

## **The tragic death in custody of David Dungay Jr**



### **When will justice be done for David Dungay Jr?**

David Dungay Jr, was a 26 year old Dungatti man, who died on December 29, 2015 in Sydney's Long Bay Prison Hospital. David called out twelve times that he couldn't breathe, as six guards held him face down, while nursing staff and four other prison guards looked on.

David was diagnosed with diabetes and asthma when a young child, and developed mental health challenges as a young adult. It is unclear whether mental health issues such as mood swings were exacerbated by his diabetes, as high blood sugar levels can induce acute behavioural symptoms. These symptoms range from mood swings including anxiety, distress and anger, to acute neurological symptoms such as semi consciousness and unconsciousness.<sup>1</sup>.

Long Bay Prison Hospital records show David was not sent to 'urgent' Prince of Wales Hospital specialist care for degenerative diabetes related kidney, feet and retinal neuropathy, as had been recommended by his medical supervisor.

Instead of getting the urgent treatment required for his diabetes, David died in custody, after being overcome and held down by prison guards, because he refused to stop eating a rice cracker.

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<sup>1</sup> <https://www.diabetesselfmanagement.com/blog/blood-sugar-emotions/>

## **July 2018 inquest – what we know so far:**

The July 2018 inquest went for 2 weeks, and was only a partial investigation of the circumstances leading to David Dungay's death in custody. The inquest was unable to be completed and was deferred until 2019, to resume in 4<sup>th</sup> March at the new Lidcombe Coroner's Court.

Here is some information, from a number of sources, detailing events so far as outlined at the first inquest:

### **29 December 2015**

On 29 December in 2015, David Dungay, a type 1 diabetic, started eating a packet of rice crackers inside his cell at Sydney's Long Bay jail<sup>2</sup>.

When the 26-year-old Dunghutti man refused to stop eating the biscuits, Corrective Services staff called the Immediate Action Team (IAT), which specialises in prisoner removals.

Dungay was given two minutes to comply with an order to stop eating the biscuits, before the IAT rushed into his cell, manoeuvred him face-down on to his mattress and handcuffed him behind his back. He was picked up, moved to another cell and held face-down again.

### **Why was David spitting blood from his mouth?**

The CCTV video that was part of the evidence at the inquest showed that staff were aware that David was spitting blood as he was dragged, transferred to the second cell while handcuffed, and while the sedative midazolam was injected into his buttock.<sup>3</sup> It is not clear what caused blood to come from David's mouth, but his mother Leetona Dungay noted that when viewing his body after death, David's face was caved in and covered with bruises.<sup>4</sup> Leetona has said that as well, his nose was broken, there was blood coming from his eyes, and the skin on his nose had a split across it.

### **What the CCTV<sup>5</sup> captured**

Dungay was moved to cell 77, and restrained for seven and a half minutes face down in the prone position, including the period when he was injected with a quick acting sedative.

The nurse who administered the injection failed to check for critical life threatening symptoms before and after this, and despite David's cries.

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<sup>2</sup> <https://www.theguardian.com/australia-news/video/2018/jul/16/i-cant-breathe-footage-shows-david-dungays-death-in-custody-video>

<sup>3</sup> <https://www.abc.net.au/news/2018-07-16/david-dungay-inquest-begins-as-harrowing-video-played/9997930>

<sup>4</sup> [tps://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay](https://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay)

<sup>5</sup> <https://www.theguardian.com/australia-news/video/2018/jul/16/i-cant-breathe-footage-shows-david-dungays-death-in-custody-video>

Later, staff forgot to remove the cap from resuscitation equipment, which can be seen on the CCTV footage, coming out of David's mouth.

Officers positioned themselves on top of him, pulling down his green prison uniform pants and calling for a nurse, who injected 10 milligrams of the sedative Midazolam. Then they retreated to the doorway.

Moments later, Dungay stopped breathing.<sup>6</sup>

Staff from the mental health unit and paramedics tried to resuscitate Dungay for almost an hour, but his death was declared at 3.42pm.

