Coroners Act, 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 47/15

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***Julieka Ivanna DHU****, with an Inquest held in Court 51 at Perth Coroners Court between 23 November 2015 and 3 December 2015 and between 14 March 2016 and 24 March 2016 and on 28 September 2016 find that the identity of the deceased person was* ***Julieka Ivanna DHU*** *and that death occurred on 4 August 2014 at Hedland Health Campus, 26 - 34 Colebatch Way, South Hedland as a result of staphylococcal septicaemia and pneumonia in a woman with osteomyelitis complicating a previous rib fracture in the following circumstances:*

Counsel Appearing :

Mrs I O'Brien assisting the State Coroner between 23 November – 3 December 2015
Mr P Urquhart assisting the State Coroner between 14 March – 24 March 2016 and on 28 September 2016
Mr P Quinlan SC, (assisted by Mr P Gazia and instructed by Aboriginal Legal Service WA) appeared for Ms C Roe and Ms D Roe
Mr H Quail appeared for Mr R Dhu
Mr J Homburg (Gilchrist Connell) appeared for Nurse Lindsay
Mr D Bourke (assisted by Ms A de Villiers, Clayton Utz) appeared for Dr V Naderi
Ms C Thatcher (assisted by Ms C Chapman, State Solicitors Office) appeared for the WA Country Health Service including Dr A Lang, Ms S Dunn, Ms G Hall, Dr R Campbell and Dr G Sakarapani
Mr B Evangel (Evangel Legal) appeared for Mr D Ruffin
Ms B Burke (Australian Nursing Federation) appeared for Ms A Hetherington, Ms H Weston, Ms T Murphy, Ms K Jones and Ms H Payne
Mr J Ley (instructed by DLA Piper) appeared for Ms C Jones
Mr P Lochore appeared for Mr R Bond
Mr B Slattery appeared for Mr C George, Ms C Sharples, Mr J Buck, Ms H Shaw, Ms V Eastman, Ms T Beckett, Mr C Matier, Ms S Burgess, Mr R Patchett and Ms N Murphy
Mr P Yovich SC (instructed by WAPOL Legal Services) appeared for the Commissioner of Police

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INTRODUCTION

1. Ms Julieka Ivanna DHU (Ms Dhu) was a 22 year old Aboriginal female who tragically died at Hedland Health Campus (HHC) on 4 August 2014, while she was in the custody of members of the Police Force, namely members of the Western Australia Police Service (the police). Ms Dhu was of the Yamatji Nanda family group on her mother's side, and the Bunjima family group on her father's side. Her untimely death traumatised her grandmother and parents and unleashed a wave of grief that has reverberated throughout the Aboriginal communities.

2. The focus of the inquest into Ms Dhu's death was on the quality of her supervision, treatment and care while she was in the custody of the police at the South Hedland Police Station Lock-Up (the Lock-Up), from the time of her arrest on 2 August 2014, until the time immediately before her death in the early afternoon of 4 August 2014. It included an examination of her medical treatment at HHC.

3. Ms Dhu suffered a catastrophic deterioration in her health while she was in the custody of the police. On 2 and 3 August 2014 she had been escorted by the police to HHC for medical attention, and then returned to the Lock-Up.

4. The two doctors who treated Ms Dhu at HHC on those occasions did not find evidence of illness, let alone serious disease. They declared her as being fit to be held in custody. The police who observed Ms Dhu at the Lock-Up did not discern that she was seriously unwell. They relied substantially on the doctors having twice declared her as being fit to be held in custody and as time passed they became dismissive of her symptoms.

5. Ms Dhu died as a result of an overwhelming staphylococcal infection. During the period of her detention, she asked for assistance and complained of ill health to a number of health clinicians and police officers.

6. Ms Dhu's appearance and demeanour was of a person who was becoming increasingly unwell, and culminated in her collapsing on 4 August 2014. However, the majority of the persons responsible for Ms Dhu's care formed the view that she was exaggerating or feigning symptoms of being unwell. On the morning of 4 August 2014 the police assumed that she was feigning her collapse.

7. That assumption persisted up until the time the doctors commenced their resuscitation attempts at HHC at 12.45 pm on 4 August 2014. Despite maximal attempts at resuscitation, Ms Dhu died.

MS DHU

8. Ms Dhu was born on 26 December 1991 at Port Hedland, to Ms Della Roe and Mr Robert Dhu. She lived with her parents until she was three years old. At that point her parents separated and Ms Dhu commenced to live with her grandmother Mrs Carol Roe.

9. Ms Dhu was raised by her grandmother in a loving environment. She spent time in Port Hedland and in Geraldton. Her parents continued to maintain a regular contact with her throughout her life and she remained close to them.

10. Ms Dhu had a cheerful and bubbly disposition as a child. She enjoyed a strong connection with the members of her family. Other than mild asthma, she remained in good health throughout her younger years.

11. She was a bright student and completed year 11 of her high school. With her mother's assistance she had trained as a receptionist. She had commenced a course at TAFE, together with her cousin. She played netball and she had learnt Aboriginal dances. In her teenage years she was engaged with her family, her friends and her community.

12. Ms Dhu had a strong personality. She spoke her mind and stood up for herself. On some documented occasions as she grew older she was involved in some arguments with people she knew. Unfortunately these incidents escalated. From 2009 Ms Dhu was convicted of a number of offences. Practically all of them comprised low level offending and originated from instances such as swearing in a public place. She remained a happy-go-lucky young woman, and her family recalled her as a very affectionate person throughout this period.

13. In 2013 Ms Dhu's family observed a change in her demeanour. She was no longer her cheerful self and she was less family-oriented. She had begun a relationship with Mr Dion Ruffin, and in its early stages she did not disclose it to her family.

14. Ms Dhu and Mr Ruffin did not have a stable home environment and they were not engaged in meaningful employment. Ms Dhu started taking amphetamines. She lost weight and she began to

look frail and unhealthy. She ceased taking care of herself in the way that she previously did.

15. Unfortunately Ms Dhu's relationship with Mr Ruffin was dysfunctional and it had a deleterious effect on her sense of self-esteem. Ms Dhu's family were united in their disapproval of the relationship due to their perception that Mr Ruffin was unkind and disrespectful to her. They wanted her to separate from him. Ms Dhu tried to separate from Mr Ruffin, but was drawn back into the relationship, willingly.

16. In early 2014 Ms Dhu and Mr Ruffin were living in Geraldton, and she was having less contact with her family. In April 2014 they had an altercation and Mr Ruffin threw Ms Dhu over his shoulder, with the result that she landed heavily on an object, causing a fracture to her ribs. Ms Dhu sought treatment at Geraldton Regional Hospital (GRH), but informed the clinicians that she had slipped on some rocks. She was discharged with pain relieving medication.

17. At the time of her arrest on 2 August 2014, Ms Dhu was living with Mr Ruffin in Port Hedland and they were planning to go to HHC to seek medical treatment for her because she had pain in her ribs. Mr Ruffin was arrested at the same time as Ms Dhu. Following the arrests, they were both detained at the Lock-Up. Within two days, and after two attendances at the HHC, Ms Dhu tragically died.

18. Ms Dhu was dearly loved by all of her family and she loved them. She was particularly fond of her younger sister and had a very affectionate relationship with her. She was a stoic young woman, who was not given to complaining of pain.

19. Sadly, in the last year of her life, Ms Dhu's health had declined, she occasionally took illicit drugs, she was in a domestic relationship that involved acts of violence, and her social circumstances generally took a turn for the worse. When they could, her family implored her to look after herself, and to cease taking illicit drugs, but unfortunately their exhortations were to no avail.

20. Ms Dhu's family remained committed in their efforts to persuade her to take a better path in life, and they had faith in her capacity to do so. Tragically, they were unable to see her grow and develop. All of their dearly held hopes that she might turn her life around, and all of their expectations of the many years they would spend with her, were taken away with the news of her sudden and unexpected death.

THE INQUEST

21. Ms Dhu's death was a reportable death within the meaning of s 3 of the *Coroners Act* 1996 (the Act) and it was reported to the coroner as required by the Act.

22. By reason of s 19(1) of the Act I have jurisdiction to investigate Ms Dhu's death. The holding of an inquest, as part of the investigation into her death, is mandated by reason of s 22(1)(a) of the Act. This is because immediately before death she was a person held in care by reason of being under the control, care or custody of the police.

23. I held an inquest into Ms Dhu's death and heard evidence from 39 witnesses between 23 November and 3 December 2015, and between 14 March and 24 March 2016. I have received 24 exhibits into evidence. On 28 September 2016 I heard argument concerning the family's applications for me to release the CCTV evidence in this matter to the media.

24. My primary function has been to investigate Ms Dhu's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Act, I must find if possible, how Ms Dhu's death occurred and the cause of her death.

25. Pursuant to s 25(2) of the Act, in this finding I may comment on any matter connected with Ms Dhu's death including public health safety or the administration of justice. This is the ancillary function.

26. Pursuant to s 25(3) of the Act, as Ms Dhu was a person held in care, in this finding I must comment on the quality of her supervision, treatment and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

27. Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

28. Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

29. After the evidence was taken at the inquest, submissions were provided to me for the purposes of s 44(2) of the Act, between 17 May and 27 June 2016.

30. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

31. In the conduct of the inquest, and for the purposes of discharging my functions under s 25(2) and 25(3), I have taken account of the need for a thorough and independent judicial investigation of deaths in custody, as outlined by Royal Commissioner Johnston QC in the *Royal Commission into Aboriginal Deaths in Custody (1991)*, conscious of the potential for me to identify systemic failures which, if acted upon, may prevent future deaths in similar circumstances.

32. I adopt the views expressed by Watterson R, Brown P and McKenzie J, *Coronial Recommendations and the Prevention of Indigenous Death* (2008) 12 (SE2) Australian Indigenous Law Report (6):

> "*The Royal Commission recommended an expansion of a coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.*"

33. My findings appear below.

MS DHU'S ATTENDANCE AT GERALDTON REGIONAL HOSPITAL

34. A contributing factor to Ms Dhu's death was her initial rib fracture in April 2014, for which she sought treatment at GRH. The infection that ultimately caused her death in August 2014 seeded (that is, lodged) in the right 10th rib fracture that she sustained in April 2014. For this reason, her treatment and care at GRH is relevant to the circumstances attending her death.

