 at T41.9.
[323] 4/3/19 at T75.20.
[324] 4/3/19 at T76.6.

23.13 **Conclusions:** The resuscitation attempt conducted by Justice Health staff on 29 December 2015 was of a low clinical standard and lacking in several vital areas. There was a fundamental deficit in failing to provide continuous basic life support to David in the absence of consistent external cardiac massage and maintenance of ventilation.

23.14 These deficits can primarily be attributed to three factors: the inexperience of the clinicians in providing life support in a real life setting; the absence of resuscitation team leadership and assignment of key roles; and focus on the cause of David's collapse rather than the resuscitation efforts.

23.15 It was submitted by the solicitor for the Dungay Family that the professional conduct of Dr Ma, RN Tharpa and RN Maharjan relative to the resuscitation attempt warrants review. Counsel for Dr Ma and the solicitor for RN Tharpa and RN Maharjan submit that such a review is not warranted. On their behalf it is submitted that the confronting nature of the resuscitation attempt, coupled with 29 December 2015 being the first occasion in which the clinicians had to apply their training and skills to a real-life situation, led to inadequate life support being provided to David. As noted above, the evidence establishes that this was indeed the case. The evidence does not establish that the inherent quality of clinical care was so deficient, absent the identified considerations regarding the resuscitation itself, as to warrant review of professional conduct. It is accepted that the clinicians were endeavouring to do their best to provide life support to David, but were overcome by the enormity and stress of the situation they were confronted with. On this basis, the submissions on behalf of Dr Ma, RN Tharpa and RN Maharjan are accepted.

Remedial action taken since 29 December 2015

23.16 At present, the Justice *Health Long Bay Hospital Medical Emergency Response Procedure* identifies the recommend a course of action to be taken by Justice Health clinicians during a medical emergency response within Long Bay Hospital wards.

23.17 In 2016 Long Bay Hospital implemented a process to delineate the roles and responsibilities of nursing staff involved in medical emergencies, including cardiac arrest. The process assigns the role of a MERTL, which is held by a registered nurse in each ward and on each shift. The role of the MERTL is to coordinate and support staff in medical emergencies including, relevantly, to assign staffed roles such as airway management, external cardiac massage, and application of a defibrillator.[325]

23.18 The procedure provides that a MERTL provides "*leadership and coordination of the team treating the patient. MERTL will ensure that the process in the Emergency Response Checklist is followed*".[326]

23.19 In evidence Paul Sonntag, the Justice Health Nurse Educator - Clinical Practice, was asked about this. He was asked whether the intention of the MERTL program was for the team leader to not actively participate in the resuscitation attempts, but to instead direct it. Mr Sonntag indicated that this would be dependent on the time of day, with this being more possible during daytime with more staff, but less likely during the day when less staff would mean that the MERTL would be actively involved. Mr Sonntag agreed that in hindsight to clarify in the Medical Emergency

[325] Exhibit 1, Tab 57 at [21].
[326] Exhibit 1, page 1287-195.

Response Procedure that the MERTL normally directs the process, but does not participate in it.[327] Mr Sonntag also agreed that would be helpful to specify the roles to be assigned during a medical emergency response.[328]

23.20 Mr Sonntag indicated that whilst staff have been trained in the procedure there had been no attempt to audit compliance with the procedure in practice, due in large part to the rare instance of medical emergencies in Long Bay Hospital.[329]

23.21 **Recommendation:** I recommend that Justice Health amend the Medical Emergency Response procedure and training/educational materials in respect of the Procedure to include a statement to the effect that it is the responsibility of the Medical Emergency Response Team Leader to assign roles to team members in the event of a Medical Emergency Response and to oversee and direct the Response, but not to actively participate in it.

23.22 **Recommendation:** I recommend that Justice Health amend the Medical Emergency Response Procedure and training/educational materials in respect of the Procedure to include specific reference to the roles which the Medical Emergency Response Procedure Team Leader is to assign to Response participants.

