

RECOMMENDATIONS FOR THE CORONER IN THE CASE OF DAVID DUNGAY



“My son went to prison to take responsibility for his actions. On his last day, he was killed despite his pleas: ‘I can’t breathe’.

The people who heard his many calls for help to breathe ignored him. He was held face down down, and smothered.

He died slowly without any of the six guards intervening to make sure he could breathe. He was smothered until he died.

Just as my son was accountable and went to prison, so the people who killed him should be made accountable for what was cruel and inhuman treatment.”

Leetona Rose Dungay, mother of David Dungay Jr.



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1 EXECUTIVE SUMMARY

Justice Action submits this report concerning the preventable death of David Dungay at Sydney’s Long Bay Prison Hospital in 2015. We submit that this death was as the result of failed duty of care by a number of staff at the prison, including breaches to established procedural protocols. At the very least, we can say that he was killed by members of the IAT staff, whose series of actions, tragically and irreversibly suffocated him. Dungay sustained grievous bodily harm that was inflicted with unlawful and reckless indifference to his cries of distress. This indifference was clearly implied through the staffs’ deliberate and neglectful failure to respond to Dungay’s pleas for his life. This report has been developed in collaboration with Mrs Leetona Rose Dungay, David Dungay’s mother, who is a co-signatory to our submission. We seek to bring the Coroner’s attention to key themes for the prevention of cases similar to that of David Dungay including preventative aspects and accountability mechanisms.

His death was caused by traumatic injuries sustained and by lack of proper care whilst in detention in Sydney’s Long Bay Prison Hospital in 2015.¹ In 1991 the report of the Royal Commission into Aboriginal Deaths in Custody revealed a complex and devastating picture of the effects of dispossession, colonisation and institutional racism on Aboriginal peoples². This Justice Action report highlights how relevant recommendations from the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC) and past Coronial inquiries have not yet been adequately implemented (refer to Appendix A).³ Our report provides recommendations and options for creating a safer environment for prisoners with medical conditions and for Indigenous prisoners.

¹ https://justice.nt.gov.au/_data/assets/pdf_file/0009/238185/aust-stand_2012.pdf

² <https://www.humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/guides/information-sheet-social>

³ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

Obligations under national and international law

Relevant obligations include:

- article 16(1) of the Convention on the Rights of Persons with Disabilities (CRPD),
- articles 4 and 5(b) of the Convention on the Elimination of All Forms of Racial Discrimination (CERD),
- and the right to humane treatment in detention is contained in article 10 of the International Covenant on Civil and Political Rights (ICCPR).

Justice Action notes that the CRPD requires that positive measures be taken to prevent exploitation, violence and abuse of people with disabilities; and that prisoners have the right to humane treatment in detention under article 10 of the ICCPR.

For further detail, see the Australian Government Guidance Sheet on the [Right to humane treatment in detention](#).⁴

Medical and jurisdictional challenges within prison hospitals

Justice Action is aware of the limitations of providing medical care to inmates within a prison hospital system. A poorly funded hospital facility and lack of full-time qualified medical staff are factors that contributed to the environment that led to Mr Dungay's death. Another factor is the tension between Correctional officers and medical staff, stemming from unclear guidelines about who is in charge and who takes direction from who.

Justice Action's work around the country, supporting families whose relatives have died in custody, is a continual reminder that prison hospitals are unhealthy and unsafe environments.

A recent investigation into Australian prisons by Human Rights Watch⁵ found widespread evidence of prisoners, particularly Aboriginal prisoners, becoming depressed and demoralised by separation from family and by abusive comments from prison guards. Institutionalised racism against Aboriginal and Torres Strait Islanders in prison is so common and accepted that its not reported by prisoners. As one woman prisoner said to a Human Rights Watch investigator, "Officers call me 'black c—t' heaps of times, it's normal".⁶ HRW's 93 page report, "I Needed Help, Instead I Was Punished: Abuse and Neglect of Prisoners with Disabilities in Australia," examines how prisoners with disabilities, including Aboriginal and Torres Strait Islander prisoners, are at serious risk of bullying, harassment, violence, and abuse from fellow prisoners and staff.

This environment of ongoing intentional bullying by prison officers is one where incidents against Aboriginal prisoners need very careful investigation.

⁴ <https://www.ag.gov.au/RightsAndProtections/HumanRights/Human-rights-scrutiny/PublicSectorGuidanceSheets/Pages/Righttohumantreatmentindetention.aspx>

⁵ <https://www.hrw.org/report/2018/02/06/i-needed-help-instead-i-was-punished/abuse-and-neglect-prisoners-disabilities>

⁶ *hrw: Interview: The Horrors of Australia's prisons; Feb 2018; Kriti Sharma and Amy Braunschweiger*

Who was David Dungay Jr?

David was a young Aboriginal man from Kempsey, Dunghutti country. At the coronial inquest, David's mother Leetona, supported by her children, spoke powerfully about David's childhood, managing his diabetes as his "nurse and diabetes educator" from a very young age, and how she watched him "grow into a lovely young man". "He made bad mistakes but he did his time and paid his debt. He was so close to being free."⁷

From childhood, David had a circle of friends. He worked for his uncle, he was sociable, played football and had happy and supportive relationships with his family. David had no history of taking drugs. David's family say that David was emotionally stable prior to going to prison.

David died three weeks before he was due to be released.

Corrective staff on the frontline

Those who work in the prison system say serious investment is needed. "As a society we have invested much more in bricks and mortar of the prisons' walls and the barbed wire and not enough in the human resources in terms of psychiatric care for this section of prisoners," said psychiatrist Dr Andrew Ellis, who works one day a week inside a NSW prison. Increasingly, this leaves Corrective Services officers on the frontline of mental-health care⁸. Most guards are not equipped to deal with mentally challenged prisoners, and some don't have the inclination.

The situation which led to Mr Dungay's death is one where non-medically trained prison guards made decisions justified by their incorrect assumptions about Mr Dungay's medical condition, diabetes. They created a "mexican standoff" situation by demanding that Mr Dungay stop eating a rice cracker. When Mr Dungay refused to stop eating the biscuit, as he was fully entitled to do, one of the prison guards called the Immediate Action Team (IAT). This submission lists the specific actions taken by the various guards in detail on page 30 at 4.3 d). The guard who called the IAT made a decision not to bring in a nurse or doctor, who would have informed the guard that Mr Dungay's eating a rice cracker was not a medical emergency⁹. It was a decision to force Mr Dungay to comply with an incorrect directive. It was a determination to exert power of Mr Dungay and was a decision that directly led to Mr Dungay's death.

This incident highlights the fact that prison guards in G Ward have not been trained to understand that their actions regarding medical issues need to be done under the supervision of and as instructed by medical staff. There are no clear lines of authority, or if there are, they are not being followed. The fact that the medical staff present did not intervene to prevent the attack by the IAT team indicates that they, too, may be intimidated by prison officers. They became passive as the

⁷ <https://www.theguardian.com/australia-news/2019/mar/08/nsw-corrections-apologises-to-family-of-david-dungay-for-custody-death>

⁸ <https://www.themonthly.com.au/issue/2018/april/1522501200/bronwyn-adcock/sick-inside>

⁹ <https://www.deathscapes.org/engagements/dispatch-sydney/>

IAT took over.

If Corrective Services officers had consulted and taken the advice of Justice Health staff, Mr Dungay would still be alive.

In any organisation, there is a hierarchy, delegations, and duty of care. Did the IAT act lawfully and within their obligations as public servants?

Liaison, not force

If an Aboriginal officer or fellow Aboriginal prisoner had been brought in to negotiate with Mr Dungay, prior to his removal from his cell, the incident may have been de-escalated. Similarly, if a medical officer had been consulted, it would have been established that there was no need for Mr Dungay's removal from his cell, and the incident would have been de-escalated.

Negotiation, discussion, respectful conversation had been effective when responding to previous potential incidents with Mr Dungay. It is also to be noted that David was in a single cell. This was a breach of a directive that David not be placed on his own. All the research has shown there are better outcomes for prisoners who are not socially isolated. Aboriginal prisoners in particular prefer to share with other Aboriginal detainees. There is little understanding outside prisons of the personal support that prisoners give each other, and of the importance of prison friendships for mutual support between prisoners who experience racism and bullying treatment from guards.

Family contact by phone in times of crisis, via phone or Skype, is another solution to respond to and avert potentially dangerous incidents.

Actions that led to Mr Dungay's death

Mr Dungay was given two minutes to comply with an order to stop eating rice crackers, before the IAT rushed into his cell, manoeuvred him face-down on to his mattress and handcuffed him behind his back. The video recording shows that Dungay was pinned with sustained downward force by two men while simultaneously being kned in the back (an illegal 'knee-ride'), and being forcibly held around the shoulders and neck region. Furthermore, a large volume of blood could be seen coming from his mouth in the footage. This was also reported by a nurse. The IAT guard was recorded on CCTV dismissively telling Dungay to 'stop spitting your blood and you might be alright'. David told the guards twelve times that he could not breathe, to which one officer replied: "You're talking, you can breathe".

Once Mr Dungay was moved to cell 77, he was restrained for an additional seven and a half minutes, face down in the prone position. David was still face down as he was injected with a quick acting sedative, and remained in that restrictive position after the injection, presumably awaiting a second injection directive by IAT. The nurse who administered the injection failed to check for critical life threatening symptoms before and after this. This is in direct contravention to the professional duties required in standard medical setting. David then became unresponsive, went "limp" and vomited, and was unable to be resuscitated despite efforts.

The CCTV video that was part of the evidence at the inquest, as well as showing the assault on Mr Dungay, showed that he was spitting blood as he was dragged, and transferred to the second cell while handcuffed, and while the sedative midazolam was injected into his buttock.¹⁰ 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 covered with bruises.¹¹ Mrs Dungay has also stated that there was blood coming from his eyes, the skin on his nose had a split across it and very large bruises on the sides of his ribs.

Officers positioned themselves on top of Mr Dungay, held him face down, pulled down his green prison uniform pants and called for a nurse, who injected 10 milligrams of the sedative Midazolam. They then retreated to the doorway. The video evidence shows that staff failed to remove the cap from the resuscitation equipment prior to inserting it in David's mouth.¹²

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

It is clear, on the evidence, that each guard had the opportunity to stop and turn David over so he could breathe. But they chose not to respond to David's cries for help, even to relieve the pressure in case he wasn't lying. Instead, they showed unacceptable callousness and a lack of basic concern towards Dungay's life as they killed him in their desire to impose their unlawful will over his consumption of biscuits.

What should have happened

If David's blood-sugar levels were elevated, Dr Spasojevic of Justice Health, Long Bay Hospital, gave evidence said she would have simply recommended an 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.¹³

Justice Action submits that this option should have been tried on 29 December 2015, as well as any medical advice regarding whether David eating a biscuit was a medical emergency.

The investigation process

We note that the scene of Mr Dungay's death was not initially examined by an independent investigator. 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, Mrs Leetona Dungay, has not received an answer to these questions. Nor has she received her son's clothing, as requested. It is a concern, therefore,

¹⁰ <https://www.abc.net.au/news/2018-07-16/david-dungay-inquest-begins-as-harrowing-video-played/9997930>

¹¹ [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)

¹² <https://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay>

¹³ <https://www.deathscapes.org/engagements/dispatch-sydney/>

that the information available for consideration by the Coroner may have been “sanitised” and is not a complete and accurate record of the crime scene.