Attendance at Geraldton Regional Hospital 21 April 2014

35. The GRH records disclose that Ms Dhu presented to emergency department at 4.58 pm on 21 April 2014 complaining of pain and swelling in her right ribs after slipping on some rocks two days previously. At triage she was not distressed or short of breath, initial observations were all normal and she reported a pain score of 7/10.[1]

36. Ms Dhu was triaged as category 4 and was reviewed by a doctor at 5.25 pm. The doctor recorded a history of pain that was increasing despite taking analgesics, and that she felt slightly short of breath at rest. On examination she was tender over the right chest wall and had slight decreased air entry on the right side. The doctor was concerned about the possibility of a small pneumothorax (air between the lung and chest wall). However a chest X-ray showed a normal heart size with clear lung fields and normal bony thorax.[2]

37. Ms Dhu was discharged from GRH the same day at 6.05 pm with a diagnosis of "*bruised chest wall*", she was prescribed pain relieving medication and advised to follow up with her GP if she required further analgesia.[3]

38. At the inquest, I received expert evidence from Dr David Speers, a highly qualified infectious diseases specialist and microbiologist, in relation to the cause of, and progression of, Ms Dhu's infection. Dr Speers opined that despite the lack of evidence of a fracture on Ms Dhu's chest X-ray it remains most likely that her fall two to three days prior to her presentation at GRH on 21 April 2014 resulted in a right 10th and 11th rib fracture.[4]

39. In Dr Speers' experience, early fractures are not always visible on X-rays. The clear history of a fall with significant tenderness at that site is consistent with a rib fracture.[5]

40. I am satisfied that Ms Dhu sustained a right 10th and 11th rib fracture in April 2014, prior to her presentation at GRH on 21 April 2014.

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[1] Exhibit 1, tab 14
[2] Exhibit 1, tab 14
[3] Exhibit 1, tab 14
[4] Exhibit 1, tab 40
[5] Exhibit 1, tab 40

Quality of Medical Care at Geraldton Hospital

41. The signs of bruising or fracture are often the same and fractured ribs are often not detectible on chest X-ray in the early stages. The main reason to X-ray the chest is to exclude complications of rib fractures such as a pneumothorax, or a chest infection. In Ms Dhu's case a chest X-ray was performed and was reported as normal.

42. If there is no other complication fractured ribs usually heal well with time and do not normally require more complex investigations to confirm the diagnosis. Bruised or fractured ribs are generally treated in the same way with pain relief, deep breathing exercises and advice to return if any other symptoms develop.

43. I am satisfied that the assessment and management that Ms Dhu received at GRH was reasonable and appropriate.

44. Unfortunately however, time passed and Ms Dhu's fracture did not heal.

FACTUAL SUMMARY 2 TO 4 AUGUST 2014

Arrest on 2 August 2014

45. On Saturday 2 August 2014 police from the South Hedland Police Station (SHPS) arrested Ms Dhu on various warrants of commitment. It was calculated that she would have to spend four days in custody unless outstanding fines imposed upon her were paid. Less than 48 hours after being taken into police custody Ms Dhu tragically died.

46. During the year prior to her death Ms Dhu was in a relationship with Mr Dion Ruffin, a man 17 years older than her. It is evident that the relationship was marred by acts of domestic violence [redacted]

47. [redacted]

[redacted]

48. [redacted]

49. Ms Dhu was the subject of four Warrants of Commitment dated 13 May 2014 issued under s 53 of the *Fines, Penalties and Infringement Notices Enforcement Act 1994* (WA) for fines and costs totalling $3,622.34 ordered by the various courts between 2009 and 2012.[7]

50. The Warrants of Commitment stipulated that the total period of imprisonment was to be four days (which was subsequently confirmed by the calculation conducted by Mr Rick Bond, formerly Sergeant Rick Bond, officer in charge of the SHPS).[8]

51. On the afternoon of Saturday 2 August 2014, First Class Constable Callan George and First Class Constable Vicki Eastman were assigned the task of arresting Ms Dhu on these Warrants of Commitment. They were also to arrest Mr Ruffin on an outstanding warrant.

52. At approximately 5.00 pm on 2 August 2014 these police officers located Ms Dhu and Mr Ruffin at a residence in South Hedland and they were arrested without incident. Both were then conveyed in the same police vehicle to the Lock-Up.

Arrival at Lock-Up on 2 August 2014

53. Ms Dhu was processed at the Lock-Up after her arrival at 5.02 pm and her custody admission was completed within half an hour.

54. It is evident from the CCTV footage of the sally port area of the SHPS that Ms Dhu had some difficulty walking when she got out of the police vehicle.[9] When questioned by First Class Constable Eastman she stated that she had a broken rib which had been medically treated. Ms Dhu was asked if she would like to see a doctor but at that point she declined.

55. During Ms Dhu's processing she reported having a blister on her foot, a broken toe, a history of asthma and cannabis use. Of the two categories that existed at the time ("*high risk*" and "*low risk*"), police classified Ms Dhu as "*low risk*" based upon her demeanour and apparent mental and physical health. After processing she was conveyed to the Lock-Up area, within the same building. It is

[7] Exhibit 1, tab 15
[8] Exhibit 1, tab 15
[9] Exhibit 5

again evident from CCTV footage that she was walking with an obvious gait, leaning over to her right hand side.[10]

Transfer to Cell 3 on 2 August 2014

56. Ms Dhu was transferred to Cell 3 by First Class Constable George at 5.31 pm on 2 August 2014.[11] Throughout the duration of her stay at the Lock-Up Ms Dhu was the sole occupier of Cell 3.

57. At 5.33 pm responsibility for the detainees were transferred from the assigned Lock-Up keeper First Class Constable Eastman to the new Lock-Up keeper, Constable Carrie Sharples.[12]

58. By 5.53 pm the CCTV camera in Cell 3 shows Ms Dhu in discomfort.[13]

Ms Dhu becomes unwell whilst in Cell 3 on 2 August 2014

59. After pushing her cell's call button at 7.40 pm, Ms Dhu was visited by Constable Sharples on two occasions at 7.41 pm and 7.45 pm.[14] Constable Sharples ascertained that Ms Dhu was unwell and notified her supervisor. She later made the following record in the electronic Custody system for Ms Dhu:

> *"Spoken to. Stated she was in pain and pointed to her rib area. (Custody episode shows an old injury). Shift Sergeant immediately notified. Detainee is [awake sitting]".*[15]

60. The shift supervisor at the time was Sergeant Ronald Patchett. The CCTV footage from Cell 3 shows Sergeant Patchett having a conversation with Ms Dhu at 7.53 pm.[16]

61. Sergeant Patchett made a record in Ms Dhu's Custody system at 7.57 pm as follows:

> *"Spoken to by SGT Patchett to clarify and verify injury as POI is a known amphet user... maintained status re: injury and pain. Detainee is awake lying down on his/her front".*[17]

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[10] Exhibit 5
[11] Exhibit 3, tab 17; Exhibit 5
[12] Exhibit 3, tab 17
[13] Exhibit 3, tab 17
[14] Exhibit 3, tab 17
[15] Exhibit 3, tab 7
[16] Exhibit 3, tab 17
[17] Exhibit 3, tab 7

Decision to convey Ms Dhu to HHC on 2 August 2014

62. Shortly after 8.00 pm on 2 August 2014 Sergeant Patchett decided to have Ms Dhu conveyed to HHC for medical assessment. At the time, the practice was to escort a detainee who was appeared to be unwell to HHC, with a view to ascertaining whether the doctor considered that the detainee was fit to be held in custody.

63. However Ms Dhu's conveyance was postponed due to one police vehicle already attending to a job and the other police vehicle being allocated to an urgent job that had just come in. There were no other police vehicles available to convey Ms Dhu to HHC.[18]

64. Constable Sharples conducted a physical cell check at 8.28 pm[19] and she subsequently made an entry in Ms Dhu's Custody system records as follows:

> *"Still complaining of pain to the rib area. All appeared correct. Advised awaiting vehicle and officers available to take to hospital. Advised there would be a delay and she stated she was okay with that. Detainee is [Awake Sitting]."*[20]

Ms Dhu transferred to charge room to await transfer to HHC on 2 August 2014

65. At 8.40 pm Constable Sharples, with Sergeant Patchett's approval, took the unusual, though commendable, step of removing Ms Dhu from her cell and taking her to the charge room so that she could wait there before being taken to the HHC.

66. The CCTV camera located in the charge room shows Ms Dhu waiting to be taken to HHC from 8.44 pm to 9.17 pm. As that camera had audio it is evident that Ms Dhu is in discomfort.[21]

67. Ms Dhu can be seen favouring her right side whilst walking and can be heard constantly moaning and crying while she waits in the charge room. Constable Sharples provides advice to Ms Dhu as to her breathing and at one point lifts Ms Dhu's shirt up. When asked by Constable Sharples as to how she injured herself Ms Dhu explained that she fell down some stairs.

68. When asked by Constable Sharples if she had been to hospital before, Ms Dhu replied that she had been to GRH but that they cannot do much for broken ribs. She is heard saying that it

[18] Exhibit 3, tab 17
[19] Exhibit 3, tab 17
[20] Exhibit 3, tab 7
[21] Exhibit 5

happened a couple of months ago but she had since slipped over. Ms Dhu described the pain on a scale of one to ten as being ten and she was told by Constable Sharples that next time it is important to advise the police straight away if she is in pain.[22]

69. Constable Sharples appeared genuinely concerned for Ms Dhu and endeavoured to minimise her discomfort while they awaiting an available police vehicle for the conveyance to HHC.

70. At 9.14 pm (according to the charge room CCTV camera)[23] First Class Constable Jaime Buck and Constable Hafiz Shaw were allocated the task of conveying Ms Dhu to HHC.