23.23 **Recommendation:** I recommend that Justice Health audit staff performance under the Medical Emergency Response Procedure and the Medical Emergency Response Procedure Checklist to ensure compliance.

[327] 5/3/19 at T45.33.
[328] 5/3/19 at T45.40.46.
[329] 5/3/19 at T46.40.

24. Issue 12: The likely cause of David's death and in particular, which of the following matters caused or contributed to it (whether separately or in combination): (i) David's diabetic condition; (ii) the manner of David's restraint/positioning; (iii) the medications David was on for his diabetes and/or his psychiatric condition as at 29 December 2015; (iv) the Midazolam administered to David on 29 December 2015; (v) any inadequacies in the life support provided to David.

24.1 Following his death David was taken to the Department of Forensic Medicine (at its former location) in Glebe. On 30 December 2015 Dr Bailey performed an autopsy. In her autopsy report of 28 July 2016 Dr Bailey opined that the cause of David's death could not be ascertained, but noted several abnormalities which potentially contributed to death:

(a) petechial haemorrhages, a feature associated with impaired blood drainage from the head which may occur through neck or torso compression that might be occasioned during restraint procedures;

(b) compression of the torso in the prone position which may reduce the entry of air into the lungs, ultimately resulting in hypoxia and/or cardiac arrest;

(c) aspirated foreign material in the lungs;

(d) biochemistry test results possibly reflective of early dehydration due to high blood glucose levels; and

(e) a possible temporal relationship between the administration of midazolam and cardiac arrest.[330]

24.2 In evidence, Dr Bailey explained: "*I could not identify a pathology that was incompatible with life and therefore accounting for his sudden death. Having said there, 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*".[331]

Diabetic condition

24.3 Dr Cromer found that there was no evidence to suggest that David had hypoglycaemia or diabetic ketoacidosis. Whilst noting that David most likely had documented elevated glucose levels which possibly rose after he ate the crackers, Dr Cromer opined that this would not have contributed to David's sudden death.[332]

24.4 Dr Cromer also indicated that hyperglycaemia may lead to a loss of consciousness and then death, but that it is a slow process. He said that there would be evidence of other symptoms prior to loss of consciousness. He said that he would not expect there to be a period of shortness of breath, but that in the event of severe diabetic ketoacidosis there would be a period of hyperventilation in the form of rapid and deep breathing.[333]

[330] Exhibit 1, page 13.
[331] 7/3/19 at T48.47.
[332] Exhibit 1, page 1547.
[333] 25/7/18 at T66.10-25.

The manner of David's restraint/positioning

24.5 Professor Brown was asked whether a failure to cease restraint at some point contributed to death. He explained: "*I think it was contributory. I can't tell you at which point ceasing it was important. It's, it's an impossible situation where you have an agitated person and a danger to others, a danger to, 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've made a big difference*".[334]

24.6 Professor Brown was also asked whether positional asphyxia was a substantial cause of the cardiac arrest. He said: "*I put in my report it was a contributory, with a combination of prone positioning and restraint. I haven't been able to say it was substantial and I don't say that now. I, I don't know what ultimately causes the cardiac arrest. A different arrhythmia is possible but I don't believe that, but I've said that both prone positioning and restraint were contributory*".[335]

24.7 However, Professor Brown went on to explain that if restraint was removed from the equation, but regard was still had to David's obesity, psychosis, and agitation, it is likely that David would not have suffered a cardiac arrest.[336]

Medication regime

24.8 Associate Professor Adams explained that "*it has long been noted that patients with schizophrenia have a higher incidence of sudden death than the general population*", with one of the reasons being that psychotropic drugs essential for the control of schizophrenia have the effect of prolongation of the QT interval.[337]

24.9 Associate Professor Adams noted that David had been prescribed both chlorpromazine and zuclopenthixol, both medications of which are known to increase the QT interval.[338] Therefore Associate Professor Adams opined that "*it is likely that the combination of antipsychotic drugs may have contributed to development of a cardiac arrhythmia due to their combined effects on contributing to QT prolongation*".[339]