The family questions the autopsy report’s findings that little damage was done to David’s body. The Coroner has received, through Mrs Dungay’s lawyer, the photos she had taken when she viewed the body, of the extensive damage done to David’s body prior to his death.

There is an urgent need for an organisation independent of Corrective Services to be made responsible for investigating all deaths in custody. Independence is required to ensure that no conflict of interest or bias can occur. An accurate record of any incident scene is essential in order to determine all contributing factors.

This is an intractable problem which requires thought and attention by policy makers.

Evidence of assault

Police said David Dungay’s death was not suspicious, but his family and supporters continue to have concerns.

“I had a feeling then, I knew that over-aggressive force was used on my son by the Correctional Services officers.”¹⁴ says his mother, Leetona Dungay.

Most concerningly, Corrective Services had actively sought the protection of certain staff’s identities in order to prevent the possibility of civil action being taken against them for their co-operation in the inquiry.

In the interests of justice, we submit that the Coroner make a specific finding on the causes of the damage to Mr Dungay’s body including, but not limited to the damage to Mr Dungay that had been photographed by his mother viewing her son’s body.

Furthermore, there are questions as to if the video of what happened in the first cell was deleted or not presented by Corrective Services staff. Without the footage, it cannot be ascertained how much of the damage to David’s body was committed in the first cell.

Certificates of exemption

The coronial enquiry for Mr Dungay was only able to proceed because guards demanded certificates of exemption which protected them from being charged. It is a concern that Corrective Services may not have co-operated with the enquiry if the exemptions had not been granted.

The Parliamentary Joint Committee on Human Rights has noted that, while article 14.3(g) of the United Nation’s *International Covenant on Civil, Political and Economic Rights* protects the right not to incriminate oneself, the right is ‘subject to permissible limitations, provided that the limitations are for a legitimate objective, and are reasonable, necessary and proportionate to that

¹⁴ <https://www.theguardian.com/australia-news/2018/apr/11/if-you-can-talk-you-can-breathe-the-death-in-custody-of-david-dungay>

objective’.¹⁵

The need for justice

The Dungay case embodies many of the life threatening problems that deaths in custody cases raise across this nation. The Government and Corrective Services cannot risk being seen to consent to life threatening treatment of prisoners.

Ultimately, responsibility for the actions that were deemed significantly ‘contributory’ to Mr Dungay’s death largely lay with the head of the Immediate Action Team (IAT), and it is this person who we urge Coroner Lee to consider referring to the Director of Public Prosecutions (DPP).

Australia has reached a turning point regarding care of people in institutions. In the last couple of years a number of institutions in Australia are being held accountable and perpetrators charged and convicted. There is a public acceptance of the need to prevent institutionalised abuse against children, older people, people with disabilities and the vulnerable.

We urge that the Coroner refer this matter to the DPP for criminal investigation. We give further details of individual actions of the different officers in the section of this submission on page 30 at 4.3 d) “Considering the actions of individuals.”

In case the Coroner decides not to refer the case to the DPP, we recommend that the guards of the IAT be removed from any position which would require them to exert physical force on a prisoner. This recommendation is made with the objective of ensuring that Corrective Services and Justice Health uphold their duty of care to protecting detained Australians.

Procedural options

A lack of procedural reforms has led to a compromise of duty of care, especially for prisoners with complex medical needs. The video recording of Mr Dungay’s death was critical in bringing to attention the case and thus the investigation into the practices of Justice Health and Corrective Services. This has demonstrated the importance of video recording equipment in prison environments.

The Correctional Services NSW and Justice Health interagency Working Committee has demonstrated slow progress in the ineffectual training rollout, with a lack of any details of how reviews and audits will occur. There have been references made of regular reviews and audits of training, but no details have been provided. All training needs to happen within a strategic framework and be subject to input from the Attorney-General’s Department.

We note that according to Custodial Operations Policy and Procedures (11.3)¹⁶:

¹⁵https://www.alrc.gov.au/sites/default/files/pdfs/publications/fr_129ch_11_privilege_against_self-incrimination.pdf

¹⁶<https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-development-committees.pdf>

“in accordance with a recommendation of the Royal Commission into Aboriginal Deaths in Custody, an Aboriginal Inmate Committee (AIC) is to be established and remain active at every correctional centre, unless an exemption is granted by the Assistant Commissioner, Custodial Corrections (ACCC). The AIC is a representative body of Aboriginal inmates and an integral part of correctional centre management. An Aboriginal Inmate Delegate (AID) will be appointed as the secretary of the AIC. The AIC is a Corrective Services NSW (CSNSW) initiative that affirms its commitment to support Aboriginal inmates to desist from reoffending, and acknowledges their family contact and cultural needs. The AIC does not address individual inmates’ personal issues. Aboriginal inmates in need of assistance can seek the help of the AID.”

Justice Action wonders why an Aboriginal Inmate Delegate (AID) was not called to assist, and whether this committee has even been set up in Long Bay prison and Ward G as required.

Lack of response to legal precedents

Three years after Mr Dungay’s death and at least eight years since a similar case¹⁷ [Inquest into the death of Lyji VAGGS COR 2010/1273] was heard in Queensland¹⁸, the Committee has not formally (within the yet-to-be-formed Operational Procedure reforms) produced a training package of reforms and timelines. The court had found that the face down restraint techniques and ‘knee-ride’ techniques that were used to control Mr Vaggs killed him, and Correctional Officers around the country should have been trained to no longer use these methods of control. If the Committee had acted to ban these dangerous methods, Mr Dungay would not have been killed.

Since Mr Dungay’s death, the Working Committee has made a commitment that rostered medical staff will assume leadership roles in Long Bay Prisons, including in Ward G.

However, a significant concern is that the standard hours of engagement for medical staff in Long Bay Prison are limited to 9-4pm during weekdays. This means that there is a real risk of a repeat death in custody at night and on weekends, when there are no medical staff available. It is clear that the prison hospital should ensure that medical staff be available at all times, just as any other hospital does.

Another concern is whether the medical staff can stand up to decisions and actions that overreach the delegation of prison guards. It is essential that these professional boundaries are established definitively so that interagency ‘cooperation’ and ‘concession’ do not degrade into ‘complicity’ and ‘collusion’. The interagency Committee had flagged the importance of medical staff maintaining a leadership role in medical situations, but has failed to safeguard this in practice or policy.

We note that even the Counsel assisting the Coroner raised concerns about the slow and ineffectual

¹⁷ https://www.courts.qld.gov.au/_data/assets/pdf_file/0003/136605/cif-vaggs-l-20120221.pdf

¹⁸ <https://www.theaustralian.com.au/national-affairs/vaggs-family-awarded-100k/news-story/abba121003b01e0dedd810f2e94ad506>

interagency Working Committee. There has been little to no evidence of the fundamental practicalities of operations practices being addressed or rectified. This is especially significant considering changes in NSW that require coronial inquiries to provide not only the examination and investigation of suspicious deaths in custody, but also to prevent avoidable deaths and injuries¹⁹. We are aware of and share in community concerns that coroner's courts will not be sufficiently funded to investigate deaths²⁰.

We are concerned that Dr Andrew Ellis, who had information required by the Coroner, was not called to give evidence. The replacement speaker, Mr Godfrey, repeatedly stated that he was not the correct person for many questions, Hence, the inquiry was forced to be closed prematurely. The Coroner had also conceded Mr Godfrey was not an appropriate witness.

We also note that the Counsel was reduced to suggesting the type of checklist format required for the training manual, and that in the absence of action by Corrective Services NSW and Justice Health, the Coroner was reduced to having to manage the training process and manual for which the committee were in fact responsible.

Racism

Every year, tens of thousands of Australians march to support Aboriginal rights around Australia. It is twenty four years since the Social Justice Commissioner has given detailed consideration to Aboriginal and Torres Strait Islander health issues. He stated that:

The gap between the numbers of our people who live and the number who should be alive is one measure of the inequality we have endured. The gap between the numbers living a healthy, socially-functional life and those living a life of pain, humiliation and dysfunction is another measure. They are both measures of our loss of elementary human rights.

There should be no mistake that the state of Indigenous health in this country is an abuse of human rights. A decent standard of health and life expectancy equivalent to other Australians is not a favour asked by our peoples. It is our right - simply because we too are human.²¹

The Coronial inquiry is an opportunity to examine institutional failures and to recommend solutions to prevent future Aboriginal deaths in custody.

In this submission, we propose a number of recommendations for consideration, to prevent further injustice to Aboriginals in custody and to provide justice to the family of David Dungay. These

²¹ Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report - 2nd report, 1994*, Australian Government Publishing Services (AGPS), Canberra, 1995, pp99-100.

recommendations can be found on pages 12-16 of this submission.

3 RECOMMENDATIONS

Consequences for the Participants Involved

- 1 Recommend that charges be laid. The counsel’s findings in paragraphs 230 and 231 stated that “...the manner of David’s positioning during the period of restraint would likely have played a role in the development of what was ultimately a fatal cardiac arrhythmia”²² and “...absent that restraint occurring at all, David would likely not have suffered cardiac arrest.”²³

One member of the six person IAT team had specific training on the dangers of what they did. The leader “A” and all the members heard him say that he couldn’t breathe 12 times and responded to him in words but continued to forcibly restrain him regardless. It is common knowledge that death can be caused by suffocation. The act of ignoring his screams for help was a breach of their duty to ensure that no more than reasonable force was administered to prevent serious harm or death.

We believe all six members of the IAT should be charged with murder or alternatively negligent manslaughter, as they recklessly exerted excessive force with the knowledge that suffocation causes death and was a probable outcome.

- 2 Justice Action urges that the actions that led to the killing of David Dungay, including those committed by individual officers, as listed on pages 29-31 of this submission, be referred to the DPP for criminal investigation.
- 3 In case the Coroner decides not to refer the case to the DPP, Justice Action recommends that the guards of the IAT be removed from any position which would require them to exert physical force on a prisoner.

This recommendation is made with a view of ensuring that Corrective Services and Justice Health uphold their duty of care to protecting detained Australians.

- 4 Justice Action also recommends that families of deceased prisoners are informed of their right to seek Legal Aid for civil claims against corrections officers for possible breach of duty of care.

De-escalation of the Crisis

²² Deputy State Coroner Derek Lee (n 23) para 230.

²³ Ibid para 231.

- 5 Recommend that it is made mandatory for Justice Health nurses, other Aboriginal inmates or an Aboriginal staff member to be called in during times of crisis to ensure the prisoner's welfare and to liaise with Corrections and Justice Health officers to achieve safe outcomes.

In David's case, there was no attempt to de-escalate the tension and discuss the concerns with others, including other prisoners. The total absence of any prisoner witnesses at the inquest despite all the cells in G Ward being fully occupied showed the prison's contempt for its prisoners. This also meant that evidence of other prisoners wasn't received about the availability of the Aboriginal Inmate Delegate as required in the Custodial Operations Policy and Procedures (11.3)²⁴ or the Inmate Development Committee as required by the Operations Manual.

There should be a requirement that prisoners from those Committees be trained and be asked to assist other prisoners in the situation that David faced. The training should be similar to that of peer workers in the mental health area with specific violence prevention training. There should also be a requirement for families to be notified and offered the opportunity to talk or skype the disturbed prisoner to assist in the de-escalation.