71. Though she was able to walk unassisted and get into the back of the police vehicle in the sally port area it is readily apparent that Ms Dhu was in discomfort.[24]

Treatment at HHC on 2 August 2014

72. Upon arrival at the HHC at 9.18 pm[25] Ms Dhu was seen by a triage nurse, Glenda Lindsay, within a matter of minutes. Nurse Lindsay recorded that Ms Dhu had broken rib pain of two months duration and that when she had fallen on some stairs two days earlier the pain had flared up. She was described as groaning and as being alert. Her pain score was recorded as three out of ten.[26]

73. Nurse Lindsay allocated a triage score of four for Ms Dhu, which placed her at low acuity. She was put in the waiting room pending her assessment and given Panadol to make her comfortable while she was waiting. Nurse Lindsay's evidence was that the male police officer (who was Constable Shaw) had told her that when Ms Dhu was told she was going to stay overnight in the cells she started complaining of pain and asked to come to hospital. [27]

74. Ms Dhu was then examined in a cubical area by the treating nurse, Samantha Dunn. First Class Constable Buck recalled Nurse Dunn touching Ms Dhu's T-shirt whereupon Ms Dhu recoiled and said "*ow*". The nurse responded with words to the effect of *"I didn't touch you"* or *"I hardly touched you"* and as the nurse turned her head away from Ms Dhu she rolled her eyes.[28] Constable Shaw

[22] Exhibit 5; Exhibit 3, tab 17
[23] Exhibit 5
[24] Exhibit 5
[25] Exhibit 9
[26] Exhibit 1, tab 18
[27] ts 724
[28] ts 1018 – 1019; ts 1050

had a similar recollection and inferred that Ms Dhu may be exaggerating her pain.[29]

75. Ms Dhu's recorded observations on the emergency department notes indicated that her vital signs were normal. Ms Dhu was then reviewed by the on-call emergency doctor, Dr Anne Lang, at 9.36 pm. Dr Lang found it difficult to obtain an adequate history from Ms Dhu. She therefore asked the two police officers in attendance about Ms Dhu's history.

76. Dr Lang recalled that one of the police officers (who she thought was the female police officer) had said Ms Dhu did not appear to be in any distress or pain when arrested but when she was informed that she would have to spend time incarcerated there was a directly proportional increase in her pain.[30]

77. First Class Constable Buck's evidence was that she had recalled hearing a police officer (who she could not name) say that prior to her leaving for the HHC but that she did not remember repeating it to the doctor.[31] Constable Shaw could not recall who said what as several officers contributed to the briefing in the Sergeant's office. Sergeant Patchett told investigators that he did hold this view.[32]

78. I am satisfied that the escorting police provided Dr Lang with information to the effect that when Ms Dhu learnt that she would have to spend time incarcerated there was an increase in her complaint of pain and of the severity of that pain. Importantly however, any medical practitioner faced with this information would need to note it, as part of the history being provided, but keep an open mind and conduct a medical review without inferring that the patient must be feigning pain, or other symptoms of being unwell.

79. Ms Dhu's emergency department notes reflect that Dr Lang noted "*behavioural issues*" as part of Ms Dhu's history. Dr Lang also recorded that Ms Dhu had been taken into police custody that evening and was reported to be "*pain free initially*" and complained of right rib pain once informed she would have to spend the night in police detention, having been informed of this by the escorting police and obviously considering it to be relevant.[33]

80. It appears from Ms Dhu's emergency department notes that when Dr Lang began her physical examination, Ms Dhu began hyperventilating (her vital signs were previously normal). Dr Lang's record reflects that Ms Dhu's examination was otherwise normal,

[29] ts 1050 - 1052
[30] ts 431 – 432; Exhibit 1, tab 18
[31] ts 1021
[32] Exhibit 3, Tab 14; ts 1042 – 1043; ts 1055
[33] Exhibit 1, tab 18

with no detectable problem in her chest, and no evidence of acute pathology.[34]

81. At the end of Ms Dhu's emergency department notes Dr Lang recorded that her impression was of "*behavioural gain*". Her discharge diagnosis was recorded as "*behaviour issues*". According to the medication chart Ms Dhu was given Endone (oxycodone, a strong analgesic) 5 mg, and diazepam (a sedative agent) 5 mg, at 9.35 pm. The records reflect that she was administered the medication prior to the completion of Dr Lang's examination.[35]

82. Though appearing nowhere in Ms Dhu's emergency department notes, at the inquest Dr Lang testified that she had actually made a finding that the source of Ms Dhu's pain was *"musculoskeletal"*.[36]

83. Dr Lang's explanation for the deficiency in her notes which she described as *"terrible"*[37] was that she was *"really time poor, which is not a justification, but it is a reality"*.[38]

84. Ms Dhu was discharged from HHC shortly before 9.45 pm. Dr Lang signed a "*Medical Fitness to be Held in Custody*" form (the Fitness to Hold Form) in which she wrote *"given analgesia. Fit to return to police custody"*.[39]

85. Dr Lang left the attending police officers with clear instructions to return if Ms Dhu's clinical condition changed."[40]

Return to Lock-Up on 2 August 2014

86. Ms Dhu was then conveyed back to the Lock-Up and placed into her cell by 9.45 pm. CCTV cameras showed her holding her right rib area as she walked to her call.[41] Shortly after being placed in her cell, the responsibility for Ms Dhu's safety and welfare was transferred to Senior Constable Nicola Murphy who was the assigned lock-up keeper.

87. Upon returning from HHC Constable Shaw provided the Fitness to Hold Form and briefed Sergeants Patchett and Cowie on his observations and inferences.[42]

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[34] Exhibit 1, tab 18
[35] Exhibit 1, tab 18
[36] ts 437
[37] ts 435
[38] ts 438
[39] Exhibit 1, tab 22
[40] Exhibit 2, tab 49; ts 445 - 446
[41] Exhibit 5
[42] ts 949; ts 1052 - 1053

88. Overnight and into the next morning, Ms Dhu had regular (as in every hour or thereabouts) physical cell checks by Senior Constable Murphy between 9.48 pm on 2 August 2014 and 7.00 am on 3 August 2014, apart from the period between 4.07 am and 6.01 am on 3 August 2014, where a cell check was missed.[43]

89. The records made by Senior Constable Murphy on Ms Dhu's Custody system of those cell checks are unremarkable, save and except for the one at 11.17 pm on 2 August 2014 in which she included that Ms Dhu was making *"a moaning noise"*.[44]

Ms Dhu's symptoms at Lock-Up on 3 August 2014

90. At 7.00 am on 3 August 2014, Constable Tamara Perry assumed the lock-up keeper responsibilities. At her handover by the shift supervisor, Sergeant Russel Cowie, Constable Perry was simply informed that Ms Dhu had been to hospital the day before.[45]

91. At 7.45 am on 3 August 2014 Constable Perry took Ms Dhu to the shower area. CCTV cameras depict Ms Dhu hunched over and shuffling as she walked to and from the shower area.[46]

92. At this point Ms Dhu informed Constable Perry that she had sore ribs and that she had fallen down some stairs. Constable Perry's evidence was that she offered Ms Dhu further medical attention but she declined, saying that she just wanted to lie down and go to sleep. In response Constable Perry stated that if she required any further medical attention she was to press the buzzer in her cell and she would be taken to hospital.[47]

93. Constable Perry also testified that after Ms Dhu had her shower she had a conversation with Mr Ruffin who was stating that she ought to get Ms Dhu *"some help"*.[48]

94. Constable Perry's account was that she told Mr Ruffin that Ms Dhu had already been to hospital and she had been cleared and that she had offered Ms Dhu more medical attention but she had said she did not want it. Her evidence was that Mr Ruffin said to her that Ms Dhu had sore ribs because he had accidentally elbowed her when they were both in a car.[49] I accept Constable Perry's evidence about this conversation.

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[43] Exhibit 3, tab 17
[44] Exhibit 3, tab 7
[45] ts 1149
[46] Exhibit 3, tab 17
[47] ts 1150
[48] ts 1151
[49] ts 1151-1152

95. However, no note in the custody records for Ms Dhu was made by Constable Perry of the conversations she had with Ms Dhu and Mr Ruffin or the observations she made of Ms Dhu's gait.

96. In the afternoon of 3 August 2014 Ms Dhu was observed from the CCTV footage from her cell camera pushing the cell call button on four occasions over a half hour period between 1.17 pm and 1.47 pm. Prompted by an intercom call during his handover briefing as shift supervisor, Mr Bond went down to see Ms Dhu at 1.50 pm. At 1.57 pm Mr Bond provided Ms Dhu with Panadol and water for her rib pain.[50]

Decision to transfer Ms Dhu to HHC on 3 August 2014

97. Just over an hour later Mr Bond did a fines enforcement calculation, verifying that Ms Dhu needed to spend four days in custody, essentially to "cut out" her fine. Mr Bond spoke to Ms Dhu about the possibility of her paying a smaller amount to be released earlier. Ms Dhu gave him her father's name.[51]

98. At approximately 3.20 pm on 3 August 2014 Mr Bond telephoned Mr Robert Dhu and asked him whether he knew if anything was wrong with his daughter. Mr Dhu said he believed his daughter used speed. Mr Bond inferred that Ms Dhu may therefore be suffering from drug withdrawals. In response to Mr Bond's inquiry, Mr Dhu explained that he was unable to pay the remaining fine. Mr Dhu's request to be able to speak with his daughter was declined.[52]

99. Mr Bond relayed the result of his telephone call to Ms Dhu during one of her intercom calls. Ms Dhu had pushed the call button inside her cell on five occasions from 3.44 pm onwards, the last occasion being at 4.10 pm. Mr Bond attended Ms Dhu's cell at 4.11 pm. Footage from the Cell 3 CCTV camera shows Ms Dhu speaking with Mr Bond and pointing to her chest in a distressed state.[53]

100. Mr Bond subsequently made a record in Ms Dhu's Custody system that she was *"complaining of all over body pains"*.[54]