24.10 In expressing this opinion Associate Professor Adams was not critical of use of the antipsychotic medication. He noted that "*the risk of their use was greatly outweighed by the potential clinical benefit*" and that their use was carefully managed as demonstrated by ECG results on 4 and 8 December 2015, which showed no signs to suggest that the medications were contraindicated.[340]

Administration of midazolam

24.11 Professor Brown noted that there was only a short time interval (two minutes and seven seconds) from the intramuscular injection of midazolam to cardiorespiratory arrest. He explained that this would not have allowed time for the midazolam to be absorbed and noted

[334] 25/7/18 at T53.46.
[335] 25/7/18 at T53.24.
[336] 25/7/18 at T60.49.
[337] Exhibit 1, page 1767-3.
[338] The QT interval is the measure of electrical activity between the Q and T waves in the heart's electrical cycle and shows activity in the heart's lower chambers, the ventricles. Normally the QT interval is about a third of each heartbeat cycle. When the QT interval is prolonged it can upset the timing of the heartbeat and cause dangerous arrhythmias (irregular heartbeats). An abnormally prolonged QT interval is associated with an increased risk of ventricular tachycardia, a fast heart rate caused by improper electrical activity in the ventricles, especially a condition known as Torsades de Pointes.
[339] Exhibit 1, page 1767-3.
[340] Exhibit 1, page 1767-80.

that there was an almost negligible subtherapeutic midazolam level in the post-mortem blood sample. Professor Brown therefore expressed the opinion that these factors indicated that the midazolam did not contribute to David's cardiorespiratory arrest[341], and concluded that the injection of midazolam "*played no part at all in the cause of David's death*". [342]

24.12 Similarly Mr Farrar expressed the view that "*the subtherapeutic concentration of midazolam in the post-mortem blood sample indicates that [David's] death occurred prior to any significant absorption of midazolam*" and opined that "*midazolam therefore did not cause [David's] death*".[343]

Inadequacies in the life support provided

24.13 Professor Brown indicated that he was unable to say whether David would have survived even if excellent basic life support had been provided from the time of his collapse until the arrival of NSW Ambulance paramedics. However Professor Brown noted that "*whatever chance [David] had, however low, was lost by the inadequate and interrupted care he received from Justice Health*".[344]

24.14 Professor Brown indicated that if an assessment had been conducted prior to the midazolam being administered David's distress would have been recognised. He was asked what would have been detectable at that point. He explained: "*…to have a cardiac arrest in asystole doesn't happen in an instant. You don't go from a normal pulse to a stop. You go through whatever insult is causing the heart to slow down and so this, to me, based on the fact that he had petechia or little tiny bruising on the face and a congested head, this would've been visible, I believe, by now. This would've been visible as a suffused possibly purple-looking face, purple lips*". Professor Brown went on to explain: "*So if you'd noticed a purple face, cyanose purple lips, a thready pulse, a slow pulse or possibly an extreme pulse, I would've said okay, just stop what you're doing, stop what you're doing, he's not well. And I can't say with any certainty but at some point, the cardiac arrest becomes inevitable, therefore there's a point prior to that where it's reversible, and it's possible, whilst he's still calling out, 'I can't breathe'. Certainly that means his brain is being perfused, it's possible had everything stopped then and focused on putting on oxygen, getting optimal mechanics of the circulation, that the cardiac arrest could, and I don't say would but I say could have been averted*".[345]

24.15 Professor Brown referred to the significance of the two minutes and 17 seconds between the midazolam injection and David's cardiac arrest. He explained that by David saying that he could not breathe demonstrated that his brain lungs and pulse were all working. This meant that there was a reversible window before the brain was starved of oxygen and circulation failed which would lead to bradycardia, asystole, and full cardiac arrest. He explained that at that point the chance of recovery would be exceptionally small (less than one percent) despite even the best resuscitation.[346]

[341] Exhibit 1, Tab 69 at [5/b].
[342] Exhibit 1, Tab 69 at [5/f].
[343] Exhibit 1, Tab 67 at [66]-[67].
[344] Exhibit 1, Tab 69 at [4/q].
[345] 25/7/18 at T42.39.
[346] 25/7/18 at T43.24.