- 6 Recommend the prohibition of the use of face down restraint techniques and 'knee-ride' techniques in all NSW prisons and in all Australian prisons²⁵;
- 7 Recommend training for Corrective Services officers not simply on the risks of asphyxia but also a range of de-escalation and negotiation alternatives, including calling in Aboriginal officers or inmates who can talk with the detainee. They should also be taught that force is to be expressly ruled out unless as a demonstrable 'last resort';
- 8 We recommend that guards in all cases be directed to respond to any inmate's requests for help in situations of asphyxiation, trauma and other life threatening conditions. Not to respond to cries for help may be construed as an indication of negative bias or harmful intention towards a prisoner, or as evidence of a deliberate and intentional act to not revive or resuscitate a prisoner.
- 9 Set a timeline in which the above mentioned training should be provided to all relevant staff. Direct the Commissioner of Corrective Services to request a formal progress report every month until training is completed. Unless staff complete the training, they should not be approved and rostered for work;

²⁴ Corrective Services of NSW, *Custodial Operations Policy and Procedures* (Policy and Procedures, December 2017).

²⁵ Recommendation 163; Royal Commission into Aboriginal Deaths in Custody, 1991

Process of Change

- 10 Recommend the establishment of an independent process to be identified or created, to be used to investigate all deaths in custody. Independence is required to ensure an accurate record of any incident scene, and, hence, an accurate determination of all contributing factors
- 11 Recommend that prison hospitals in NSW should ensure that experienced and well qualified medical staff be available onsite at all times, not just during 9-5 on weekdays.
- 12 Require all staff employed in any IAT and any Corrective Services and medical staff in Long Bay Prison, G Ward (or a comparable ward where interagency cooperation is involved) be required to have emergency resuscitation qualifications and experience. In addition they should be trained in 'Red Flag' or 'Emergency Signs of Distress'.
- 13 Ensure medical staff in G ward have a proven high level of competency, and substantial employment history in emergency response and CPR delivery (including equipment use). There needs to be policy input from Attorney-Generals to introduce work practices and salary compensation to make the job more attractive to employees. This could be done, for example, by including penalty rates that provide extra pay in consideration of the traumatic nature of the work and by limiting the terms of contracts given to staff in order to prevent the development of workplace stress disorders. All staff working in the hospital area need face to face mentoring and supervision as is already common practice with psychologists and social workers working with challenging patients or in detention areas.
- 14 Recommend that clear lines of authority are established between Justice Health staff and Corrective Services.
- 15 Recommend that IAT are not to conduct cell transfers for people with medical conditions unless requested and supervised by a doctor.
- 16 Recommend a clear delineation of responsibility for Corrective Services and Justice Health to ensure those responsible for arranging external hospital appointments are identified and subject to supervision to ensure deadlines are reached.
- 17 Recommend that the Working Committee include prisoner representatives as part of the interested stakeholders. Despite David's death, Corrective Services showed a lack of responsiveness to the death of David Dungay by failing to tell staff of the risk of positional force causing death until 19 months later²⁶. This showed its lack of concern for the safety of prisoners despite its obligations. This requires the Coroner to recognise

²⁶ Deputy State Coroner Derek Lee, *Closing Submissions of Counsel Assisting: Inquest into the Death of David Dungay – Case No. 2015/00381722* (Coroners Inquest, June 2019) para 188.

the difference in power relations and the right to respectful treatment in a structural way. Without prisoner input on the right to life and health, the sector most affected is ignored and disenfranchised. The Coroner would be complicit in the same behaviour to ignore the need for structural involvement by prisoners themselves.

- 18 Disband the current interagency Working Committee, and establish an independent body of clinical experts, that includes advocates, a policy worker from the NSW Attorney-General's office and peer workers, to develop these interagency operational procedures.
- 19 Recommend that, in accordance with a recommendation of the Royal Commission into Aboriginal Deaths in Custody, an Aboriginal Inmate Committee (AIC) is to be established and remain active at every correctional centre, unless an exemption is granted by the Assistant Commissioner, Custodial Corrections (ACCC). The AIC is a representative body of Aboriginal inmates and an integral part of correctional centre management. An Aboriginal Inmate Delegate (AID) will be appointed as the secretary of the AIC. The AIC is a Corrective Services NSW (CSNSW) initiative that affirms its commitment to support Aboriginal inmates to desist from reoffending, and acknowledges their family contact and cultural needs. The AIC does not address individual inmates' personal issues. Aboriginal inmates in need of assistance can seek the help of the AID.²⁷
- 20 Recommend that the use of solitary confinement (time-out) be discontinued²⁸ as a form of management;
- 21 Recommend that prison instructions require that its guards should interact with detainees in a manner which is both humane and courteous, at all times. Prison authorities should regard it as a serious breach of discipline for an officer to speak to a detainee in a deliberately hurtful or provocative manner²⁹
- 22 Recommend that a training video be made based on the circumstances of Mr Dungay's death and use the footage of his death, to teach Corrective officers a number of skills including:
 - not to make uninformed assumptions about prisoners with medical conditions,
 - that a person who is suffocating can still speak,
 - not to use the knee ride and face down techniques,
 - how to use a ventilation tube, and
 - samples of positive interventions demonstrating the role of the Aboriginal Inmate Delegate (AID) or Aboriginal staff members who can be brought to talk to the prisoner in times of crisis, and the positive results gained when this was

²⁷ <https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-development-committees.pdf>

²⁸ <https://www.hrlc.org.au/opinion/the-legality-of-solitary-confinement-and-the-direction-australian-policy-should-take>

²⁹ Recommendation 134; Royal Commission into Aboriginal Deaths in Custody, 1991.

previously used with David.

- 23 Recommend that Corrective Services make further efforts to recruit Aboriginal staff not only as correctional officers but also to all employment classifications within Corrective Services³⁰.

It is to be noted that only 5.4% of corrections officers employed within corrective services in NSW identify as Aboriginal. NSW says that this has already surpassed their goal of 2.6%, but it does not accurately address the fact that 28% of people in Australian prisons are Aboriginal. There should be a designated number of Aboriginal staff per number of Aboriginal prisoners.

- 24 Justice Action recommends that findings and lessons be circulated nationally to corrective officers in all states and territories such as the “Vagg Case” from another jurisdiction.

David’s Entitlement to Development

- 25 Recommend that prisoners are given positive development while incarcerated. The evidence of David being refused parole because he hadn’t undertaken programs meant that he remained in prison without any positive input. His continuous disempowerment was in evidence despite his youth and short record of offending.

He was 18 years old and had a period of criminal behaviour for only two months before entering custody. He stated that he did not wish to be forcibly medicated and wanted to settle down. His family was continuously in support. There was no evidence that David was offered any programs or jobs that interested him. Instead, there was evidence of continual disempowerment by custodial and health staff who were not culturally aware or sympathetic.

The evidence and the video recordings showed that he wasn’t respected in any way, and that the culture of the prison and health authorities was totally unsympathetic to him. The removal of his rice crackers, which he paid for with his own money, was a part of that disrespect. He was outraged as would be any person.

Corrective Services should be obligated to engage prisoners, particularly indigenous prisoners, their families and their community in their development. Programs should be flexible enough to meet the requirements of the State Parole Authority. External providers, such as the indigenous community, should be encouraged to assist in the prisoner’s development as well.

- 26 Recommend that prisoners are given psychological support while incarcerated. Considerable evidence was given regarding the contradictory psychiatric assessments on David’s condition. His family did not accept that he had a mental illness and did not

³⁰ Recommendation 178; Royal Commission into Aboriginal Deaths in Custody, 1991

want the forced medication to be applied on David.

David's diabetes from an early age meant that he was trained and well able to care for himself, with the assistance of his mother Leetona. If he had been given assistance, he could also have gained confidence in his ability to cope with the stresses of prison life. No psychologist offered him continual guidance in CBT. Instead, he was so disempowered that his diabetes vulnerability became the focus of his empowerment. This had the opposite effect of what is said to be intended.

Justice Health became his enemy with their forced medications. It affected his ability to function as a man – sexually and even to think. He should have had the respectful handling of a mentor and the cultural support expected for a young indigenous person.

Evidential Proposals

- 27 Include all evidence including CCTV video evidence and the post-mortem photographs taken by Mrs Dungay, in the final report which will then be made publicly available.
- 28 Release the CCTV evidence and the recording of Mr Dungay's last conversation with his sister, made a few hours before he died, to Mr Dungay's family.
- 29 Make a specific finding on the causes of damage to Mr Dungay's body, including but not limited to any damage to the cranium, head or brain, and bruises to the back, neck and face.
- 30 Make a specific finding on what damage was done to Mr Dungay in the first cell, and whether Mr Dungay was already close to death at the time he was being assaulted and dragged out by the IAT.
- 31 Make specific findings on the exact circumstances in which the death of Mr Dungay occurred, including whether or not Mr Dungay's rights under the NSW Mental Health Act were violated, as discussed under section 4.2 (b) *Legal Liabilities, Mr Dungay's rights under the 2007 NSW Mental Health Act* at page 24 of this submission.
- 32 Direct that all images of the deceased be placed on record within the documentary evidence and the neuropathology report referred to by the autopsy report (for any evidence of brain trauma that may be indicative of physical abuse before he died) to be placed into the post-mortem report;
- 33 Recommend that the Royal Commission recommendations referred to in this submission, and the attached report (Appendix 1) be implemented into Corrective Services and Justice Health policies and practice.
- 34 Recommend that AFP guidelines and the *Corrective Services Operations Manual* be

revised to properly incorporate recommendation 124.³¹ Incorporating this recommendation would ensure de-briefing procedures are more rigorous and may prevent future incidents.

3 PREVENTATIVE ASPECTS

3.1 David Dungay's Health Issues

Growing numbers of physically and mentally ill people entering prison is a worrying trend that is currently occurring throughout the Western world.

There will be ongoing problems in Australian prisons until more money is invested in human resources within prisons, including psychiatric care of prisoners and increased training and support services for staff.³² Corrective Services officers are on the frontline of responding to prisoners who need mental health care. Yet most don't have the capacity to provide adequate healthcare and some simply do not have the inclination.³³

a) Medical failures contributing to Mr Dungay's death

After Mr Dungay's death, it was recognised by New South Wales Correctional Services that extremely inadequate medical practices contributed to his death. These practices included Dr. Ma stopping chest compressions for periods of up to eight minutes,³⁴ and nursing staff inserting a ventilation device with the cap still on.³⁵ Recommendation 161 of the RCIADIC stated the importance of accessibility to proper medical attention for Indigenous peoples in custody.³⁶ Resuscitation as a priority is also set out in recommendation 158 of the RCIADIC.³⁷

Dr. Ma's failure to resuscitate at regular intervals demonstrates that while internal procedures have theoretically implemented this recommendation, there was a disconnect in the practical delivery of it. In Mr Dungay's case, Corrective Services officers did promptly attract the aid of a medical practitioner once Mr Dungay was nonresponsive, as stated in recommendation 136 of the

³¹ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

³² <https://www.themonthly.com.au/issue/2018/april/1522501200/bronwyn-adcock/sick-inside>

³³ <https://www.themonthly.com.au/issue/2018/april/1522501200/bronwyn-adcock/sick-inside>

³⁴ Lorena Allam et al., 'David Dungay inquest: mother's moving demand for justice over son's death', *The Guardian* (online at 8 March 2019) <<https://www.theguardian.com/australia-news/2019/mar/08/nsw-corrections-apologises-to-family-of-david-dungay-for-custody-death>>.