101. Mr Bond then made the decision for Ms Dhu to be conveyed to HHC for a second time, for medical assessment. First Class Constable George took Ms Dhu from her cell at 4.50 pm,

[50] Exhibit 3, tab 17; ts 1700 – 1701; ts 1193
[51] Exhibit 3, tab 16; ts 1702 - 1703
[52] Exhibit 3, tab 16; ts 41 – 42; ts 1706; ts 1791 - 1792
[53] Exhibit 3, tab 17; Exhibit 6
[54] Exhibit 3, tab 7

handcuffed her outside her cell and then conveyed her to the sally port area. From there she was taken by First Class Constable Tane Beckett and First Class Constable Vicki Eastman to HHC. The CCTV camera in the sally port area showed Ms Dhu experiencing difficulty getting into the back of the police vehicle.[55]

Treatment at HHC on 3 August 2014

102. Upon arrival at the HHC, at 4.59 pm on 3 August 2014 Ms Dhu was seen by the triage nurse, Alyce Hetherington. Nurse Hetherington made typed and handwritten entries onto the triage form in Ms Dhu's emergency department notes.[56]

103. Though First Class Constable Eastman observed Ms Dhu to be breathing rapidly upon attendance at the HHC,[57] Nurse Hetherington had ticked the description *"unremarkable"* for Ms Dhu's breathing. She also ticked that her pulse was rapid and that her skin was *"warm"*. Nurse Hetherington recorded that Ms Dhu was *"moaning ++"* and had *"multiple complaints"*.[58]

104. Nurse Hetherington recorded that Ms Dhu had said that her ribcage was sore and that she was *"grunting"* during triage. Nurse Hetherington also recorded that Ms Dhu was *"tachycardic and dehydrated"* and that Ms Dhu had told her she was *"stoned"* when she went into custody as she had *"had a few cones"* and she had also consumed *"half a point"* of speed two nights before.[59]

105. Ms Dhu also told Nurse Hetherington that she used "*speed*" once a fortnight intravenously, which was recorded in her notes. First Class First Class Constable Eastman heard Ms Dhu tell the nurse about this drug usage.[60]

106. Nurse Hetherington's handwritten note on the triage form also indicated that Ms Dhu's heart rate (using a pulse oximeter) was 126 beats per minute. Nurse Hetherington testified that this high level was in her view due to Ms Dhu's significant dehydration, her recent drug use and that she was also agitated and distressed.[61] Nurse Hetherington gave Ms Dhu a triage category score of 4.

107. No temperature reading or pain score was recorded or taken by Nurse Hetherington. The record of Ms Dhu's heart rate was Nurse

[55] Exhibit 5
[56] Exhibit 1, tab 18
[57] ts 1271
[58] Exhibit 1, tab 18
[59] Exhibit 1, tab 18
[60] Exhibit 3, tab 8; ts 1270
[61] ts 623

Hetherington's only handwritten entry on the triage form, the rest of her entries were made electronically.

108. Almost two hours passed before Ms Dhu was eventually seen by a doctor. During the period when she was waiting, the escorting police officers were asked to have her wait in the reception area of the emergency department. Ms Dhu continued to make moaning noises due to the pain she was experiencing. As a result, First Class Constable Eastman then decided to have Ms Dhu wait outside in the air conditioned police vehicle.[62]

109. When Ms Dhu re-entered the hospital she was taken into a cubical and examined by the treating nurse Gitte Hall at 6.45 pm. Nurse Hall had not looked at the triage form completed by Nurse Hetherington prior to her examination of Ms Dhu, stating that though that is usually done, due to her being busy that evening, she did not do that.[63]

110. On Ms Dhu's observation chart Nurse Hall recorded a heart rate of 113 beats per minute. Once again, no temperature was taken. Nor was a pain score recorded by Nurse Hall.[64]

111. Ms Dhu complained to Nurse Hall that she had aches and pains all over her chest, shoulder, abdomen and legs and that it was nowhere specific.[65]

112. From her observations and conversations with Ms Dhu, Nurse Hall was of the view that Ms Dhu was displaying symptoms consistent with drug withdrawal[66] and that her complaints *"coincided with the story that she was withdrawing from drug use"*.[67]

113. The on duty emergency doctor, Dr Vafa Naderi, examined Ms Dhu shortly afterwards at about 6.48 pm. His recorded notes reflect that he found Ms Dhu difficult to assess and that he was aware of her previous presentation, including Dr Lang's diagnosis.[68]

114. At the end of Ms Dhu's emergency department notes Dr Naderi recorded his impressions, where he questioned whether Ms Dhu was displaying withdrawal symptoms and/or anxiety and personality problems. His discharge diagnosis was *"? withdrawal from drugs*" and "*behavioural issues*".

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[62] ts 1275
[63] ts 670
[64] Exhibit 1, tab 18
[65] ts 678
[66] ts 672
[67] ts 678
[68] Exhibit 1, tab 18

115. According to the medication chart Ms Dhu was given a dose of diazepam (a sedative agent) and some paracetamol at 7.05 pm. Dr Naderi signed the Fitness to Hold Form declaring that Ms Dhu was fit to be held in custody.[69]

116. No entry was made as to what medical treatment was provided by Dr Naderi or any other medical staff on the Fitness to Hold Form. Nor was there any information as to the diagnosis that had been made (completion of this part of the form was optional). However as First Class Constables Eastman and Beckett left HHC with Ms Dhu, one of the nurses advised the two police officers that Ms Dhu's symptoms could be due to withdrawal from drugs. This observation was later relayed to Mr Bond back at the Lock-Up, most likely by Constable Eastman.[70]

Return to Lock-Up on 3 August 2014

117. Ms Dhu was then conveyed back to the Lock-Up, arriving by 7.12 pm. After she got out of the police vehicle in the sally port of the SHPS, the audio from the sally port's CCTV camera recorded First Class Constable George commenting about her treatment in a manner that indicated he was somewhat disbelieving in Ms Dhu's complaint as at that time.[71]

118. At 8.49 pm on 3 August 2014 Detective Senior Constable Nathan Nunn (formerly Senior Constable Nathan Nunn) assumed the responsibility of lock-up keeper. The Custody system records relating to physical cell checks of Ms Dhu from then on are unremarkable. Nevertheless, in his interview with officers from the internal affairs unit (IAU) on 6 August 2014, Detective Senior Constable Nunn stated that he noticed Ms Dhu moaning during one of his cell checks.[72]

119. A Custody system record made by Detective Senior Constable Nunn reflected that he gave Ms Dhu two tablets of Panadol and the Cell 3 camera records this as having occurred at 12.26 am on 4 August 2014.[73]

Ms Dhu's symptoms at Lock-Up on 4 August 2014

120. Mr Bond assumed the shift supervisor responsibilities at the Lock-Up at 7.00 am on 4 August 2014. He was given a verbal handover

[69] Exhibit 1, tab 26
[70] ts 625.
[71] ts 879.
[72] Exhibit. 4, tab 31 at 30
[73] Exhibit 3, tab 17

from Sergeant Cowie before 7.00 am. Mr Bond asked about Ms Dhu and he recalled that Sergeant Cowie said she was fine, she had slept through the night. There were no issues.[74]

121. First Class Constable Christopher Matier (formerly Constable Matier) assumed the lock-up keeper responsibilities from Detective Senior Constable Nunn at 7.00 am on 4 August 2014.

122. During a cell check at 8.46 am First Class Constable Matier spoke with Ms Dhu. The camera in Cell 3 indicates that she was unsteady on her feet and that she appeared to be getting agitated.[75] After she had pushed the cell call button at 8.54 am First Class Constable Matier attended at 8.58 am and gave Ms Dhu a Panadol tablet.

123. From the CCTV camera in Cell 3 it is evident that Ms Dhu pushed the cell call button for the last time at 9.54 am on 4 August 2014.[76]

124. It is apparent that it was during this intercom call that she spoke to First Class Constable Matier and advised him that she could not feel her legs.[77] Though First Class Constable Matier estimated that this call was around 11.30 am, the evidence establishes that it was approximately 1½ hours earlier.

125. When Ms Dhu asked to be taken to hospital during this intercom call, First Class Constable Matier asked her if she was sure, as this would be for the third time.[78] It was First Class Constable Matier's evidence that when he said this Mr Bond, who was seated at his desk in the same office, overheard him and said *"no"* to Ms Dhu's request.[79]

126. Between 9.03 am and 10.05 am the CCTV camera in Cell 3 shows Ms Dhu appearing to vomit on a number of occasions into a styrofoam cup.[80]

127. At 10.17 am the audio of the CCTV camera in the charge room of the SHPS recorded a conversation between First Class Constable Matier and a detainee. Background noise can be heard from the cells and First Class Constable Matier can be heard asking detainee whether Ms Dhu had been screaming all night, to which the detainee responded in the affirmative. First Class Constable Matier was of the view that Ms Dhu was behaving in this manner

[74] ts 1714
[75] Exhibit 6
[76] Exhibit 3, tab 17
[77] ts 1482
[78] ts 1482
[79] ts 1482
[80] Exhibit 3, tab 17

in order to be released, and he continued reading documents that were in front of him.[81]

128. At 10.28 am the audio of the CCTV camera in the charge room picked up First Class Constable Matier saying something about *"hospital"* and again Mr Bond overrode it, responding this time: *"That would be the third time she's been to hospital. She is fit to be held"*.[82]

129. At 10.59 am First Class Constable Matier conducted a physical check of Ms Dhu and noted in the custody records that: *"detainee is awake, lying down on his/her back"*.[83]

130. Ten minutes after that (at 11.09 am) the CCTV camera in Cell 3 showed Ms Dhu lying down on the mattress on her back. She did not stand up again after this time and was only ever able to lift herself up twice to a seated position before she fell backwards striking her head on the concrete.[84] There is no evidence that any police officer saw Ms Dhu fall on either occasion.