Cardiac arrhythmia

24.16 Associate Professor Adams opined that it is likely that David died due to a fatal cardiac arrhythmia noting that there are three main reasons to support this:

(a) no obvious cause of death at autopsy, which is consistent with what might be expected at autopsy when an arrhythmia is the cause of death;

(b) the IAT footage is consistent with development of an arrhythmia and its deterioration into a fatal arrhythmia; and

(c) David had multiple potentiating factors for the development of an arrhythmia including: antipsychotic medication with a propensity to prolong the QT interval, type I diabetes, hyperglycaemia, possible evidence of hypoxaemia (in circumstances where David was complaining of difficulty breathing and was restrained in a prone position), and a situation of extreme stress and emotional upset.[347]

24.17 Associate Professor Adams explained that it was possible that David's arrhythmia commenced in cell 71 and that this explained his shortness of breath. Associate Professor Adams noted: "*I was a little concerned that that may have been when his arrhythmia had started, that he may have developed ventricular tachycardia, which at that point would have had the effect of lowering his blood pressure to make him feel dizzy and also causing increased pressure within his heart, which has the effect of making you short of breath as well*.[348]

24.18 Associate Professor Adams went on to explain that if David was already in ventricular fibrillation in cell 71 then any exertion or struggle "*could have made the ventricular tachycardia faster and less effective at providing a cardiac output and increasing the degree of failure*".[349] Associate Professor Adams also noted that restraint "*could cause a degree of hypoxia, which would further accentuate any sort of arrhythmias that would, would have occurred or may have occurred*."[350] However, Associate Professor Adams expressed the view: "*Whether that's significant, it's probably a little doubtful in that I'd suspect [David] probably already had the arrhythmia before, any restraint might have caused, caused hypoxia*".[351]

24.19 Dr Bailey considered the following factors to be important:

(a) David's heightened agitation increased his blood pressure and heart rate;

(b) there are higher incidences of sudden cardiac death in persons with diabetes and some obesity;

(c) David had been placed in the prone position which would decrease his mechanical ventilation capacity which might decrease his blood oxygen level.

24.20 Dr Bailey went on to note: "*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,*

[347] Exhibit 1, pages 1767-2 to 1767-3.
[348] 7/3/19 at T10.33.
[349] 7/3/19 at T11.7.
[350] 7/3/19 at T11.20.
[351] 7/3/19 at T8.35.

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 a potentially fatal cardiac dysrhythmia. That's an absolutely hypothetical scenario, but these are all of the contributing factors that I think have come together in this case. I think he's 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".[352]

24.21 Ultimately Dr Bailey explained that she did not doubt that the mechanism of death was cardiac arrhythmia, and that she could find no other reason for David's sudden collapse, but said that she did not know what the underlying reason for the arrhythmia was.[353]

24.22 Professor Brown was taken to Associate Professor Adams' opinion that David may have been experiencing an arrhythmia in cell 71. He said that he considered it but thought it was unlikely because he considered that this would be associated with a sudden collapse. In David's case there was a period of struggle and repeated complaints of difficulty breathing, which Professor Brown considered to be unusual in the context of suspected cardiac arrhythmia.[354] However Professor Brown acknowledged that it is possible for ventricular fibrillation (a cardiac arrhythmia) to convert to asystole (the absence of electrical and mechanical activity of the heart). Professor Brown expressed the view that the asystole was related to a deterioration in David's general circulation, associated with his difficulty breathing. He said that it was possible that the arrhythmia was the early trigger and that it converted to asystole but thought it unlikely and that he could not demonstrate this. However, ultimately Professor Brown said that he would defer to the expertise of the cardiologist.[355]

24.23 **Conclusions:** Having regard to the opinions expressed by Associate Professor Adams and Dr Bailey it is most likely that the cause of David's 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 long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, a degree of likely hypoxaemia 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 Davis's death. However, the expert evidence also established that prone restraint, and any consequent hypoxia, was a contributing factor although it is not possible to quantify the extent or significance of its contribution.