³⁵ Helen Davidson, 'David Dungay inquest: nurse contradicts testimony from corrections officer', *The Guardian* (online at 4 March 2019) <<https://www.theguardian.com/australia-news/2019/mar/04/david-dungay-inquest-nurse-contradicts-testimony-from-corrections-officer>>.

³⁶ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

³⁷ *Ibid.*

RCIADIC.³⁸ However, as previously noted, there were three failures to provide Mr Dungay with adequate medical attention: when he began and continued to complain the he couldn't breathe; when he was forcibly injected; and finally, when the staff failed to deliver effective CPR actions.

During the inquiry, Nurse Zhu had stated there was evidence that there were numerous nursing requests for Mr Dungay attend an 'urgent' medical specialist appointment for approximately two weeks. This brings into serious question the communication barriers to deliver necessary medical activities to a patient. Who was responsible for organising for Mr Dungay to attend his treatment?

We still do not know why Mr Dungay was not delivered to the Prince of Wales Hospital medical specialist to address the diabetes related degenerative problems that had developed since his incarceration. We do not know if the communication breakdown was with medical staff, or Corrective Services staff.

Justice Action recommends a new management of diabetes and other complex medical conditions be developed to avoid prisoners being subjected to high-risk medical treatments. Diabetes management in prisons should be designed in tandem with independent specialists such as Diabetes Australia and leading diabetes consultant specialists. Discussions with these organisations should be centred around risk factors that arise during incarceration such as food quality in prisons and the lack of ability to exercise. Justice Action also recommends a review of medicine delivery, and advises that injections of sedatives should be a last resort and should only be done with the patient in a safe position as determined by medical staff.

Justice Action recommends that the New South Wales government implement proper systems of liaison between Aboriginal Health Services and police to ensure the effective transfer of information relevant to the health, medical needs and risk status of Aboriginal persons taken into police custody.

While there have been concerns for detainee confidentiality, this could be addressed through the implementation of protocols for the safe transfer of sensitive information about Aboriginal detainees.³⁹ Furthermore, intensive and regular training by both corrective officers and medical staff should be implemented and monitored by the State to ensure the medical emergency procedure is followed.

b) The Working Committee NAME

The Working Committee was created by Justice Health and Corrective Services staff to specifically address and redress the joint failures in the duty of care identified in this case so far. It also sought to create standards of procedure in relation to forced medication and restraint. Main lines of questioning in the inquest highlighted the fundamental inadequacies of the two 'Local Operating

³⁸ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

³⁹ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5, 130.

Procedures' (LOPs) documents created by the committee. References to the 'Safety Huddle' or 'Risk Briefing' were unclear in their substantial aims and benefits over current practices. G Ward practices should immediately be reset to be in line with NSW Health policies.

The effective management of diabetes (and 'complex' or multiple health problems) including the adequate provision of exercise, diet and stress management, was not sufficiently addressed by the Working Committee Inquiry. Unless authorities reform our custodial policies and address compliance with standards of care that are enshrined in our International commitments such as the *The United Nations Convention on the Rights of Persons with Disabilities* certain populations will remain vulnerable to poor treatment and care.

The Working Committee has stated that between 9am-4pm on weekdays, the medical staff will be decision makers regarding the Rapid Tranquilisation Policy, the Emergency Sedation Policy and the delivery of forced injections. However, there is yet to be a development of a protocol of mutual working relations, the responsibility for patients/prisoners, and the use of forceable injections. Emergency specialist Professor Brown stated in the inquest that if medical staff had directly observed and made a medical emergency assessment on Dungay, his death may have been prevented.

If unresolved, this leaves open the unacceptable risk of such deaths still occurring specifically in the hours outside standard working hours, which account for 138 hours per week.

c) Inefficiencies in the Committee NAME

The delay in implementing new practices since Mr Dungay's death in 2015 highlights the committee's inefficiency in resolving ineffective operational procedures and training programs. Alternative restraint methods or degrees of restraint were limited in achieving reform in operational procedures to match the rhetoric of 'least restrictive practice' or restraint as a 'last resort'. The term 'time out' (solitary confinement) was used but not explained, and left open the risk that regressive and contentious matters like focussing on 'segro' or isolation in cells may be misinterpreted and used as positive management methods⁴⁰.

A positive step by the Committee was the decision to introduce 'audits' into training. However, how, when and what would be audited, and who would be privy to the audits of the training and 'simulation process' were not articulated in detail or discussed. There is considerable concern for the broadly proposed 'simulation process', which is the Committee's basis for future training programs and operations manual. The Australian government has a website⁴¹ which gives standards, processes and guidance for federal and state organisations who need to ensure efficient training for staff.

⁴⁰ <https://www.hrlc.org.au/opinion/the-legality-of-solitary-confinement-and-the-direction-australian-policy-should-take>

⁴¹ <https://training.gov.au/Training/Details/BSBLDR805>

Justice Action is disappointed that the Dungay family's request for Mr Ellis to speak on behalf of the working committee was rejected, and that little was discussed of the practical application or clinical expertise necessary to informing good operational practices. As stated prior, Mr Godfrey, had repeatedly stated that he was not the correct person for many questions. The Coroner conceded he was not an appropriate witness. This also resulted in other witnesses for Mr Dungay's case not being able to present evidence.

Much of the questioning of the interagency working procedures between Justice Health and Corrective Services revealed the same gaps and problems, with the exception of modest gains in medical officer team leader roles in consultation and the need for direct observation. The 'simulation process' was so vague it appeared to be leaving all future Coronial Inquiries with the responsibility to advocate and write operational manuals. Counsel assisting the Coroner concluded that there was little to no evidence of the fundamental practicalities of operations practices being addressed or rectified by the Committee.

The evidence provided by two members of the Working Committee failed to demonstrate that critical issues about the working relationship and operational procedures protocols between the two entities had been rectified. There seemed to be a range of open-ended conceptions of the 'simulation process', none of which specifically addressed the failure presented to the Coroner.

Outstanding matters remain in relation to both timeliness and the redesigning of inherent faults in operational procedures between the entities. Many – if not all - of the core faults that were revealed appear to remain grossly underdeveloped by this working committee, and it is unclear how this strategy will succeed.

3.2 Risk Training

The RCIADIC emphasises the training of officers in approaching risk situations.⁴² Regarding possible harm to Aboriginal detainees, recommendation 133 advises that appropriate training is to be provided to assist officers in identifying persons who are at risk of death or injury, including through self-harm or illness.⁴³ While a review of the implementation of RCIADIC's recommendations found that appropriate training is fully provided by the Commonwealth and New South Wales Governments,⁴⁴ the organisational failures of Dungay's case demonstrate that there is either a need for retraining or a need for greater emphasis on training and inmate interaction.

The aggressive manner in which Dungay was treated also demonstrates a failure to follow recommendation 134 of the RCIADIC that advocates for Aboriginal detainees to be treated

⁴² *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5, 130.

⁴³ *Ibid.*

⁴⁴ Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 260-1.

humanely and courteously.⁴⁵ We recommend that the failure to do this in the case of David Dungay should be treated as a serious breach of discipline and negligence of duty of care. We also recommend that ethics training be provided to help prevent future altercations. In addition to this, Justice Action recommends that corrective officers be held accountable for negligence and breaches of their duty of care.

Recommendation 130 of the RCIADIC holds that the training of prison officers should be designed to alert them to the risk of Aboriginal people in their care suffering from illnesses and other health conditions.⁴⁶

Justice Action recommends that officers should be trained to enable them to identify persons in distress or at risk of death or harm due illness, especially if the medical staff is not in attendance. As in other industries, it is the responsibility of staff to undertake the necessary 'Red Flag' or 'emergency Signs of Distress' training. The Coroner should direct that the Corretive Services Custodial Operational Policy and Practice Manual' consider these as immediate changes and set a clear timeline for implementation.

3.3 Peer Support

There is extensive evidence to support the notion that social interventions reduce feelings of isolation in prisoners, improves their behaviour while incarcerated and ultimately aids in their integration into society upon release.⁴⁷ Additionally, consistent social interaction improves prisoners' ability to communicate with prison staff and reduces tensions between the two parties.⁴⁸ Therefore, it is not surprising that the RCIADIC made several recommendations founded on this premise.

As recommended by recommendation 144 of the RCIADIC, Indigenous detainees should not be placed alone in police cells, and ideally should be placed with other indigenous detainees.⁴⁹ The RCIADIC also stated that where placement in a cell alone is necessary, careful surveillance should be undertaken to support the detainee.

At a Commonwealth and state level, this recommendation has been reported as being fully implemented.⁵⁰ Hence, Justice Action asks why David Dungay was on his own prior to his death?

In addition to this, Justice Action recommends that inmate support should be implemented in

⁴⁵ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁴⁶ *Ibid.*

⁴⁷ Joshua C. Cochran and Daniel P. Mears, 'Social isolation and inmate behaviour: A conceptual framework for theorising prison visitation and guiding and assessing research' (2013) 41 *Journal of Criminal Justice* 252.

⁴⁸ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁴⁹ *Ibid.*

⁵⁰ Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 280-281.

situations where support is required to put the detainee at ease, or where guidance is necessary for disciplinary reasons. The presence of a fellow inmate, rather than complete isolation, may create a situation where the detainee will be more responsive, and less likely to be victimised.

Again, Justice Action submits that an Aboriginal Inmate Delegate (AID) as identified in Custodial Operations Policy and Procedures (11.3)⁵¹, should be made available to assist Aboriginal inmates where required.

3.4 Community Support

Recommendation 145 states that police should take all reasonable steps to both encourage and facilitate visits by family and friends of persons detained in police custody.⁵² Providing family support to prisoners is advantageous in limiting prison incidents and increasing positive outcomes. Indeed, as Hobbs affirms, 19.7% of self-harm prisoners reported that being separated from family was their greatest concern in prison.⁵³ Justice Action recommends a liaison of Indigenous officials or Aboriginal welfare officers with Indigenous prisoners to create a communal sense of belonging and support between families, community and the inmate. It is through such support that a detainee's wellbeing will improve.

In this instance, corrective officers should have rung Mrs Dungay and allowed her the opportunity to talk or skype with David before the IAT team intervened.

3.5 De-escalation

Recommendation 163 says prison officers should receive regular training in restraint techniques, including the application of restraint equipment.⁵⁴ The Commission further recommends that the training of prison and police officers in the use of restraint techniques should be complemented by training that positively discourages the use of physical restraint methods except in circumstances where the use of force is unavoidable. Academic research has strongly suggested that restraint is inherently dangerous to detainees regardless of the method or duration.⁵⁵

On previous occasions, when prison staff needed to talk with Mr Dungay about his blood sugar levels, Justice Health nurses, other Aboriginal inmates and an Aboriginal delegate were able to speak to him and calm him down⁵⁶.

⁵¹ <https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-development-committees.pdf>

⁵² Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the Recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 280-81.