131. At 11:23 am Mr Bond entered Ms Dhu's cell. She told him that her hands were blue, or numb. Mr Bond performed a *"finger pinch"* test but he found nothing of note. He obtained a blanket for Ms Dhu and made a record of her complaint and what he looked at.[85]

132. At approximately 12.00 pm, and still without any intention of taking Ms Dhu to hospital, Mr Bond in his capacity as shift supervisor decided that Ms Dhu ought to have a shower. He instructed Senior Constable Burgess to undertake that task and Senior Aboriginal Police Liaison Officer Sophie Edwards was allocated to assist her.

133. At 12.06 pm Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards stood at the door of Ms Dhu's cell and had a conversation with her.[86] Ms Dhu remained lying on her back on the mattress and told the officers that she was in pain, that she could not move her legs and that her mouth was numb. Without entering the cell Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards attended Mr Bond's office and advised him of what had happened.

134. Sergeant Bond, Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards then walked over to Cell 3. Mr Bond then walked away in order to obtain gloves. The other two officers

[81] Exhibit 3, tab 17; Exhibit 11
[82] Exhibit 3, tab 17; Exhibit 11
[83] Exhibit 3, tab 7
[84] These two occasions occur at 11.45.51am and 11.52.24am – see Exhibit 3, tab 17 and Exhibit 5
[85] Exhibit 3, tab 17
[86] Exhibit 3, tab 17; Exhibit 21

entered the Cell 3. As depicted on the Cell 3's CCTV (that had no audio), at 12.11 pm Senior Constable Burgess approached Ms Dhu who was still lying on her back and with her right hand grabbed Ms Dhu's right hand to pull her up into a sitting position. She then lost her grip of Ms Dhu who fell backwards, striking her head on the concrete floor.[87]

135. After that, at 12.14 pm Mr Bond entered Cell 3. Ms Dhu was lifted by the police, this time to a supported seated position, and then the police returned her to a position lying on her back. All three police officers then left Cell 3. Ms Dhu was left lying on the mattress on her back.[88]

136. Mr Bond stopped to talk to Mr Ruffin in the next cell (it was just after 12.14 pm). Mr Ruffin spoke about Ms Dhu's health, their relationship and her prior drug use. Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards waited in the corridor of the Lock-Up.

Decision to transfer Ms Dhu to HHC on 4 August 2014

137. Sergeant Bond, Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards then entered the charge room at 12.18 pm and it was evident that a decision had then been made to convey Ms Dhu to HHC, because Mr Bond was heard shouting to Mr Ruffin: *"I'm too busy now taking your missus to the hospital to do your lunch"*.[89]

138. I am satisfied that Mr Bond made the decision to take Ms Dhu to HHC when the three officers left Ms Dhu's cell at 12.14 pm on 4 August 2014. However, almost 20 minutes elapsed before police officers re-entered Ms Dhu's cell for this purpose. First Class Constable Matier and Senior Constable Burgess are seen on the CCTV to have entered Ms Dhu's cell at 12.33 pm.[90]

139. Ms Dhu was unable to get up. She had limited use of her head and hands, which can be seen moving on the CCTV. After being handcuffed by First Class Constable Matier as she remained lying on her back on the mattress, Ms Dhu was dragged along the floor and then carried by the two police officers to the waiting police vehicle in the sally port area.[91] She was lifted into the secure pod at the rear of the vehicle.

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[87] Exhibit 3, tab 17; Exhibit 5
[88] Exhibit 3, tab 17; Exhibit 5
[89] Exhibit 3, tab 17; Exhibit 11
[90] Exhibit 3, tab 17; Exhibit 5
[91] Exhibit 3, tab 17; Exhibit 5

140. The only police officer who showed any display of urgency after the decision was made to take Ms Dhu to HHC was Constable Sharples. The CCTV in the sally port showed her walking briskly to the back of the police vehicle to open the rear doors before the other two police officers who were carrying Ms Dhu got there. In stark contrast, First Class Constable Matier was filmed walking at a normal pace back into the charge room after Ms Dhu was placed into the back on the police vehicle and then, in the same manner, exiting the SHPS to get into the police vehicle which was being driven by Senior Constable Burgess.

141. The police left with Ms Dhu for HHC at 12.39 pm on 4 August 2014 and arrived at the hospital within a matter of minutes.

Treatment at HHC on 4 August 2014

142. The CCTV cameras outside and inside the emergency department's reception area of HHC recorded Ms Dhu's cardiac arrest. The police vehicle arrived and was parked outside the emergency department doorway shortly after 12.40 pm. Senior Constable Burgess walked off and returned about one minute later with a wheelchair.

143. Ms Dhu was clearly completely incapacitated as the police officers lifted her out of the back of the police vehicle. She appeared to be unconscious. The two police officers placed her into the wheelchair. There was no urgency shown by either police officer, notwithstanding Ms Dhu's evident state of collapse.

144. No medical attention was given to Ms Dhu until the police officers wheeled her into the emergency department and the triage nurse on duty, Nurse Caroline Jones, observed her from behind the reception counter, apprehended the seriousness of the situation and acted. She quickly realised that Ms Dhu was in cardiac arrest and raised the alarm. Nurse Jones ran as she wheeled Ms Dhu into the resuscitation room where CPR was immediately commenced.

145. Despite the very best efforts of medical staff tragically Ms Dhu was unable to be revived and she was pronounced dead at 1.39 pm on 4 August 2014.

146. It is likely that Ms Dhu went into cardiac arrest on the walkway outside the HHC, as she was being placed into the wheelchair, or very shortly afterwards. I address the reasons for this below.

CAUSE AND MANNER OF DEATH

147. The forensic pathologist Dr Jodi White made a post mortem examination on the body of Ms Dhu at the State Mortuary on 7 August 2014. After further investigations, on 7 October 2014 she provided a report of her findings.[92] Dr White's investigations reflected upon both the cause and the manner of Ms Dhu's death.

Post Mortem Examination

148. Upon examination Dr White found evident old healing fractures of ribs 10 and 11 on the right side, laterally and posteriorly. There was one fracture site on each of those ribs.[93] Dr White also found a possible re-fracture of the 10th rib. In her opinion the re-fracture occurred post mortem because there was no haemorrhage around the fracture site.[94] The re-fracture was most likely caused by the resuscitation attempts, which is not uncommon.

149. Dr White considered the old healing fractures could have occurred some weeks or months prior to her examination. In relation to those fractures she opined that at least a moderate force would be required to cause them. In Dr White's experience, such fractures are seen when a person falls onto a surface or an object, or when there is a blow or impact at that site.[95]

150. Dr White found there was a localised infection involving the right 10th rib with extensions into the soft tissues posteriorly with evident abscess formation. That is, the abscess was located behind the ribs within the muscle of the posterior right trunk, next to where the bone was broken. The infection site was over five to seven centimetres, meaning that the infection was extensive.[96]

151. Dr White found fibrinopurulent adhesions involving the right lung, and focal abscess formation in the lungs. This was consistent with Ms Dhu having also had a severe chest infection. Dr White ultimately found that Ms Dhu had a very severe and advanced pneumonia.[97]

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[92] Exhibit 1, tab 37
[93] Exhibit 1, tab 37.1
[94] ts 87 - 88
[95] ts 87 - 88
[96] ts 90
[97] ts 91

152. Dr White observed scattered soft tissue injuries to the limbs many of which showed evident healing. One of these comprised a scabbed healing lesion on the upper aspect of the right foot (the surface of the ankle) over 4 mm in size. Dr White was unable to say whether it might have originated from a blister.[98]

153. Microscopic examination showed osteomyelitis involving the right 10th rib with extensive local extension into the soft tissues and florid acute haemorrhagic pneumonia. Neuropathology confirmed no evident traumatic head injury. Microbiology showed a pure growth of staphylococcus aureus from lung tissue, blood cultures, spleen and soft tissues from the infected rib site.[99]

154. Toxicology showed prescribed medication diazepam, paracetamol, Ibuprofen in non-toxic levels and low methylamphetamine, amphetamine and tetrahydrocannabinol levels.[100] Whilst the levels of the illicit drugs detected at post mortem do not assist in determining how affected Ms Dhu may have been by drugs on 2 August 2014, I note that she was able to clearly communicate her pain and her history of a previous rib fracture to Constable Sharples, a few hours after her arrest on 2 August 2014. I am satisfied that Ms Dhu was not substantially affected by drugs upon her arrest.

Cause of death

155. On 7 October 2014, after assessing the results of the further investigations, Dr White formed the opinion that Ms Dhu's cause of death was staphylococcal septicaemia and pneumonia in a woman with osteomyelitis complicating a previous rib fracture.[101] I accept and adopt that cause of death.

Manner of death

156. In considering the manner of Ms Dhu's death, I do not have regard to whether or not there was medical error. The manner of Ms Dhu's death is determined by reference to her cause of death and all of the circumstances attending her death. I am precluded from framing a finding that appears to determine any question of civil liability. I respectfully adopt the formulation outlined in *R (Benton) v HM Coroner for Birmingham and Solihill* (1998) 162 JP 807, [2000] Inquest LR 72:

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[98] ts 94 - 95
[99] Exhibit 1, tabs 37 and 38
[100] Exhibit 1, tabs 37 and 39
[101] Exhibit 1, tab 37

"It is necessary to contrast two possible situations. The first is where a person is suffering from a potentially fatal condition and medical intervention does no more than fail to prevent that death. In such circumstances the underlying cause of death is the condition that proved fatal and in such a case, the correct verdict would be death from natural causes. This would be the case even if the medical treatment that had been given was viewed generally by the medical profession as the wrong treatment. All the more so is this the case where such a person is not treated at all even if the failure to give the treatment was negligent. Thus in such circumstances the recording of a verdict of death by natural causes is not in any way a finding that there was no fault on the part of the doctors. That question for the reasons already explained is not one that the inquest does, or is permitted to, address.

On the other hand, where a person is suffering from a condition which does not in any way threaten his life and such person undergoes treatment which for whatever reason causes death. Then assuming that there is no question of unlawful killing the verdict should be death by accident, misadventure. Just as the recording of death by natural causes does not absolve the doctors of fault so the recording of death by accident/misadventure does not imply fault."