An expert medical witness said David Dungay Jr had little chance of survival once his heart had arrested but "whatever chance he had was lost" by the inept attempts at resuscitation.<sup>7</sup> The prone restraint technique is known to be risky, however it was employed by guards – at least six holding him down – and for a duration that exceeded the time for medication delivery. These actions by guards were considered by an emergency medical expert witness to have contributed to his death<sup>8</sup>.

### **"I can't breathe"**

David told the guards twelve times that he could not breathe, before eventually losing consciousness and dying. David's death is the subject of an investigative Guardian Australia podcast, 'Breathless'<sup>9</sup>. Damning footage shows what actually happened before, during and after David Dungay died in December 2015.<sup>10</sup>

David was restrained by six IAT officers in the "prone" position, facedown, on both cell beds and repeatedly screams "I can't breathe" - to which one officer replies: "You're talking, you can breathe". David became unresponsive, went "limp" and vomited, and was not resuscitated<sup>11</sup>.

### **A person with asphyxia can still speak**

At the 2018 inquest, Professor Anthony Brown, Emergency Physician, Royal Brisbane Hospital, gave expert evidence on the issue of Mr Dungay's death due to positional asphyxia. Significantly, Professor Brown stated that 'a person suffering from positional asphyxia can still talk and cry out, even as they are running out of oxygen in their blood

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<sup>6</sup> <https://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay>

<sup>7</sup> <https://www.theguardian.com/australia-news/2018/jul/25/david-dungay-inquest-shown-harrowing-footage-and-told-of-prolonged-cpr-failures>

<sup>8</sup> <https://www.deathscapes.org/engagements/dispatch-sydney/>

<sup>9</sup> <https://www.theguardian.com/australia-news/audio/2018/jul/13/breathless-episode-1-death-david-dungay-jr-podcast>

<sup>10</sup> <https://www.theguardian.com/australia-news/video/2018/jul/14/introducing-breathless-the-death-of-david-dungay-jr-podcast-video>

<sup>11</sup> <https://www.sbs.com.au/nitv/nitv-news/article/2018/07/17/i-cant-breathe-resuscitation-efforts-david-dungay-effectively-without-value>

stream.<sup>12</sup> This medical view contradicted the prior evidence given by a number of the Immediate Action Team that, in their view, because Mr Dungay could talk – that is, through his repeated and ever more desperate cries of ‘I can’t breathe’ – then he could breathe.

### **Positional asphyxia**

Professor Brown outlined how the prone position and restraint under which David was placed ‘were likely contributors’ to his death, together with other co-factors, including agitation and his struggle with the correctional officers .

Professor Brown concluded that David would have experienced an inability to take deep breaths and an inability to expand his chest, which caused the congestion of blood to his head and which, in turn, resulted in his cardiac arrest. He concluded that if guards’ actions in relation to this hadn’t occurred, David’s death could have been averted<sup>13</sup>.

Professor Brown concluded that there were two restraint positions that ‘contributed to his death’ – one was the guard’s deliberate use of face down restraint position, and the other was the pressure to his upper body that would have obstructed breathing.<sup>14</sup>

Five of the six IAT members had not undertaken any training in respect of positional asphyxia risk and had no effective knowledge of it, however the one staff who had did not use his training. Furthermore, the nurse – while reporting that the event was ‘terrifying’ - had only recently passed CPR training.

### **Not a medical emergency**

On Wednesday 25 July 2018, Dr Spasojevic of Justice Health, Long Bay Hospital, gave evidence. Dr Spasojevic confirmed that David’s blood-sugar levels earlier on the day of his death were asymptomatic and, when questioned as to whether she thought that his eating rice crackers might constitute a ‘medical emergency,’ she stated that his eating crackers was ‘not a medical emergency.’<sup>15</sup>

Dr Spasojevic’s medical assessment of the situation thus contradicted the corrective officers’ evidence given earlier in the inquiry, when they asserted that the Immediate Action Team had been brought in because his eating crackers constituted a ‘medical emergency.’

When David Evenden, Counsel for the Dungay family questioned Dr Spasojevic, he put on record the family’s concern that David was eating the biscuits because he had often complained to them ‘that he was not getting enough food.’