⁵³ Gaynor S. Hobbs, 'Prisoners: Use of Social Support' No 1, *Theses: Doctorates and Masters* (2000) 6.

⁵⁴ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁵⁵ Joy Duxbury and Frances Aiken and Colin Dale, 'Deaths in Custody: The Role of Restraint' (2011) 2(4) *Journal of Learning Disabilities and Offending Behaviour* 178-89, 185.

⁵⁶ <https://www.abc.net.au/news/2018-07-16/david-dungay-inquest-begins-as-harrowing-video-played/9997930>

Justice Action submits that this option should have been applied on 29 December 2015 in addition to obtaining medical advice in order to determine whether David eating a biscuit was a medical emergency.

Furthermore, recommendation 182 states that instructions should require that, at all times, correctional officers should interact with prisoners in a manner which is both humane and courteous.⁵⁷ Corrective Services authorities should regard it as a serious breach of discipline for an officer to speak to a prisoner in a deliberately hurtful or provocative manner.⁵⁸

We recommend that guards in all cases be directed to respond to any inmate's requests for help in situations of asphyxiation, trauma and other life threatening conditions. Not to respond to cries for help may be construed as an indication of bias or harmful intention towards a prisoner, or as evidence of a deliberate and intentional act to not revive or resuscitate a prisoner.

4 ACCOUNTABILITY MECHANISMS

4.1 Gathering Evidence and Information

a) Recording Information

Recommendation 138 of the RCIADIC states that the information regarding complaints, requests or behaviour relating to mental or physical health be adequately recorded in relevant journals.⁵⁹ This recommendation was made to ensure that changes in the health and medical conditions of detainees could be better identified and, therefore, the detainee's needs could be adequately met. Additionally, this recommendation aimed to improve the accountability of prison staff.⁶⁰

The failure to record medical information was paramount in the death of David Dungay. A substantial miscommunication had occurred in conversations between Dr Trevor Ma, Nurse Maharja and Corrective Services staff. This miscommunication involved the management of Mr

⁵⁷ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁵⁸ *Ibid.*

⁵⁹ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁶⁰ Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 270.

Dungay's diabetic condition, the sedative given on the day of his death, and the movement from a non-camera cell to a camera cell.⁶¹

David Dungay experienced a deterioration of his condition while he was incarcerated. The fact that he was not taken to necessary appointments is an indicator of the substantial gap in medical care for prisoners as compared to the standard of care afforded to other Australians in unlocked hospitals.

b) Debriefing Sessions

Recommendation 124 establishes procedures for the conduct of debriefing sessions that occur following incidents such as deaths, medical emergencies and actual/attempted suicides.⁶² This recommendation is reported as being fully implemented by the Federal and State Governments.⁶³ In New South Wales specifically, it is implemented within the *NSW Police Force Handbook and Custodial Policies and Procedures*.⁶⁴

However, the Australian Federal Police (AFP) guidelines fall short of the 'reflection' component of adequate debriefing, as sessions and mechanisms for incorporating 'lessons learned' have not been formalised.⁶⁵ Therefore, the AFP displays an unwillingness to initiate reforms that will create more effective programs and procedures. Such reforms would ensure the welfare of both Corrective Services officers and prisoners.⁶⁶ Standard protective procedures should exist in all jurisdictions.

4.2 Legal Liabilities

a) Criminal Liability

Corrective Services staff recognise that they owe a legal duty of care to persons in their custody. The standing instructions to the officers of these authorities specify that each officer involved in the arrest, incarceration or supervision of a person in custody has a legal duty of care to that person. They may be held legally responsible for the death or injury of the person caused by a breach of that duty. These authorities ensure that such officers are aware of their responsibilities and are trained appropriately to meet them, as prescribed under recommendation 122 of the RCIADIC.⁶⁷

As written in recommendation 123, instructions should be understood by all officers and should be

⁶¹ Justice Action, *Report on Inquest 4 March 2019* (Online Report, March 2019).

⁶² *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁶³ Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 240.

⁶⁴ *Ibid* 240-41.

⁶⁵ Australian Federal Police, *AFP National Guideline on persons in custody and custodial facilities*.

⁶⁶ Department of the Prime Minister and Cabinet, Parliament of Australia, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody* (Parliamentary Final Report, October 2018) 240.

⁶⁷ *Ibid*.

available to the public.⁶⁸ While benchmark guidelines have been implemented at a state and federal level, the aggressive approach taken by Corrective Services officers, and the organisational failures that occurred in the case of David Dungay have not resulted in punishments being given to any custodial officers. Justice Action suggests that recommendations 122 and 123 of the RCIADIC be implemented in a practical manner that allows misconduct to be effectively identified and rectified.

Justice Action also recommends that families of deceased prisoners are informed of their right to seek Legal Aid assistance for civil claims against corrections officers for any possible breaches of their duty of care.

b) Mr Dungay's rights under the NSW Mental Health Act 2007

The NSW Mental Health Act of 2007, in Chapter 4, 'Care and Treatment' Part 1 'Rights of patients or detained persons and primary carers', Division 1, outlines the principles for care and treatment, that includes point 68 (a) within a context of 'least restrictive' practice :

that people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given⁶⁹.

Subsection 69 of the Act continues, stating that it is an offence to ill-treat patients:

'An authorised medical officer, or any other person employed at a mental health facility, must not wilfully strike, wound, ill-treat or neglect a patient or person detained at the facility under this or any other Act.
Maximum penalty: 50 penalty units or imprisonment for 6 months, or both.'⁷⁰

Witnesses heard that Mr Dungay was diagnosed with a number of medical conditions while in prison – 'unstable diabetes', obesity, childhood asthma, degenerative effects of diabetes, and a mental disorder - either as an acute, temporary response to the mental and behavioural effects of his diabetes becoming unstable, or due to symptoms attributable to a diagnosis of Schizophrenia. As an incarcerated patient prone to a mental disorder⁷¹, his care and treatment comes under this Mental Health Act. Therefore, those whom the Coroner may deem to have acted with medical neglect or ill treatment would be subject to claims in relation to the stated penalties of misconduct.

Under sections 6.3, 'Inmates health needs', and 13.2 'Medical Emergencies', version 1.0 of the Custodial Operations Policy & Procedures Intranet page , the current NSW Justice Health Policy

⁶⁸ *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5.

⁶⁹ <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf> page 28

⁷⁰ <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf> page 28

⁷¹ <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf>
Definition of a Mentally ill or a Mentally disordered persons is defined on page 7

expressly details that ⁷²:

A - JH staff must ensure the same standard of healthcare is provided to inmates;

B - the first responding officer is responsible to call for urgent medical assistance or ambulance, and to provide first aid and CPR until other personnel take control;

C- Immediately following a call for urgent medical assistance, that first aid must be provided to an inmate, and if there is more than one officer present, one officer must commence first aid while the other calls for medical assistance. That officers must start Cardiopulmonary Resuscitation if the inmate is unresponsive and not breathing normally, until JH & FMHN personnel or paramedics arrive to take control.

This does not apply if the inmate is a patient in a hospital ward, where Corrective Officers must assist if requested⁷³;

D- The governor of the correctional centre is responsible for ensuring that the health centre provides essential medical services to inmates within the correctional centre.

As an incarcerated patient suffering a mental health condition⁷⁴, Mr Dungay's care and treatment comes under the Mental Health Act. The events which led to Mr Dungay's death are indicative of the medical incompetence, inaction and errors which may be subject to claims under the Mental Health Act.

The CCTV recordings show Mr Dungay being treated extremely poorly by prison guards. The legislation is clear: an authorised medical officer, or any other person employed at a mental health facility must not wilfully strike, wound, ill-treat or neglect a patient or person detained at the facility under this or any other Act. The maximum penalty is 50 penalty units or imprisonment for 6 months, or both.⁷⁵

c) Responding to criminal actions and misconduct

The NSW government can charge prison guards for misconduct. While rare, there have been cases where custodial staff have faced consequences for misconduct⁷⁶.

⁷² See of the Custodial Operations Policy & Procedures Intranet page 4

<https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-health-needs.pdf>

⁷³ <https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-health-needs.pdf> See 1 'First aid and medical assistance', section 1.1, 'Call for urgent medical assistance'; plus section 1.2 'Providing first aid', In, version 1.0 of the Custodial Operations Policy & Procedures Intranet page 4

⁷⁴ <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf>

Definition of a Mentally ill or a Mentally disordered persons is defined on page 7

⁷⁵ <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf>

page 28

⁷⁶ <https://www.9news.com.au/national/cop-killer-kempsey-jail-inmate-sexual-relationship-with-prison-guard-assault-glenn-mcenallay/0cc511b6-067e-48ee-a5ad-cd1234ba4e38>

Justice Action requests that the Coroner seriously consider how to address the pre-existing culture that perpetuates potentially criminal irresponsibility and a lack of accountability in those who are given the power to ‘care’. Those who not only fail standards of humanitarian care, but who perpetrate acts of violence on prisoners, should be referred – and Justice Action urges that you do so - to the Director of Public Prosecution. The DPP can then consider conducting its own investigation to determine whether the officers who killed Mr Dungay should be charged.

d) Human Rights Failures

Racism is a concern for Aboriginal and Torres Strait Islander people both in prisons and hospitals. The media is reporting on how our NSW health and justice systems are embedded with ‘implicit racism’^{77 78} where unconscious biases and stereotyping of Aboriginal people result in discrimination and prejudice, often with life-threatening and fatal results^{79 80 81}. This includes the recognition of mortality rates, health outcomes, and breaches to custodial as well as to medical practices that are far from the expected standard of care.^{82 83}

Dr Tim Southphommasane, who advocated his concern for the perpetuation of racism by our institutions, concurs that: ‘Racism’s invisibility is in health and in justice system. When we cannot see systemic racism, this is also a form of racism’.⁸⁴ Hence, we must take proactive steps to reduce the over- inclusion and suffering, and substandard medical care of aboriginal people within the justice system.

In March of 2018, Fiona McLeod, the outgoing head of the Law Council of Australia, said ‘over-incarceration rates of Indigenous Australians pointed to a failure in both imagination and political will’.⁸⁵ This unflinching condemnation of the Government’s handling of Aboriginal people in our justice system underscores the intransigence within our systems to deal with racism effectively.

Furthermore, in February, Human Rights Watch investigating prisons in Western Australia and Queensland wrote a report titled, ‘I needed Help, Instead I was Punished’. This report referred to

⁷⁷ <https://www.smh.com.au/national/nsw/our-system-has-implicit-racism-in-it-coronial-inquest-hears-20190313-p513xn.html>

⁷⁸ <https://www.sbs.com.au/nitv/nitv-news/article/2018/03/14/institutional-racism-evident-australian-justice-system> 14 Mar, 2018

⁷⁹ <https://www.smh.com.au/national/nsw/our-system-has-implicit-racism-in-it-coronial-inquest-hears-20190313-p513xn.html>

⁸⁰ <https://www.sbs.com.au/nitv/article/2016/03/25/no-more-room-prejudice-says-counsel-over-deaths-custody>

⁸¹ ABC Larissa Behrendt audio program interview to an expert panel ‘Addressing Racial Bias in the Health Services.’ 18/03/2019.