157. Ms Dhu's pre-existing and extensive infection was not diagnosed at HHC. By this stage her osteomyelitis was well established. The manner of Ms Dhu's death is by way of natural causes.

Evidence concerning time of death

158. The time of Ms Dhu's death, as far as it can be ascertained, is an important consideration, particularly having regard to her collapse at HHC on 4 August 2014.

159. I am satisfied that Ms Dhu was alive, though very close to death, when the police vehicle left the Lock-Up at 12.39 pm on 4 August 2014 and drove towards HHC, with her in the back of the vehicle.

The Lock-Up's corridor

160. At the inquest a concern was raised about some apparently dark brown coloured matter left on the Lock-Up's corridor floor on 4 August 2014, after Ms Dhu was carried along it, on the way to the police vehicle. Specifically, this was when First Class Constable Matier and Senior Constable Burgess commenced carrying Ms Dhu to the sally port. At one point she was lowered onto or close to the floor. Though there was no dark brown coloured matter on the floor before Ms Dhu was placed there, it was evident once she was removed from that spot.

161. The question then arose concerning the nature of that material, and whether it could have been from an involuntary bowel movement from Ms Dhu. The dark brown coloured matter also appeared to have later been removed, and the question then arose as to whether the area had been cleaned before forensic investigators arrived.

162. The questions became relevant for the following reasons:

a. At the time of the inquest there was no CCTV available to the court for the period after Ms Dhu's removal from the corridor;
b. There were concerns expressed about it possibly being faecal matter and that it may have been cleaned up by a person before the forensic examiners came to the site;
c. If it were faecal matter it could reflect on the timing of Ms Dhu's loss of consciousness making it more likely that she lost consciousness on the way to HHC;
d. If it were faecal matter it would cast significant doubt over the assertions of Senior Constable Burgess and First Class Constable Matier to the effect that, at that point, they believed Ms Dhu was feigning the extent of her ill health.

163. At the inquest Senior Constable Burgess stated that though it was hard to tell, the coloured matter or object could be a magazine or it could be a bowel movement.[102]

164. Additional information was provided by counsel for the Commissioner of Police and copied to the other counsel dated 23 March 2016. That information was to the effect that IAU investigators believed the dark coloured matter was a paper bag. I undertook a further investigation of the matter.

165. The further investigation included an examination of additional CCTV footage obtained from the Western Australian Police Service. That footage was received on 22 April 2016.[103]

166. An examination of that footage coupled with a more detailed examination of the footage of First Class Constable Matier's removal of Ms Dhu from her cell[104] shows that either a brown paper bag (most likely the one that had been provided to Ms Dhu previously)[105] or a magazine (also having been provided previously)[106] has become caught up under her trousers when First Class Constable Matier began dragging her along the floor. It can be seen flapping whilst it is under her trousers. It has then

[102] ts 1610.
[103] Exhibit 21
[104] Exhibit 5
[105] Exhibit 3, tab 17 at 10
[106] Exhibit 3, tab 7

become separated when First Class Constable Matier and Senior Constable Burgess commenced carrying Ms Dhu, and was left on the corridor's floor.

167. I am satisfied that the dark brown coloured material under Ms Dhu's trousers on the floor of the corridor that she was being carried along was not faecal matter. It was either a magazine or a paper bag. It has a dark brown appearance on the CCTV. It is still visible on the CCTV on the floor of the corridor at 1.10 pm on 4 August 2014.[107] No CCTV vision is available after that point.

Ms Dhu's cardiac arrest

168. On 4 August 2014 shortly after 12.40 pm Ms Dhu arrived at the HHC. She was in the back of the police vehicle. Outside the emergency department, on the public pathway, Senior Constable Burgess and First Class Constable Matier lifted Ms Dhu out of the back of the police vehicle and into a hospital wheelchair. From the CCTV footage it is clear that she had no independent movement in her limbs.

169. The police officers adjusted Ms Dhu's body into the wheelchair. Alarmingly, they left her with her head hanging backwards over the top of the wheelchair, facing upwards and with her neck hyperextended. She had no independent movement in her neck. From the CCTV images, Ms Dhu does not display any signs of life at this point. The police officers did not display any sense of urgency in their conveyance of Ms Dhu into the emergency department of HHC.[108]

170. First Class Constable Matier's evidence was that shortly before Ms Dhu was lifted out of the back of the police vehicle he heard Ms Dhu repeat the words: "*I can't move, I can't move*".[109] I accept that evidence.

171. The question arises as to when Ms Dhu went into cardiac arrest, because shortly after Ms Dhu spoke those words, she was conveyed into the emergency department of HHC and identified by Nurse Jones to be unresponsive. This resulted in the immediate initiation of resuscitative measures, which were undertaken for 53 minutes, tragically without success.

172. Dr Campbell, emergency consultant, was working in the HHC emergency department when Ms Dhu presented at approximately 12.45 pm on 4 August 2014. Together with Dr Gan, he was in

[107] Exhibit 21
[108] Exhibit 9
[109] ts 1508 - 1509

charge of her resuscitation. Dr Campbell recalled that Nurse Jones was running as she wheeled Ms Dhu into the resuscitation area.[110]

173. Upon her arrival Dr Campbell found Ms Dhu to be pulseless, apnoeic and unresponsive. She was in handcuffs, which a police officer removed. Dr Campbell immediately commenced cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS). Several senior doctors and many nurses were in attendance. Vigorous chest compressions were applied with personnel changing every five minutes or so.[111]

174. Ms Dhu was administered adrenaline, and at 12.55 pm she was intubated. Minutes later she was noted to have pulseless electrical activity with no palpable pulse, so a vigorous IV fluid exchange was commenced. Ms Dhu's pupils remained fixed and dilated. She did not make a blink of an eye or a respiratory effort throughout. This led Dr Campbell to give consideration to her "*down time*" which he described at the inquest as the time between cardiac arrest and presentation to the emergency department.[112]

175. Dr Campbell and a number of other clinicians had noted Ms Dhu's skin felt cool to the touch upon arrival. Dr Campbell's evidence was to the effect that Ms Dhu could have gone into cardiac arrest some number of minutes before her presentation to the emergency department, but he could not put a time on it.[113]

176. At 1.38 pm on 4 August 2014, the four doctors (including Dr Campbell) decided to cease active resuscitation. After 53 minutes of active resuscitation, Ms Dhu had not responded in any meaningful way. Very sadly Ms Dhu was pronounced dead at 1.39 pm.[114]

177. I am satisfied that Dr Campbell and the team at HHC applied all possible and proper measures in their sustained efforts to resuscitate Ms Dhu. I agree with Dr Campbell's opinion that upon presentation, noting her cool skin and her asystole on the monitor, Ms Dhu's prognosis was grim.[115] I concur with the views expressed by Ms Dhu's family though their counsel, that the quick actions of nursing and medical staff on that day should be commended.

178. At the inquest I heard evidence directed to establishing the timing and reasons for Ms Dhu's loss of consciousness. Dr Speers opined

[110] Exhibit 1, tab 28
[111] Exhibit 1, tab 28
[112] ts 711 - 712
[113] ts 713 - 714
[114] Exhibit 1, tab 3
[115] Exhibit 1, tab 28

that when Ms Dhu lost blood perfusion to her extremities and was unable to sit or walk, which was at approximately 11.30 am on 4 August 2014 when she was in her cell, she was in an established state of septic shock, and experiencing peripheral shutdown.[116]

179. Just over one hour later, shortly after 12.40 pm when police officers arrived at HHC and lifted Ms Dhu into the wheelchair, she lost consciousness and she did not regain consciousness after that point. Dr Speers explained that is a reflection of the loss of blood supply to the brain with the physical sitting up of the person. In his experience, with sepsis a person can be speaking one moment and then become unconscious the next:

> *"….the body will work to maintain blood supply to the brain virtually at all cost and, as I said, younger people will be able to do that better than older people. When you reach a threshold where the compensatory mechanisms can no longer continue that, that is when you will suddenly lose the blood pressure and it can disappear very quickly. So people can go from being able to talk to you to being unconscious in relatively short spaces of time."*[117]

180. First Class Constable Matier recalled that he observed the movement of Ms Dhu's chest after she was placed in the wheelchair, but that she had no movement in her limbs.[118] The CCTV footage reflects that he adjusted her feet into the foot supports of the wheelchair. If Ms Dhu did take a breath in the wheelchair, it was momentary and shortly before she went into cardiac arrest.

181. Taking account of the fact that Ms Dhu had managed to speak some words before being lifted out of the police vehicle and placed into the wheelchair outside the HHC, the evidence from Dr Campbell regarding her "*down time*", and the evidence from Dr Speers regarding her likely loss of consciousness, I am satisfied that Ms Dhu went into cardiac arrest as she was being placed by police in a sitting position in the wheelchair, or very shortly afterwards and most likely whilst she was still outside the HHC. She tragically died despite maximal attempts at resuscitation.

EXPERT EVIDENCE ON MS DHU'S INFECTION

182. At the inquest, I received expert evidence from Dr Speers, infectious diseases specialist and microbiologist, in connection with how Ms Dhu's fracture became infected, and the nature and progression of her infection. Prior to giving evidence, Dr Speers

[116] ts 234
[117] ts 235
[118] ts 1516

reviewed information pertaining to the investigation, including Ms Dhu's medical notes and Dr White's forensic pathology report (and its related investigations, including the microbiology report) and he prepared a report.[119]

Dr Speers' evidence

183. Microbiology testing at post mortem showed a pure growth of staphylococcus aureus from Ms Dhu's lung tissue, blood cultures, spleen and soft tissues from the infected rib site.