24.24 As Dr Bailey noted it is not possible to precisely identify the degree to which each of these comorbidities contributed to cardiac arrhythmia. Rather, the various comorbidities in combination increased the risk of cardiac arrhythmia. Whilst Professor Brown considered that a cardiac arrhythmia whilst David was still in cell 71 was unlikely, and preferred the view that David suffered a cardiac arrest which proceeded to asystole in cell 77, he ultimately deferred to the opinion of Associate Professor Adams.

[352] 7/3/19 at T51.50.
[353] 7/3/19 at T61.2.
[354] 25/7/18 at T47.10.
[355] 25/7/18 at T47.50.

24.25 The expert evidence established that because David was continuing to complain of difficulty breathing prior to becoming unresponsive, there was a small window in which interventional life support might have made a difference to the eventual outcome. However, Professor Brown posited this only as a possibility and noted that even if adequate life support had been provided the chances of recovery for David were exceptionally small.

25. Acknowledgments

25.1 For a variety of reasons, the conduct of this inquest was challenging and complex. Throughout it, the Assisting team of Jason Downing, Counsel Assisting, and his instructing solicitors, James Loosley and Jessica Murty, have been resolute in their approach to examine the evidence meticulously, present the evidence fairly and impartially, afford respect and dignity to David and his family, and to assist the Court in a professional and meaningful manner. Their considerable efforts and diligence should be gratefully acknowledged and recognised as embodying the fundamental principles of the coronial jurisdiction.

25.2 The work of Detective Sergeant Babb in conducting the initial police investigation and compiling the voluminous brief of evidence is also acknowledged and appreciated.

26. Findings pursuant to section 81 of the Coroners Act 2009

26.1 The findings I make under section 81(1) of the Act are:

Identity
The person who died was David Dungay.

Date of death
David died on 29 December 2015.

Place of death
David died within the Mental Health Unit at Long Bay Hospital, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death
The cause of David's death was cardiac arrhythmia.

Manner of death
David died whilst being restrained in the prone position by Corrective Services New South Wales officers. David's long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint were all contributory factors to David's death.

27. Epilogue

27.1 It is fitting to conclude some words from a poem written by David's sister, Cynthia, to David: "*Only a heart as dear as yours would give so unselfishly the many things you [have] done, all the time, that you were there for me. Help me to know deep down inside how much you really cared. Even the thoughts I might not say, I appreciate all you do for me. Greatly blessed is how I feel having a brother just like you*".

27.2 On behalf of the Coroner's Court of New South Wales, and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to Leetona, Cynthia, Ernest, Christine and other members of the Dungay family; to David, Janeeka, Jakiah, Jivarhn, Janessa and Jehziac,

and other members of the Hill family; and to David's friends for their immeasurable and tragic loss.

27.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
22 November 2019
Coroner's Court of NSW

Inquest into the death of David Dungay

Appendix A to Findings

Recommendations made pursuant to section 82(1) *Coroners Act 2009*

To the Commissioner, Corrective Services New South Wales (*CSNSW*) and Chief Executive, Justice Health & Forensic Mental Health Network (*Justice Health*):

1. I recommend that training on the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be provided to all CSNSW and Justice Health staff working at Long Bay Hospital, including theory, practical training and assessment.

2. I recommend that CSNSW and Justice Health audit compliance with the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* and *Enforced Medications - Long Bay Hospital Mental Health Unit* Local Operating Procedures.

3. I recommend that Section 4.6 of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to mandate the attendance of a psychiatrist/medical officer to assess a patient in the event of administration of enforced medication.

4. I recommend that the Joint Planned Medication Checklist of the *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to include information indicating that risk factors for restraint and positional asphyxia have been considered by Justice Health and CSNSW staff prior to the administration of enforced medications.