⁸² <https://www.legislation.nsw.gov.au/inforce/bb9dde66-bc52-ea95-89d4-8a3c5dd9507b/2007-8.pdf>

⁸³ https://www.washingtonpost.com/news/worldviews/wp/2018/04/16/australian-mother-recounts-tremendous-loss-after-mentally-ill-daughter-was-killed-by-police/?noredirect=on&utm_term=.a6db323b435c

⁸⁴ <https://www.sbs.com.au/nitv/article/2016/03/25/no-more-room-prejudice-says-counsel-over-deaths-custody>

⁸⁵ Southphommasane titled ‘On Hate and Race politics, Sydney Ideas USYD, 21 March 2019. Refer to recent book launched, Tim Soutphonnasane, ‘On Hate’, Melbourne University Press, 2019.

⁸⁵ <https://www.sbs.com.au/nitv/nitv-news/article/2018/03/14/institutional-racism-evident-australian-justice-system> 14 Mar, 2018

Aboriginal prisoners and those with a disability being at high risk of bullying, harassment, violence and abuse from prison officers⁸⁶. While ATSI people are 2% of the population they represent 28% of the adult prison population. The Human Rights Watch report also states there was strong evidence of racism towards Aboriginal and Torres Strait Islander inmates in 11 out of 14 prisons. An Aboriginal cultural liaison officer told Human Rights Watch that racism is 'alive and well in prisons'. Concerns were raised about the prisoner-carer model with Corrective Services by Human Rights Watch researcher, Kriti Sharma who stated 'having a disability puts you at high risk of violence and abuse'⁸⁷.

The Redfern Statement to the Federal Parliament in February 2017 was to facilitate the ninth 'Closing the Gap' report to parliament, and yet many expressed their disappointment at the lack of progress. The Royal Commission into Aboriginal Deaths in Custody, contained 339 well-considered recommendations, few of which have been acted on, none of which has been reported on. The incarceration rate for Aboriginal and Torres Strait Islander people was seven times that of other Australians when the commission completed its work 26 years ago; it is now 13 times the rate⁸⁸. Yet imprisonment rates for adult prisoners continue to increase by 4-6%, with NSW having the largest adult prisoner population⁸⁹.

A significant document is the 'Blueprint for change' written by the Law Society of NSW, which details great concerns regarding the over-representation of indigenous people in criminal justice system. It also notes that the impact of their incarceration is particularly critical. Statistics from the Australian Bureau of Statistics and BOSCAR NSW crime statistics and research reveal that between 2001 and 2015 the number of indigenous Australians in NSW prisons doubled and the rate of imprisonment rose by 40%. Therefore, the risk of aboriginal deaths in custody would also rise substantially⁹⁰.

4.3 Public Exposure

Unlike past deaths in custody, the Dungay Family have been able to maintain visibility in the public eye. They have made numerous, moving statements on Dungay's death, including:

"While in custody there is supposed to be a duty of care and I think that was not taken seriously with what they did to my uncle and we need to raise awareness, not just for Aboriginal deaths in custody, but for all deaths in custody," and that "We will not rest until

⁸⁶ <https://www.sbs.com.au/nitv/nitv-news/article/2018/02/07/indigenous-prisoners-and-those-disabilities-serious-risk-abuse-says-human-rights?cid=inbody:institutional-racism-%E2%80%98evident%E2%80%99-in-australian-justice-system>

'Indigenous prisoners and those with disabilities are 'serious risk' of abuse says Human Rights Watch.'

⁸⁷ <https://www.sbs.com.au/nitv/nitv-news/article/2018/02/07/indigenous-prisoners-and-those-disabilities-serious-risk-abuse-says-human-rights?cid=inbody:institutional-racism-%E2%80%98evident%E2%80%99-in-australian-justice-system> 'Indigenous prisoners and those with disabilities are 'serious risk' of abuse says Human Rights Watch.'

⁸⁸ <https://www.theaustralian.com.au/opinion/closing-the-gap-this-coolamon-carries-a-special-baby/news-story/a788b902ae8a3a644207816035244278>

⁸⁹ <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0>

⁹⁰ <https://www.lawsociety.com.au/sites/default/files/2018-03/Indigenous%20incarceration%20rates%20and%20justice%20targets.pdf>

the truth surrounding the death of our brother and son is known. We will not rest until those responsible are held to account'.⁹¹

Mrs Leetona Dungay was invited to speak at the HEAD ON photography festival, held in Sydney during 4-19 May 2019. Mrs Dungay spoke throughout the festival, at forums and at public showings of blown-up photographs of David's killing, at various venues around Sydney.

a) CCTV Video Evidence

Mrs Dungay has requested that the suppression of the video showing correctional officers attempting to resuscitate David Dungay be reversed. Her request was not accepted.

Since there were no parts of the scene that were specific to his person, for example, the video did not show Dungay having his clothes cut off his body, it is a matter of public interest that this suppression order be lifted, and the video be allowed for public viewing. Hence, Justice Action submits that the video is evidence and should be made available for the public record.

b) The case of *Lyji Vaggs*

The Queensland Coronial Inquiry into ADIC of Lyji Vaggs⁹² found that he had died in custody following failure to apply proper emergency equipment to revive Vaggs once he collapsed, being restrained by more than six staff, and being injected twice with an anti-psychotic sedative, died within 17 minutes. In an article titled, "Doctors out of their depth, inquest told", the Doctor responsible reported that 'It was a situation far beyond my control and I wasn't really sure what to do'. The Vaggs case⁹³ hearing preceded Dungay's death by one year, and brought to attention similar issues of:

- treatment Vaggs received weeks leading up to his death,
- the lack of engaging an Indigenous support person,
- how he came to be heavily restrained that he suffered from prone asphyxia,
- overworked and frightened staff (despite Vaggs being a voluntary admission),
- usage problems with emergency resuscitation equipment, and
- the appropriateness of the sedative medication⁹⁴.

Here, it was the life-threatening combination of prone asphyxia and drugs that also 'significantly contributed' to Vaggs' death. If the recommendations of Coroner Michael Barnes' two week inquest were heeded and responded to by NSW Corrective Services, Mr Dungay would be alive today. We recommend as such that judgements be circulated to authorities in all jurisdictions.

⁹¹ <https://www.smh.com.au/national/aboriginal-man-david-dungay-hills-death-in-custody-suspicious-family-20160119-gm95o7.html>

⁹² https://www.courts.qld.gov.au/_data/assets/pdf_file/0003/136605/cif-vaggs-l-20120221.pdf

⁹³ <https://www.theaustralian.com.au/national-affairs/vaggs-family-awarded-100k/news-story/abba121003b01e0dedd810f2e94ad506>

⁹⁴ https://aiatsis.gov.au/sites/default/files/docs/digitised_collections/the_koori_mail/510.pdf

c) Operational Procedures

The existing Operational Procedures (COPP) clearly place Corrective Services' First Responding Officer in charge - *until* control is taken over by medical personnel or paramedics. This Inquiry also heard the evidence by the Queensland Emergency Physician, Dr Brown, who concurred that if the restraint had not occurred then Dungay would likely not have died of a cardiac arrest due to oxygen depletion.

Furthermore the NSW Custodial Operations Policy and Procedures clearly refers to diabetes as a condition that inmates may also receive assistance for. While the Justice Health staff are to arrange for the transfer of an inmate, the Governor of a jail is responsible for particular aspects of the management of a 'diabetic inmate'⁹⁵ as well as for any visits booked for the day where an inmate is to be taken for medical treatment or a medical appointment and notifying next-of-kin or a ECP about such visits⁹⁶.

Justice Action requests the Coroner to refer matters regarding suspected breached of professional misconduct by Justice Health staff to the Department of Public Prosecution. This is required for justice to be afforded to Dungay and his family. This is also required to ensure protection of incarcerated patients. It would be of grave public concern if corrective services was seen to be assenting without protest or correction to its own staff engaging in breaches of its own policies and procedures, especially in light of how life-threatening breaches can be.

d) Considering the actions of individuals

From the evidence considered at this Coronial Inquiry, Justice Action now urges that Coroner Lee refer matters of potential criminal actions by Corrective Services and Justice Health staff for consideration by the Department of Public Prosecutions.

Firstly, we seek that key, responsible Corrective Services staff be referred for investigation, specifically the person known in this inquiry as Corrective Services Officer 'F'. Dr Brown agreed that if restraint had not occurred, that Mr Dungay would have not died of cardiac arrest. The 'contributory' effect of restraint by Corrective Services officers was severe. There was no acceptable reason for the IAT to hold Mr Dungay face down for a time that exceeded permissible limits.

Officer F

The Inquiry heard evidence that Corrective Services officer F had been responsible for initiating several key decisions and actions that contributed to Dungay's death. He called the IAT to initially

⁹⁵ <https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/inmate-health-needs.pdf> See 3.3 'Procedures', section 6.3, 'Inmates health needs', version 1.0 of the Custodial Operations Policy & Procedures Intranet page 6

⁹⁶ <https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/hospitalisation-of-inmates.pdf>

See 1.3 'Procedure for notification of emergency contact person', point 3, 'Hospitalisation of Inmates', version 1.0 of the Custodial Operations Policy & Procedures Intranet

intervene. He then decided there was 'no point' to engage an Aboriginal Officer. During last year's inquest, Officer F, who was the Acting Assistant Superintendent on the day Dungay died, denied the actions taken against the prisoner were excessive. He also said he initially didn't take Dungay's screaming seriously and thought he "could possibly" having been tricking them to try and get out of the restraint.⁹⁷

He failed in his duties to initiate any risk assessment or emergency sign check, despite signs such as Dungay saying repeatedly he couldn't breathe, prior to Dungay becoming 'unresponsive'. Officer F also initiated the cell extraction and transfer. His subsequent claims of there being legitimate medical reasons and medical directive was not substantiated in evidence. Furthermore, Officer F's claim that the transfer of Dungay was based on an actual risk of self harm had no substance.

Other officers

CSO A was the Corrective Services instructor who had not trained others nor himself on positional asphyxia risks.

Corrective Services officer B had positioned himself at the 'head' position to monitor Dungay's breathing, yet failed to respond to Mr Dungay's cries that he couldn't breathe.

Corrective Services officer C was responsible for the sustained compression of Mr Dungay's upper body caused by the knee-ride position that he used to hold Mr Dungay down.

Corrective Services officer 'G' directed nurse staff to urgently supply two medications, and also directed the form of its delivery to Mr Dungay to be as he lay in the prone position. It was CSO 'G' who also commented that 'If sedated, would make my shift a lot easier'.

Other considerations include the unnecessarily aggressive and premature engagement of the IAT and the fact that the considerable strain applied to Dungay's neck and head was clearly visible to the staff. The pressure on Mr Dungay's neck and torso had significantly contributed to Mr Dungay's restricted breathing.

It is clear that each guard had the opportunity to stop and step in so that David could breathe. But they chose not to respond to David's cries for help, instead, they engaged in what prisoners call a "killing".

Justice Action urges that Coroner Lee consider referring Corrective Services officers 'F', 'G', and 'C' to the DPP. Justice Action also asks why the video of what happened in the first cell was deleted by Corrective Services staff. It is not known how much of the damage to David's body was committed in the first cell.