184. In Dr Speers' experience, staphylococcus aureus (a bacteria) is by far the commonest cause of infection following trauma and the most common cause of osteomyelitis (bone infection). He believed the source of staphylococcus aureus causing Ms Dhu's rib infection would have been her skin.[120]

185. Staphylococcus aureus lives on the skin and usually causes no harm, though it can cause local skin infections. Intravenous drug users are at increased risk of staphylococcal bacteraemia (where the skin staphylococci circulate in the blood) because the skin is breeched on multiple occasions with a needle (through the skin into a vein) allowing the staphylococci that normally live on the skin to enter the bloodstream.[121]

186. Dr Speers opined that Ms Dhu's rib fracture would have become infected following an episode of staphylococcal bacteraemia with subsequent lodging at the site of traumatic fracture. This is called haematogenous osteomyelitis as the infecting bacteria have accessed the bone from the bloodstream.[122]

187. Dr Speers explained that at the fracture site the blood supply is rich but sluggish making the deposition of circulating bacteria more likely. In addition small pieces of avascular necrotic bone (dead bone due to losing its blood supply) present at the fracture site make good hiding places for these bacteria. Staphylococci are much more able to adhere to these bone fragments than other bacteria.[123]

188. Dr Speers reported on the progress of such an infection. He opined that following the deposition of the bacteria into the blood clot or healing tissue at the site of fracture, bacterial multiplication would

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[119] Exhibit 1, tab 40
[120] Exhibit 1, tab 40; ts 221 - 222
[121] ts 221 - 222
[122] Exhibit 1, tab 40; ts 220 - 221
[123] Exhibit 1, tab 40; ts 220 - 221

occur, nourished by the rich supply of nutrients from the blood and damaged tissues. The multiplying bacteria trigger the immune system to activate to fight the infection.[124]

189. The immune system endeavours to fight the infection by recruiting immune cells such as neutrophils which descend on the site to phagocytose (consume) the bacteria. The bacterial infection and the release of toxins from bacterial breakdown due to the immune response causes pus formation and inflammation, which if left untreated will progress to an abscess.[125]

190. An abscess is the body's natural response to wall off the infection from the rest of the body. The infection may be able to be contained within the abscess or may spread to adjacent tissues or escape into the bloodstream (both occurred in Ms Dhu's case). If the infection escapes into the bloodstream it can cause septicaemia (blood poisoning) and/or secondary infections of the lungs (pneumonia), amongst other conditions. Ms Dhu had septicaemia and pneumonia.[126]

191. The infection of a fracture site would occur most often within days of the fracture but if there is persisting blood flow abnormality or ongoing tissue damage and healing, e.g. from movement delaying fracture healing, the fracture could be seeded and infected weeks or even months later. The progression from a local bone infection to involve the adjacent tissues and then subsequently spread to cause septicaemia or distant infection occurs over days to weeks.[127]

192. If successfully resolved by the immune system and local tissue response the bone infection will heal but if not it can persist (causing chronic osteomyelitis). Chronic osteomyelitis at a fracture site is usually marked by non-union (failure of the fracture to unite or heal) or delayed healing and the production of abnormal bone which is visible on an X-ray.[128] Ms Dhu had chronic osteomyelitis.

193. Dr Speers considered Dr White's evidence regarding the likelihood of the re-fracture of the 10th rib having occurred post mortem and opined that the infection was in the original fracture.[129]

194. I am satisfied that on one or more of the occasions when Ms Dhu injected herself with amphetamines, the staphylococcus aureus that was on her skin entered her bloodstream, resulting in an

[124] Exhibit 1, tab 40; ts 223
[125] Exhibit 1, tab 40; ts 223
[126] Exhibit 1, tab 40; ts 223
[127] Exhibit 1, tab 40; ts 223
[128] Exhibit 1, tab 40; ts 223 - 224
[129] ts 224

episode of staphylococcal bacteraemia that lodged at the site of her 10th rib fracture, which had not healed from the time she sustained it in April 2014. This caused an infection at that site, and she ultimately developed chronic osteomyelitis. Her immune system, which was already compromised due to her drug use, was not able to deal with the infection. The infection progressed and an abscess was formed, as part of the body's immune response, to try and contain the infection. However, the infection continued to progress and it spread to Ms Dhu's adjacent tissues and into her bloodstream.

195. Dr Speers explained that if the infection escapes into the bloodstream then systemic features (such as fever, sweats, malaise, anorexia and lethargy) would become much worse with high fevers, chills and shakes, a rapid pulse, and the person would appear flushed and warm. Prostration would then ensue where the person would want to lie down and rest, not want to eat or drink and may develop vomiting and/or diarrhoea. This is called sepsis.[130]

196. In Dr Speers' experience, younger people with sepsis would tend to have a rapid pulse but maintain their blood pressure. Tachycardia is a common symptom of sepsis. The systemic inflammatory symptoms (such as fever, sweats, malaise, anorexia and lethargy) would not occur from a rib fracture and would be a clue to an underlying infection.[131]

197. Ms Dhu's rapid pulse on 3 August 2014, at 126 beats per minute and shortly afterwards at 113 beats per minute, and her warm skin, which were noted on her emergency department notes, and the fact that she appeared asleep when Dr Naderi entered the cubicle, persuade me that on that presentation to HHC, her sepsis was well established.

198. Dr Speers addressed the further progression of such an infection. As the infection worsens the person would be unable to walk or even sit up, and the blood pressure would drop causing the body's organs to shut down. This would be evidenced by cold and mottled hands, feet and lips, a thin pulse and loss of urine production. This is called septic shock. The person could become delirious, and if left untreated would progress to a depressed conscious state (sleepiness), then unconsciousness (but responds to pain), then deep coma (unable to be roused by pain) then die.[132]

199. I am satisfied that on 4 August 2014, Ms Dhu developed septic shock, lost consciousness and then tragically died.

[130] Exhibit 1, tab 40; ts 226
[131] ts 227
[132] Exhibit 1, tab 40; ts 226

The relevance of Ms Dhu's blister to her foot

200. A question had arisen as to whether it was likely that an injury to Ms Dhu's foot (apparently a blister that had been burst by Mr Ruffin with Ms Dhu's consent on 2 August 2014) contributed to the infection which led to her death.

201. Dr David Speers initially opined it was *"possible"* that Ms Dhu's foot blister could have been the source of the infection.[133] Dr White testified that the injury to Ms Dhu's foot, having occurred on or about 2 August 2014 was: *"too close for the amount of infection that she had and how ill she was and how far it had progressed.... But I'm not saying that she didn't have additional bacteria which entered the bloodstream on that day."*[134]

202. Dr White formed her opinion by having regard to the size of Ms Dhu's abscess, post mortem, and it's implications for the extent of her infection:

> *"I think the degree of infection that I saw at post-mortem, particularly the abscess behind the chest, it would take days for that to develop and because of that blister being popped only two or three days before, that's not long enough in a time scale to get an abscess this big behind your back....and for the changes to develop in the lungs, so it's my view that it would be at least a week or up to two weeks that, at some point, she has had a break in the skin, that the bacteria has entered and has seeded that site and has started to form an infection and then it has spread into the bloodstream and a chest infection has started to form. At any other time from then, she may have had additional injuries or even when she used amphetamines, that's another point when you can introduce bacteria so there may have been multiple other times where bacteria were introduced again, but that pricking the ball just a few days before, I don't think that's enough time to have produced that amount of infection which I found behind her ribs."*[135]

203. Dr Speers agreed with Dr White on this point, stating that whilst he could not exclude the blister as a possible source: *"the spread of the infection from the rib to the adjacent tissues, I believe, would have happened over days to weeks, so it was my opinion that perhaps the infection of the rib had actually started more than just a few days before her presentation"*.[136]

204. I am satisfied that the breech to Ms Dhu's skin that occurred when Mr Ruffin popped the blister on her foot two days before her death,

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[133] Exhibit 1, tab 40
[134] ts 153.
[135] ts 156
[136] ts p.222.

did not contribute to her death. Ms Dhu's infection was already well established by that time.

The outcome of microbiological analysis of police cell swabs

205. Samples were taken from the Lock-Up and from Cell 3 where Ms Dhu had been detained, for microbiology analysis, on 15 August 2014. Specifically, samples were taken from a chair in the interview room, from the holding cell, and from the floor, door and mattress of Cell 3.

206. According to the Industrial and Environmental Microbiology report all swabs taken returned a level of < 20 CFU/100cm^2 for coagulase positive staphylococci (another name for staphylococcus aureus) and E coli. These results were in the "*ideal*" range.[137]

207. Dr Speers was asked whether it was possible that the results of the analysis of the swabs from Cell 3 could have been associated with Ms Dhu's contraction of a staphylococcus infection. Clearly the E coli is a bowel pathogen; it was unrelated to Ms Dhu's death. Dr Speers did not consider the staphylococcus aureus detected in Cell 3 and in the interview room to have been associated with Ms Dhu's death.[138]

208. I am satisfied that Ms Dhu's infection was already incubating before her arrest and that the staphylococcus aureus detected by microbiological analysis of police cell swabs did not contribute to her death.

WAS MS DHU'S DEATH PREVENTABLE?

209. At the inquest I received expert evidence from Dr Speers whom I have already indicated is an infectious diseases specialist and microbiologist, and from Dr Dunjey, consultant emergency specialist, that was relevant to the question of whether Ms Dhu's death was preventable. Both are highly qualified in their areas of expertise. That evidence addressed the prevalence of this type of infection, its signs and symptoms, the difficulties that may be experienced in diagnosing it, and whether antibiotic treatment at certain points may have prevented Ms Dhu's death.

[137] Exhibit 2, tab 44
[138] Exhibit 1, tab 40

Infection following a closed rib fracture

210. Secondary infections of open fractures (fractures where the bone is exposed to the external environment due to a break in the covering skin and soft tissue) are far more common than infection following a closed fracture (fractured bone is not exposed). Ms Dhu suffered a closed rib fracture.[139]

211. Infection following a closed fracture is rare based on the large number of closed traumatic fractures that occur with few reported secondary infections. It is more likely to occur in those who have multiple episodes of staphylococcal bacteraemia.[140]

212. I accept that Ms Dhu's infection was rare. She was a known intravenous drug user. The purpose of the two medical assessments at HHC was to ascertain whether she had a diagnosable condition, rare or otherwise.