5. I recommend that the *Joint Planned Interventions by CSNSW and JH&FMHN in Long Bay Hospital* (January 2019) and *Enforced Medications - Long Bay Hospital Mental Health Unit* (January 2019) be amended to provide that Justice Health medical personnel are able to give directions to CSNSW correctional officers regarding the positioning of a patient for the administration of injections.

To the Commissioner, Corrective Services New South Wales:

6. I recommend that all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.

7. I recommend that Corrective Services New South Wales review the use of the proclamation process by the Immediate Action Teams in Long Bay Hospital to ensure that appropriate consideration is given, at the time the proclamation issued, to the possibility that a mentally ill inmate patient may not be in a position to comply or respond to the proclamation in a rational manner.

8. I recommend that CSNSW continue to provide *Positional Asphyxia Awareness* online training to all custodial staff up to and including the rank of Functional Manager/Senior Assistant Superintendent, and audit completion rates annually to identify correctional staff who have not yet completed such training.

9. I recommend that CSNSW continue to provide specialist practical training on positional asphyxia to Immediate Action Team and Special Operations Group officers, and audit completion rates annually to identify officers who have not yet completed such training.

10. I recommend that CSNSW provide training to all Corrective Services Officers working in the Mental Health Unit in restraint techniques, positional asphyxia and the risks of sudden death from restraint.

11. I recommend that CSNSW audit at least one-third of all video recordings, as a representative sample, of uses of force by Immediate Action Teams in order to verify that sections 13.7.8 and 13.7.9 of the Custodial Operations Policy and Procedures have been complied with, with consideration to be given to additional auditing if the nominated representative sample does not allow for such verification.

12. I recommend that CSNSW complete the trial of a suitable soft restraint system for use in the Mental Health Unit as an alternative to the use of handcuffs, with the relevant training to be provided to applicable staff including staff in G Ward.

13. I recommend that CSNSW, through the Special Operations Group, create and implement a revised use of force training package for Mental Health Unit staff which places greater emphasis (50% weighting) on de-escalation techniques versus physical control and restraint techniques.

14. I recommend that CSNSW review the current version of the Custodial Operations Policy and Procedure to ensure that clear instructions are provided requiring the retention of all potentially relevant video footage, including CCTV footage, in the event of a death in custody.

To the Chief Executive, Justice Health & Forensic Mental Health Network:

15. I recommend that Justice Health implement training for all clinical staff working at Long Bay Hospital Mental Health Unit, including medical officers, in relation to the NSW Heath Policy Directive *Aggression, Seclusion and Restraint in Mental Health Facilities New South Wales* (PD2012_035).

16. I recommend that Justice Health give consideration to whether a position other than the prone position should be utilised for enforced medication to be administered under the *Enforced Medication and Rapid Tranquilisation - The Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.180) and emergency sedation to be administered under the *Emergency Sedation – Forensic Hospital and Long Bay Hospital Mental Health Unit* (Policy Number 1.441).

17. I recommend that Justice Health amend the Medical Emergency Response procedure and training/educational materials in respect of the Procedure to include a statement to the effect that it is the responsibility of the Medical Emergency Response Team Leader to assign roles to team members in the event of a Medical Emergency Response and to oversee and direct the Response, but not to actively participate in it.

18. I recommend that Justice Health amend the Medical Emergency Response Procedure and training/educational materials in respect of the Procedure to include specific reference to the roles which the Medical Emergency Response Procedure Team Leader is to assign to Response participants.

19. I recommend that Justice Health audit staff performance under the Medical Emergency Response Procedure and the Medical Emergency Response Procedure Checklist to ensure compliance.

To the Chief Executive, Nursing and Midwifery Board of Australia:

20. I recommend that, pursuant to section 151A of the *Health Practitioner Regulation National Law (NSW) No 86a*, the transcript of the evidence of Registered Nurse Charles Xu be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Registered Nurse Xu on 29 December 2015 should be the subject of review.