### **What should have happened**

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<sup>12</sup> <https://www.deathscapes.org/engagements/dispatch-sydney/>

<sup>13</sup> <https://www.theguardian.com/australia-news/2018/jul/16/david-dungay-inquest-told-inadequate-resuscitation-may-have-contributed-to-death>

<sup>14</sup> <https://www.theguardian.com/australia-news/2018/jul/16/david-dungay-inquest-told-inadequate-resuscitation-may-have-contributed-to-death>

<sup>15</sup> <https://www.deathscapes.org/engagements/dispatch-sydney/>

If David's blood-sugar levels were elevated, Dr Spasojevic said she would have simply recommended a subcutaneous injection of extra insulin, which David could have done himself. This medical view was supported by Dr Cromer, an endocrinologist, who stated when questioned that 'removing the biscuits would not be a medical emergency' given his certified blood-sugar levels on the day.<sup>16</sup>

On previous occasions, when prison staff needed to talk with David about his blood sugar levels, Justice Health nurses, other Aboriginal inmates and an Aboriginal delegate were able to speak to him and calm him down<sup>17</sup>.

Whether that was an option that should have been tried on 29 December 2015 will be explored in the course of the evidence.

### **Evidence of assault**

Police said David Dungay's death was not suspicious and a corrective services investigation found no criminal negligence, but his family and supporters continue to have concerns.

"It didn't even look like my son's body. His face was caved in, bruises all around, stitches here and there," says his mother, Leetona Dungay.

"I had a feeling then, I knew that over-aggressive force was used on my son by the correctional services officers."<sup>18</sup>

Leetona has since said that as well, David's nose was broken, there was blood coming from his eyes, and the skin on his nose had a split across it. Leetona asks why it took two hours for a detective to enter the cell to examine the scene. Why was the cell completely cleaned before the detective entered, and all forensic evidence cleaned away. All staff uniforms, sheets, needles and David's clothes should have been kept aside for evidence purposes. Despite asking, Leetona has not had an answer to these questions and still has not received her son's clothing as requested.

Corrective Services actively sought the protection of certain staff's identities to prevent the possibility of civil action being taken against them for their cooperation in the inquiry.

### **July 2018 Inquest delayed - 2019**

David Dungay's family had already waited two and a half years for the July 2018 inquest. The inquest had been set down for a two-week hearing but very quickly ran behind schedule. By Wednesday 25 July 2018 the Coroner had only heard from around two thirds of the listed witnesses. Consequently, Coroner Derek Lee announced that the inquest would have to be delayed until 2019.<sup>19</sup>

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<sup>16</sup> <https://www.deathscapes.org/engagements/dispatch-sydney/>

<sup>17</sup> <https://www.abc.net.au/news/2018-07-16/david-dungay-inquest-begins-as-harrowing-video-played/9997930>

<sup>18</sup> <https://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay>

<sup>19</sup> <https://www.theguardian.com/australia-news/2018/jul/26/uproar-in-court-as-coroner-delays-david-dungay-inquest-for-almost-a-year>

The delay has been very difficult for the Dungay family.

The family's lawyer, George Newhouse, told Guardian Australia the family would have preferred the inquest be completed at the July 2018 hearing. "They are absolutely devastated by further delays," he said. "It denies closure for their pain and loss of their son, brother, uncle, and loved one."<sup>20</sup>

## **A need to acknowledge and address institutionalised violence against Indigenous prisoners**

There are a disproportionate number of deaths in custody of Aboriginal Australians as a result of excessive force by prison guards or police.

The deaths reinforce the dangers of structural racism, over-policing and criminalisation of Aboriginal Australians.

There is an urgent need to implement solutions on healthcare in police custody, and improved processes for inquests and legal aid and support to families<sup>21</sup>.

The inquest will reopen from 4 March 2019 at the new Forensic Medicine & Coroners Court Complex, 1A Main Ave, Lidcombe NSW 2141. Phone: (02) 9563 9000

*This paper has been prepared by Loretta Picone and Amalina Wallace on behalf of the Dungay family, and with the assistance of Justice Action. 12 February 2019.*



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<sup>20</sup> <https://www.theguardian.com/australia-news/2018/jul/26/uproar-in-court-as-coroner-delays-david-dungay-inquest-for-almost-a-year>

<sup>21</sup> <https://www.humanrights.gov.au/publications/indigenous-deaths-custody-part-d-implementing-recommendations>