⁹⁷ <https://www.9news.com.au/national/news-nsw-david-dungays-family-calls-for-justice-as-inquest-set-to-resume/13a19906-1ac2-41f1-98a0-98915ce38f6c>

Medical staff

Justice Action notes that the evidence suggests that the attending nurse in contact with Mr Dungay and the IAT failed to conduct any appropriate emergency medical assessment or 'Red Flag' sign. We also note that they stated they were afraid of the IAT and so did not intervene to ensure Mr Dungay received the immediate medical intervention that he needed to keep breathing.

It is significant that a medical professional did not stand up to decisions and actions of the prison guards who killed a prisoner. It may be indicative of a culture of fear in Justice Health, where medical officers may be intimidated by guards, just as prisoners are.

On the other hand, it may be that the medical staff were passive because of a lack of inclination to intercede and save the prisoner. It is for this reason that Justice Action requests that the Coroner recommend that the medical staff who failed to intervene against the guards, who failed to take the cap off the respiration tube, and thus failed to resuscitate Mr Dungay, also be referred to the DPP for investigation for their contribution to Mr Dungay's death, in order to determine if there was any criminal intent.

5 CONCLUSION

It would be tempting to regard this as a tragic accident caused by ignorance or incompetence. But this was not a peripheral result of well intentioned actions. The tragic death of David Dungay was one that could have been prevented. In order to prevent similar deaths in the future, Justice Action recommends that the RCIADIC is revisited and a renewed emphasis is placed on putting the Recommendations into action. Furthermore, we recommend ensuring that the procedures to do so are enshrined in the manual of Custodial Operations Policy and Procedures.

While legislation and procedures are important, they are ineffective if Corrective Services officers choose not to follow them. An important piece of evidence, the video recording of the treatment of David in the first room, was deleted by Corrective Services officers. Justice Action is concerned that actions by guards in the first room may have significantly contributed to David's death. Why was the video record destroyed? It is crucial that this question be answered.

Justice Action, and many in the legal community, are concerned with the culture of cover ups, intimidation and abuse in Corrective Services, which manifests itself through events such as the killing of David Dungay and the deliberate removal of evidence.

There is a cultural problem in Australian prisons, which needs to be addressed at the highest level. Individuals within the Department of Corrective Services need to be held to account. Not to do so is to allow them to continue acting outside the law.

Justice Action thanks Coroner Lee for considering this submission, and hopes that it will provide some assistance in his examination of these painful and difficult events: the preventable killing of David Dungay Jr and the ongoing crisis of Aboriginal deaths in custody.

APPENDIX A

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY 1991: David Dungay, an analysis.

An analysis of the recommendations made in the Royal Commission into Aboriginal Deaths in Custody, and how they may have affected the treatment of David Dungay.

ABORIGINAL DEATHS IN CUSTODY

2

THE ROYAL COMMISSION AND ITS RECORDS, 1987-91



Peter Nagle and Richard Summerrell

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INTRODUCTION

In 1987, The *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC) was established under the Hawke Government to investigate the deaths of Aboriginal and Torres Strait Islander people held in state and territory prisons. An increasing public concern regarding the frequency of, and lack of explanation for, Aboriginal and Torres Strait Islander deaths in custody prompted the Royal Commission.⁹⁸

The Commission examined all deaths in custody in each state and territory that occurred between 1 January 1980 and 31 May 1989. The actions surrounding each specific death were investigated, alongside how they may be prevented in the future. The Commission's terms of reference enabled it to consider a wide range of social, cultural and legal factors that may have been relevant to the deaths in question.⁹⁹

The RCIADIC Final Report was signed on 15 April 1991, and made 339 recommendations across 26 themes.¹⁰⁰ The recommendations were far reaching, and included the implementation of humane conditions in prisons, greater training for corrections officers, and improved accessibility to information for Aboriginal and Torres Strait Islander people.¹⁰¹

The responsibility for implementing the recommendations from the RCIADIC's covers the Commonwealth as well as the eight States and Territories in Australia. However, almost 30 years after the RCIADIC was finalized a recent review has found that only two thirds of the recommendations have been fully implemented across Australia.¹⁰²

This analysis will look at the status of recommendations made by the Commission and the implementation of specific recommendations and how they may have affected the treatment

⁹⁸ Dr Coral Dow and Dr John Gardiner-Garden, 'Overview of Indigenous Affairs: Part 1: 1901 to 1991', *Parliament of Australia* (Web Page, 10 May 2011)

<https://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/bn/1011/indigenouaffairs1>.

⁹⁹ *National Archives of Australia* (n 1); *Dow and Gardiner-Garden* (n 2). (Needs to be checked and formatted)

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

¹⁰² 'Review of the implementation of the Royal Commission into Aboriginal Deaths in Custody', Deloitte Access Economics, August 2018, page x-xi

of David Dungay who died in custody on December 29, 2015.

RECOMMENDATIONS AND THEIR LEVEL OF IMPLEMENTATION 2018

We submit the following recommendations and seek that the Coroner generate a Plan for Implementation of each of the recommendations.

A. Implementation by Jurisdiction

A 2018 review found that 78% of recommendations from the RCADIC have been fully or mostly implemented across all levels of government. 16% of recommendations have been partially implemented, and 6% have not been implemented at all.¹⁰³

The following table describes the percentage of RCIADIC recommendations that have been implemented by the Commonwealth and each state and territory.

Average Implementation of RCIADIC recommendations (by jurisdiction)¹⁰⁴

<i>Jurisdiction</i>	<i>Implementation of recommendations from RCIADIC (%)</i>
Commonwealth	74
New South Wales	74
Victoria	68
Queensland	72
South Australia	58
Western Australia	62

¹⁰³ ‘Review of the implementation of the Royal Commission into Aboriginal Deaths in Custody’, Deloitte Access Economics, August 2018, page x-xi.

¹⁰⁴ *Ibid.*

Tasmania	48
Northern Territory	60
Australian Capital Territory	68

B. Implementation of recommendations

The following section describes the RCIADIC recommendations determined relevant to the death of David Dungay by Justice Action. It also provides an update on the implementation of said recommendations across Australia.

It should be noted that the implementations below are based on a review which was published in 2015 and that a number of these may have changed based on a review released 2018.

1. Recommendation 122

That Governments ensure that:

- a. Police Services, Corrective Services, and authorities in charge of juvenile centres recognise that they owe a legal duty of care to persons in their custody*
- b. That the standing instructions to the officers of these authorities specify that each officer involved in the arrest, incarceration or supervision of a person in custody has a legal duty of care to that person, and may be held legally responsible for the death or injury of the person caused or contributed to by a breach of that duty; and*
- c. That these authorities ensure that such officers are aware of their responsibilities and trained appropriately to meet them, both on recruitment and during their service.*

Implementation

The implementation of a duty of care varies significantly across Australia. Guidelines in some jurisdictions establish a standard of care, but fall short of expressly setting out that a legal duty of care is owed by *each* Custodial Authority officer. It is difficult to see how the standard of care is to be achieved if ignorance of the actual legal duty of care and who owes that duty is present. Further, the guidelines do not link a breach of that duty to disciplinary or legal action.¹⁰⁵

¹⁰⁵ Change the record, 'Review of the implementation of the recommendations of the RCIADIC – May 2015' (Webpage May

Only implementing guidelines was deemed insufficient to achieve change and the RCIADIC also emphasised that training of Corrective Services Officers is needed. This has been implemented with differing degrees in each jurisdiction. Victoria has fully implemented this recommendation, and Queensland, the Northern Territory, New South Wales and Western Australia have partially implemented it. However, Tasmania, South Australia and the Australian Capital Territory have not published guidelines regarding this recommendation.¹⁰⁶

2. Recommendation 123

That Police and Corrective Services establish clear policies in relation to breaches of departmental instructions. Instructions relating to the care of persons in custody should be in mandatory terms and be both enforceable and enforced. Procedures should be put in place to ensure that such instructions are brought to the attention of and are understood by all officers and that those officers are made aware that the instructions will be enforced. Such instructions should be available to the public.

Implementation

Most States and Territories have not made full manuals of Custodial Authorities freely available to the public. Where standards have been made publicly available, they are loosely summarised or not clearly set out in one comprehensive document. This limits accountability to the public.¹⁰⁷

3. Recommendation 124

That Police and Corrective Services should each establish procedures for the conduct of de-briefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides so that the operation of procedures, the actions of those involved and the application of instructions to specific situations can be discussed and assessed with a view to reducing risks in the future.

2015) < <https://changetherecord.org.au/review-of-the-implementation-of-rciadic-may-2015>>, 313.

¹⁰⁶ Ibid, 316.

¹⁰⁷ Ibid, 311.

Implementation

This recommendation has been implemented differently depending on whether it relates to Police or Corrective Services. For Corrective Services the recommendation has been fully implemented in Queensland, the Australian Capital Territory and Western Australia. For Police it has been implemented in Western Australia but only partially in New South Wales, Queensland and Victoria.¹⁰⁸

4. Recommendation 130

That: a. Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;

Implementation

Specific legislation has been introduced in New South Wales, Western Australia, Queensland and the Australian Capital Territory to allow access to medical records by prisons, in accordance with privacy laws. Corrective services websites in Tasmania, Victoria, South Australia, Western Australia and the Australian Capital Territory refer to the Corrections Guidelines, which govern the provision of medical information in certain circumstances, subject privacy laws.¹⁰⁹

5. Recommendation 133

That: a. All police officers should receive training at both recruit and in-service levels to enable them to identify persons in distress or at risk of death or injury through illness, injury or self-harm

Implementation

No State or Territory has published detailed guidelines in connection with identifying health risks of detainees. However, failure to recognise medical conditions and injuries has been

¹⁰⁸ Ibid.

¹⁰⁹ Ibid, 347.

highlighted as a matter of concern in Australian Capital Territory and in Western Australia critical skills training (police life support) is compulsory and undertaken every two years by Police, Custody, and Commissioned officers.¹¹⁰

6. Recommendation 134

That police instructions should require that, at all times, police should interact with detainees in a manner which is both humane and courteous. Police authorities should regard it as a serious breach of discipline for an officer to speak to a detainee in a deliberately hurtful or provocative manner.

Implementation

This recommendation has been included in legislation or guidelines in Western Australia, South Australia, Victoria and New South Wales. It has partially been implemented in Tasmania and the Northern Territory.¹¹¹

7. Recommendation 138

That police instructions should require the adequate recording, in relevant journals, of observations and information regarding complaints, requests or behaviour relating to mental or physical health, medical attention offered and/or provided to detainees and any other matters relating to the well being of detainees. Instructions should also require the recording of all cell checks conducted.

Implementation

This recommendation has been implemented in New South Wales legislation within the Law Enforcement (Powers and Responsibilities) Regulation 2002. It has also been included in Victoria, Queensland, South Australia and the Northern Territory through standing orders, procedures, policies and general orders. Tasmania fully implemented this recommendation in the Tasmania Police Manual.¹¹²

¹¹⁰ Ibid, 332-33.

¹¹¹ Ibid, 337.

¹¹² This needs to be fact checked – where not able to confirm in the report.

8. Recommendation 144

That in all cases, unless there are substantial grounds for believing that the well being of the detainee or other persons detained would be prejudiced, an Aboriginal detainee should not be placed alone in a police cell. Wherever possible an Aboriginal detainee should be accommodated with another Aboriginal person. The views of the Aboriginal detainee and such other detainee as may be affected should be sought. Where placement in a cell alone is the only alternative the detainee should thereafter be treated as a person who requires careful surveillance.