Magistrate Derek Lee
Deputy State Coroner
22 November 2019
Coroner's Court of NSW

Inquest into the death of David Dungay

Appendix B to Findings

Non-publication orders made pursuant to section 74(1) *Coroners Act 2009*

1. No publication of any of the CCTV footage or handheld camera footage from the point just before David Dungay becomes unresponsive to the end to the footage. (Timestamp: CCTV 2 min 35 sec (camera 6) and 8 min 15 sec (IAT file 8 from the index to electronic material at page 17 of the first volume of the brief and the entirety of IAT file 9).

2. No publication of names, residential and work addresses or identifying features (including photographs) or anything else that might tend to identify the following CSNSW officers and staff:
   a. [redacted]
   b. [redacted]
   c. [redacted]
   d. [redacted]
   e. [redacted]
   f. [redacted]
   g. [redacted]
   h. [redacted]
   i. [redacted]
   j. [redacted]
   k. [redacted]
   l. [redacted]
   m. [redacted]
   n. [redacted]
   o. [redacted]
   p. [redacted]
   q. [redacted]
   r. [redacted]
   s. [redacted]
   t. [redacted]
   u. [redacted]

3. Any faces (or other identifying features) of those persons in the video footage (up to the point of the non-publication order in Order 1) to be pixelated.

4. No publication of the residential and work addresses or any identifying features (including photographs) of the following:
   a. Stuart Davey
   b. Steve Davis
   c. Leah Nicholson
   d. Peter Severin
   e. Andrew Godfrey
   f. Todd Jeffreys

except for photographs of Commissioner Severin.

5. No publication of the faces (or other identifying features) (by way of pixilation) of RN Charles Xu in the video footage (up to the point of the non-publication order in Order 1).

6. No publication of the address of Dr Trevor Ma contained in his statement dated 6 January 2016.

7. No publication of the following material in the brief of evidence tendered as Exhibit 1 in the inquest:

Vol/Tab, Page, [para]	**Document**	**Content of NPO**
1/9 p. 69-70	Statement of Detective Sergeant Damien Babb	[84] 4th sentence; [85] 1st and 2nd sentences; [86] whole paragraph.
1/23, p. 143	Statement of Senior Assistant Superintendent [redacted]	His direct phone number. Full statement.
1/31, p. 336	G Ward Daily Movements Log	Names of other inmates, unrelated to the death.
1/36, p. 356	Long Bay Daily State #057083	Names of inmates [redacted] and [redacted]
1/39, p. 368	Site Plan of Long Bay Hospital Sector 1	Full page.
2/40, p. 452	Death in Custody Report	Name and MIN of inmate [redacted]
2/40, pp. 471-479 pp. 483-490 pp. 498-499 pp. 503-507 pp. 510-512 pp. 531-534	Death in Custody Report	Full pages.
2/40.1, pp. 560 & 563	Attachments to Bagley report – Inmate profile document	Names of other inmates. Family members' addresses.
2/40.3, p. 577	Attachments to Bagley report – Parole offender report	Deceased's home address.
2/40.29, p. 744	Inmate's Health Plan	Full page.
2/40.30, pp. 751-769	Attachments to Bagley report - Long Bay Hospital – Metropolitan Special Programs Centre IAT post duties	Full pages.
3/40.32, pp.780-788	Attachments to Bagley report, Operations Procedure Manual	Full page
3/40.33, pp. 790-840	Attachments to Bagley report, Operations Procedure Manual	Full page

Vol/Tab, Page, [para]	Document	Content of NPO
3/40.34, pp. 842-873	Attachments to Bagley report, Operations Procedure Manual	Full pages.
3/40.35, pp. 875-897	Attachments to Bagley report, Operations Procedure Manual	Full pages.
3/40.37, p. 901	Attachments to Bagley report – Parole records	Full page.
3/40.38, pp. 922-944	Attachments to Bagley report – IAT Training records	Portions identifying firearms training undertaken
3/40.41, pp. 978-984	Attachments to Bagley report – Phone call transcripts. CD	• Identity of other inmates, towns where family live. • Family members' phone numbers • Family phone numbers
3/40.42, pp. 988-989	Attachments to Bagley report – Employee Daily Schedule	Identity of CSNSW officers unrelated to the inquest, their work start times and locations.
3/40.42, pp. 990-991	Attachments to Bagley report – emails	Direct email address and phone numbers of CSNSW staff
3/40.44, pp. 995-997 & 1006	Attachments to Bagley report – CSNSW emails and JH document	Contact details of CSNSW staff and deceased's family
3/40.44, p. 1021	Attachments to Bagley report – Long Bay Hospital Daily State	Names of other inmates
3/40.50, pp. 1056-1057	Attachments to Bagley report –IAT exam	Full pages.
3/41, p. 1064	Inmate profile document	Family's addresses.
3/42, pp. 1067-1233	OIMS notes	• Next of Kin phone number; • Solicitor's direct phone number; • Next of Kin address; • Details of relatives; friends, persons unrelated to the inquest; • MIN and name of another inmate.

Vol/Tab, Page, [para]	Document	Content of NPO
4/48, p. 1248.8	Attachment to Statement of Stuart Davie, AC's Memorandum	Third paragraph, last sentence, commencing "When a medical…" Whole of sixth paragraph commencing, "Where medical…"
4/48, p. 1248.9	Attachment to Davie statement, AC's Memorandum	Direct phone number and email address of Mr Bagley.
4/48, pp. 1248.10-1248.50	Attachment to Davie statement, COPP 13.7 Use of Force	Full pages.
4/48A, p. 1248.57	Statement of Steve Davis	[51] "Mark IV Streamer"
4/48A.A pp. 1248.65 to 1248.67	Attachment "A" to Davis statement	Full pages
4/48A.B, pp. 1248.70-1248.73	Attachment "B" to Davis statement	Full pages.
4/48A.C, p. 1248.80	Attachment "C" to Davis statement	Whole of fourth paragraph commencing "Close attention…" Whole of fifth paragraph commencing "Advanced Defensive Tactic Techniques…"
4/48A.D, p. 1248.88	Attachment "D" to Davis statement	Whole of final paragraph commencing "Close attention…"
4/48A.E, pp. 1248.92-1248.99	Attachment "E" to Davis statement	Full pages.
4/48A.F, pp. 1248.108-1248.111, pp. 1248.113-1248.116	Attachment "F" to Davis statement	Full pages.
4/48A.G, pp. 1248.120-1248.122	Attachment "G" to Davis statement	Full pages.
4/48A.H, pp. 1248.126-1248.135	Attachment "H" to Davis statement	Full pages.

Vol/Tab, Page, [para]	Document	Content of NPO
4/48A.I, pp. 1248.138-1248.151	Attachment "I" to Davis statement	Full pages.
4/48A.J, pp. 1248.154-1248.162	Attachment "J" to Davis statement	Full pages.
4/48A.K, pp. 1248.166-1248.173	Attachment "K" to Davis statement	Full pages.
4/48A.L, pp. 1248.176	Attachment "L" to Davis statement	Full page.
4/48A.M, pp. 1248.179-1248.191	Attachment "M" to Davis statement	Full pages.
4/48A.N, pp. 1248.195-1248.203	Attachment "N" to Davis statement	Full pages.
4/48A.O, pp. 1248.207-1248.212	Attachment "O" to Davis statement	Full pages.
4/48B.A, pp. 1248.219-1248.230	Attachment "A" to Bagley statement	Full pages.
4/48B.B, pp. 1248.232-1248.235	Attachment "B" to Bagley statement	1248.232: commencing at para. 13.7.6.2 1248.233-1248.235: Full pages.
4/48B.C, pp. 1248.238	Attachment "C" to Bagley statement	Direct phone number and email address of Mr Bagley.
5/66, pp. 1528-1529	Statement of inmate [redacted]	Inmate's name and age.
6/77 pp. 1978, 1980-1982, 1984-1992, 1995-1996	Attachments to [redacted] statement	Full pages

8. No publication of Exhibit 4.