Implementation

New South Wales, Queensland, the Australian Capital Territory, South Australia and Western Australian guidelines refer to placing Indigenous Australian detainees together where possible.¹¹³

9. Recommendation 146

That police should take all reasonable steps to both encourage and facilitate the visits by family and friends of persons detained in police custody.

Implementation

Only New South Wales has fully implemented this Recommendation in its guidelines. The Commonwealth and other states and territories have partially implemented this through¹¹⁴

10. Recommendation 152

That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

- a. The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;*

¹¹³ Ibid, 338.

¹¹⁴ Ibid.

c. The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;

g. The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:

i. persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;

iii. persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or

v. apparently angry, aggressive or disturbed persons;

Implementation

New South Wales has implemented this recommendation. Other states and territories have not explicitly legislated it.¹¹⁵

11. Recommendation 155

That recruit and in-service training of prison officers should include information as to the general health status of Aboriginal people and be designed to alert such officers to the foreseeable risk of Aboriginal people in their care suffering from those illnesses and conditions endemic to the Aboriginal population. Officers should also be trained to better enable them to identify persons in distress or at risk of death or harm through illness, injury or self-harm. Such training should also include training in the specific action to be taken in relation to the matters which are to be the subject of protocols referred to in Recommendation 152 (g).

Implementation

Victoria is the only state that has fully implemented this recommendation.¹¹⁶

12. Recommendation 160

That:

¹¹⁵ Ibid.

¹¹⁶ Ibid.

- a. All police and prison officers should receive basic training at recruit level in resuscitative measures, including mouth to mouth and cardiac massage, and should be trained to know when it is appropriate to attempt resuscitation; and
- b. Annual refresher courses in first aid be provided to all prison officers, and to those police officers who routinely have the care of persons in custody.

Implementation

Only New South Wales, Western Australia and Queensland have published guidelines regarding resuscitation training.¹¹⁷

13 Recommendation 161

That police and prison officers should be instructed to immediately seek medical attention if any doubt arises as to a detainee's condition.

Implementation

All states and territories had claimed that recommendation 161 was implemented into practice. However, the Australian Human Rights Commission stated that some delay or deficiency in attempting to resuscitate detainees was evident in 17 of the 61 cases investigated by the coroners between 1989-1996.¹¹⁸ Hence, recommendation 161 has not been implemented sufficiently.

14. Recommendation 163

That police and prison officers should receive regular training in restraint techniques, including the application of restraint equipment. The Commission further recommends that the training of prison and police officers in the use of restraint techniques should be complemented with training, which positively discourages the use of physical restraint methods except in circumstances where the use of force is unavoidable. Restraint aids should only be used as a last resort.

¹¹⁷ Ibid.

¹¹⁸ 'Indigenous Deaths in Custody: Report Summary', *Australian Human Rights Commission* (Web Page 1996)

<<https://www.humanrights.gov.au/publications/indigenous-deaths-custody-report-summary>>.

Implementation

Victoria, Western Australia and the Australian Capital Territory have enacted legislation implementing this recommendation. Victoria and Western Australia also specify a training requirement in guidelines.¹¹⁹

15. Recommendation 178

That Corrective Services make efforts to recruit Aboriginal staff not only as correctional officers but also to all employment classifications within Corrective Services.

Implementation

5.4% of corrections officers employed within corrective services in NSW identify as Aboriginal. NSW says that this has already surpassed their goal of 2.6%. However, it is arguable that even that is too low.¹²⁰

16. Recommendation 182

That instructions should require that, at all times, correctional officers should interact with prisoners in a manner which is both humane and courteous. Corrective Services authorities should regard it as a serious breach of discipline for an officer to speak to a prisoner in a deliberately hurtful or provocative manner.

Implementation

NSW, Victoria and South Australia implemented this recommendation through standards, training, and procedures for responding to inhumane or discourteous treatment of prisoners.

¹²¹ Western Australia, Queensland and the Australian Capital Territory have implemented the recommendation through legislation and policy.

13. Recommendation 183

¹¹⁹ Change the record, 'Review of the implementation of the recommendations of the RCIADIC – May 2015' (Webpage May 2015) < <https://changetherecord.org.au/review-of-the-implementation-of-rciadic-may-2015>>.

¹²⁰ Ibid.

¹²¹ Ibid.

That Corrective Services authorities should make a formal commitment to allow Aboriginal prisoners to establish and maintain Aboriginal support groups within institutions. Such Aboriginal prisoner support groups should be permitted to hold regular meetings in institutions liaise with Aboriginal service organisations outside the institution and should receive a modest amount of administrative assistance for the production of group materials and services. Corrective service authorities should negotiate with such groups for the provision of educational and cultural services to Aboriginal prisoners and favourably consider the formal recognition of such bodies as capable of representing the interests and viewpoints of Aboriginal prisoners.

Implementation

NSW does not provide peer support opportunities or programs that the other states implement. For example, Victoria's system allows prisoners access to an Aboriginal wellbeing officer or Aboriginal Liaison officer and Queensland has support groups operating in correctional centres. In WA there are peer support groups operating in all prisons.¹²²

CONCLUSION

With 78% of RCIADIC recommendations being mostly or fully implemented across all levels of government as of 2018, the review also shows that 16% of the recommendations are being partially implemented, while 6% of the recommendations have not been implemented at all. New South Wales was shown to be the state that fully or mostly implemented the highest number of recommendations, with Queensland behind by 2%. On the other hand, Tasmania has implemented the least amount of recommendations at 48%, with South Australia at 58% implementation of the RCIADIC.

The recommendations analysed were selected in determined relevance to the death of David Dungay, and are cited entirely from the RCIADIC. The implementations of the recommendations outline the level and area of implementation of states that have partially, mostly or fully implemented the recommendation.

¹²² Ibid.

Appendix 1

RCIADIC: EVENTS AND AFTERMATH

Timeline

The following timeline was published by NITV on April 15 2016 and shows some of the events leading up to the Royal Commission and highlights important events in the aftermath of its release.¹²³

1 September 1983

John Pat, a 16-year-old boy, dies in police custody in Roebourne, Western Australia, after being beaten to death by a group of off-duty, drunk police officers. There is a public outcry following his death.

2 August 1987

Lloyd Boney is found dead in a police cell in Brewarrina, NSW. His death is regarded as the catalyst for the Royal Commission, as Prime Minister Bob Hawke orders a Royal Commission to investigate Aboriginal deaths that had occurred in State and Territory gaols.

3 April 1991

The Report of the Royal Commission into Aboriginal Deaths in Custody delivers 339 recommendations.

4 1993

The Deaths in Custody Watch Committee in Western Australia is set up by a coalition of concerned parties. Its aim is to monitor and work to ensure the effective implementation of the findings from the Royal Commission into Aboriginal Deaths In Custody.

5 April 1994

Protesters in Sydney and Brisbane renew their calls for the Australian government to adopt

¹²³ 'The Royal Commission into Aboriginal Deaths in Custody: timeline of events and aftermath'. *NITV* (Online at 15 April 2016) <<https://www.sbs.com.au/nitv/article/2016/04/14/royal-commission-aboriginal-deaths-custody-timeline>>.

the recommendations of the Royal Commission into Aboriginal Deaths in Custody.

Indigenous community leaders claim the recent Criminal Justice Commission report into the death of Aboriginal dancer Daniel Yock in Brisbane is a "whitewash."

6 October 1996

The Aboriginal and Torres Strait Islander Social Justice Commissioner prepares a report on the 96 deaths in custody since 1989 and presents it to the Aboriginal and Torres Strait Islander Commission. The report finds that each death in custody breached, on average, 8.5 of the recommendations made in the Royal Commission Report.

7 November 2004

Cameron Doomadgee is arrested for swearing and less than an hour later is found dead in his cell, sparking riots on Palm Island. It is the 147th death since the handing down of the Royal Commission Report. Manslaughter charges are laid against Chris Hurley though he is later acquitted, making him the first police officer to appear before a court in relation to an Indigenous death in custody.

8 January 2008

Mr. Ward dies of heatstroke after collapsing in the back of a police van that was transporting him in at a temperature of 42°C. A coronial inquest finds that the two guards, the company in charge of prison transportation, and the WA Department of Corrective Service contributed to his death. His family receives a \$3.6 million compensation payout from the WA Government.

9 2008

An Australian Indigenous Law Review study shows that Australian states and territories have only acted on a fraction of the coronial recommendations of the Report.

10 September 2013

The Western Australian Government is asked to apologies to the family of teenager John Pat. The Parliament agrees to make a formal apology to the family.

11 August 2014

Ms. Dhu dies in a WA hospital, three days after she was arrested for unpaid fines. A coronial inquest finds she died of septicemia and pneumonia, and criticized both the police officers and the health service involved. Lawyers involved in the case claimed that if the recommendations of the Royal Commission Report had been implemented, Ms. Dhu would not have died.

12 November 2015

The High Court of Australia upholds the Northern Territory's paperless arrest laws after the Territory coroner branded the laws as 'manifestly unfair' and disproportionately targeted Indigenous Australians.

Mr. Langdon died in custody of heart failure after being arrested under the scheme.

Statistics

- 1. Aboriginal and Torres Strait Islanders account for about 3.3% of Australia's population.¹²⁴**
- 2. Aboriginal and Torres Strait Islander people accounted for 28% of the total Australian prison population in 2018.¹²⁵**
- 3. 2608 deaths in custody occurred in Australia during 1979 to 2018. Out of these 985 deaths occurred in police custody or other custody-related operations and 1600 in prison. 18 of the deaths occurred in youth detention or welfare facilities and 5 deaths in other criminal justice settings.¹²⁶**
- 4. Of the 2608 deaths 500 were Indigenous meaning Indigenous people accounted for**

¹²⁴ Nicholas Biddle, Francis Markham, 'Census 2016: what's changed for Indigenous Australians?', *The Conversation* (Online, 28 June 2017) <<https://theconversation.com/census-2016-whats-changed-for-indigenous-australians-79836>>.

¹²⁵ Australian Bureau of Statistics, *Prisoners in Australia, 2018* (Catalogue No 4517.0, 12 December 2018).

¹²⁶ A Ticehurst, S Napier & S Bricknell . 2018. 'National Deaths in Custody Program: Deaths in custody in Australia 2013–14 and 2014–15' Statistical Reports No. 5. Canberra: Australian Institute of Criminology <<https://aic.gov.au/publications/sr/sr5>>.

almost 20% of all deaths in custody since 1979.¹²⁷

5. 147 Indigenous people have died over the decade of 2008-2018 and over 400 have died since the end of the royal commission.¹²⁸
6. 115 deaths in custody occurred in Australia during 2013 to 2014. Out of the 115 people 25 were Indigenous.¹²⁹
7. Aboriginal deaths in custody increased by 150% since the Royal Commission in 1991.¹³⁰

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¹²⁸ Lorena Allam, Calla Wahlquist, Nick Evershed, 'The 147 dead: terrible toll of Indigenous deaths in custody spurs call for reform' *The Guardian* (Online at 28 August 2018) <<https://www.theguardian.com/australia-news/2018/aug/28/the-147-dead-indigenous-leaders-demand-action-over-unacceptable-deaths-in-custody>>.

¹²⁹ Ticehurst (n 9).

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