The difficulties in diagnosing this infection

213. In Dr Speers' experience, the initial infection of the fracture site would not have caused symptoms until at least three to four days, as the subsequent inflammation from the immune response is responsible for many of the symptoms of infection (pain, redness, heat, swelling). Infection of a rib fracture would not have felt different to that of the fracture itself initially as it would cause only localised symptoms, predominantly pain with chest wall movement and breathing, exacerbated by coughing.[141]

214. In Ms Dhu's case, an abscess developed, and rather than moving towards the surface, where a tender swelling could have been felt, it moved internally to involve the local soft tissues and through the pleura (lining of the lung). This explains why the doctors were unable to feel a swelling in that area when they palpated Ms Dhu's chest wall.

215. The systemic features of infection, such as fevers, sweats, rapid pulse and prostration, would have been clues to an underlying infection.

216. In Dr Dunjey's experience, a delay in the diagnosis of staphylococcal septicaemia is so common as to be part of the natural history of the condition:

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[139] Exhibit 1, tab 40
[140] Exhibit 1, tab 40
[141] Exhibit 1, tab 40

"It's a condition that is rare and lethal and rapidly progressive and in its early stages it can look like a viral infection. And so it's a little bit like the meningococcus infection in children; it's often misdiagnosed, almost always. And, unfortunately, as people get sicker and sicker and the diagnosis gets more obvious, often it's too late to do anything about the conditions. So it's often misdiagnosed, almost always."[142]

217. Dr Dunjey reported a mortality rate of 20% to 40% for staphylococcal septicaemia, and on this basis opined that it may be that Ms Dhu would have died even with earlier diagnosis and maximal medical therapy.[143]

218. I am satisfied that some of Ms Dhu's features upon presentation on 3 August 2014 (taking account of her presentation the day before) would have been clues to an underlying infection, namely her rapid pulse, warm skin, difficulty breathing, her history of a broken rib, her complaints of rib pain, developing into complaints of all over body pain, on a background of a history of intravenous drug usage.

The likely effect of antibiotics

219. It is generally accepted that the early administration of antibiotics improves outcome overall. The effect of antibiotic timing on clinical outcome in sepsis is complex. It is an inexact science. I accept that it cannot be oversimplified to an arbitrary time interval prior to death. However the likely effect of antibiotic administration can be ascertained by reference to Ms Dhu's features upon presentation at HHC, and what is now known about the extent of her infection.

220. The first possible time point for antibiotic administration to Ms Dhu was at the first presentation at HHC on 2 August 2014. At this stage, Ms Dhu's sepsis was already under way. Dr Speers opined that, while antibiotics would have been life-saving for Ms Dhu at this time point, there was no objective evidence that Ms Dhu had an infection.[144] Dr Dunjey was of a similar opinion, namely that on her first visit to HHC on 2 August 2014, there were no clues to her life threatening illness.[145] I accept these opinions.

221. The second possible time point for antibiotic administration was at the second presentation at HHC on 3 August 2014. She was probably bacteraemic at this point, but unfortunately, her temperature was not recorded, even though her skin was felt to be warm at triage. Dr Speers opined that Ms Dhu was more ill at this

[142] Exhibit 2, tab 49; ts 266
[143] Exhibit 2, tab 49
[144] Exhibit 1, tab 40; ts 231
[145] Exhibit 2, tab 49

presentation with new symptoms and signs potentially due to sepsis, but it was not obvious she had a significant infection as several of these signs could have been due to her pain and agitation. At this time point, antibiotics would have been potentially life-saving.[146] I accept Dr Speers' opinion regarding the likely effect of the antibiotics.

222. However, in light of the evidence at the inquest, taken as a whole, I incline towards Dr Dunjey's opinion, given his extensive experience in treating patients, and consider it likely that attending staff at HHC had undergone premature diagnostic closure. Essentially there were several points at which Ms Dhu's serious illness may have been recognised on 3 August 2014, but these steps were omitted or forgotten by staff at HHC on that day. Dr Dunjey described premature diagnostic closure as being completely understandable in the context and testified that it is known to occur in medical practice.[147] I address this below, in the context of the individual roles of the clinicians.

223. The third possible time point for antibiotic administration was prior to the third presentation at HHC on 4 August 2014. Ms Dhu vomited on a number of occasions between 9.00 am and 10.15 am and by 11.25 am, complained that her hands were going blue. Dr Speers opined that antibiotics had no role to play at this late stage. Ms Dhu may have died even if admitted and given appropriate antibiotics several hours earlier on 4 August 2014 as her established staphylococcal septicaemia was probably far advanced and potentially irreversible, giving her only a slim chance of survival with full resuscitation and appropriate intravenous antibiotics. Dr Speers' further opined that in the hour before she presented at HHC on 4 August 2014, Ms Dhu was in an established state of septic shock.[148] I accept these opinions.

224. I also take into account Dr Dunjey's opinion to the effect that on Ms Dhu's second presentation to HHC, on 3 August 2014, she was already very ill and in the process of dying from septicaemia and pneumonia.[149] Her dire state on 3 August 2014 had clear implications for her deterioration and survivability on 4 August 2014.

225. I am satisfied that whilst there may have been a slim possibility of survival if Ms Dhu had presented to HHC some hours before on 4 August 2014, sadly, it was unlikely that she would have survived given the overwhelming nature of her infection, and its rapid progression.

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[146] Exhibit 1, tab 40; ts 231 - 232
[147] Exhibit 2, tab 49
[148] Exhibit 1, tab 40
[149] Exhibit 2, tab 49

The evidence concerning antibiotics as prophylaxis

226. Given that antibiotics would have been life-saving for Ms Dhu on 2 August 2014, and potentially life-saving for Ms Dhu on 3 August 2014, I explored whether they may have been any basis for prescribing antibiotics as prophylaxis (that is, a preventative) on either of those presentations at HHC.

227. Dr Speers informed the court that antibiotic prophylaxis is recommended following open fractures due to the bacterial contamination of the fractured bone upon exposure to the external environment. The infection of a closed fracture is a rare event and therefore preventative measures such as prophylactic antibiotics are not routinely recommended.[150]

228. I questioned Dr Speers on whether there would be any basis for antibiotic prophylaxis to a high-risk patient, such as an intravenous drug user, in a closed fracture setting. Dr Speers opined as follows:

> *"When I say it's not standard to give antibiotic prophylaxis, I'm quoting the Therapeutic Guidelines: Antibiotic, which is the antibiotic guidelines used by all infectious disease physicians around Australia. I don't believe there is anything written in that document that says you would give it because someone is a user of intravenous drugs. Although it is more common in people who use intravenous drugs, it is still a relatively uncommon event and it would be a situation of giving many, many people antibiotics for the possibility of preventing a single case. Most guidelines for the use of what we call prophylactic or preventative antibiotics based on a risk benefit and if there is no evidence that it is particularly useful, it wouldn't be recommended."*[151]

229. Dr Speers explained that the appropriate antibiotics need to be given for the appropriate type of infection. Having regard to the fact that there are standards for the prescription of antibiotics to ensure the appropriate use of antibiotics in Australia and in fact in all countries, he stated that: "*There is a significant worldwide problem of antimicrobial resistance and, therefore, using antibiotics appropriately is reinforced by most healthcare systems around the world now.*"[152]

230. I accept Dr Speers' opinion concerning antibiotic prophylaxis. I am satisfied that there was no basis for antibiotic prophylaxis on

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[150] ts 225
[151] ts 225
[152] ts 259

2 August 2014, and there was no reasonable indication of infection on 2 August 2014. Unfortunately, it was on 2 August 2014 that antibiotics would have been life-saving for Ms Dhu, but she did not display symptoms of infection on that presentation.

231. I am also satisfied that there was no basis for antibiotic prophylaxis on 3 August 2014. However, the question of whether there was a reasonable indication of infection on 3 August 2014 (such as to warrant the prescription of antibiotics) is more complex, particularly as Ms Dhu's temperature was not taken on that presentation, nor was a chest X-ray performed. This is addressed later in this finding.

Conclusion as to whether Ms Dhu's death was preventable

232. Ms Dhu's death could have been prevented if her infection had been diagnosed at HHC on 2 August 2014, but she did not display symptoms of infection on that date. There was no reason not to discharge Ms Dhu into the custody of police. Whilst there were some errors and omissions at HHC on 2 August 2014, none contributed to Ms Dhu's death.

233. Ms Dhu's death could potentially have been prevented on 3 August 2014. She displayed symptoms of infection on this date. Unfortunately, as her temperature was not taken, I cannot now say for certain whether she was febrile, but I consider it highly likely that she was febrile. Whilst a chest X-ray was not taken, I consider it highly likely that she had developed pneumonia by this stage.

234. There were missed opportunities at HHC for ascertaining the extent of Ms Dhu's infection at on 3 August 2014. Had that extent been known, I have no doubt she would not have been discharged into the custody of the police. There were errors and omissions at HHC on 3 August 2014. The extent to which they contributed to Ms Dhu's death cannot be known because by this stage antibiotics would not have been as effective as they would have been the day before. I am satisfied that Ms Dhu's death could potentially have been prevented with antibiotics on 3 August 2014 if her infection had been diagnosed.

235. The errors and omissions giving rise to the missed opportunities at HHC on 3 August 2014 relate to Ms Dhu being under-triaged, to the failure to record a full set of vital signs, and to the failure to perform appropriate investigations.[153] Some of this was affected by

[153] Exhibit 2, tab 49

premature diagnostic closure, and is addressed later in this finding.

236. Very sadly, by 4 August 2014, Ms Dhu's survivability by the administration of antibiotics and resuscitative measures some hours prior to the actual time of her presentation at HHC, was unlikely. By the time she presented at HHC at 12.45 pm on 4 August 2014, in cardiac arrest, her prospects were grim.

THE CAUSE OF MS DHU'S RIB INJURY

The role of Mr Ruffin

237. At the inquest Mr Ruffin admitted that he was responsible for breaking Ms Dhu's rib in April 2014.[154]

238. In answers to questions from his counsel, Mr Ruffin explained the circumstances of that occasion when Ms Dhu's rib was broken. His evidence was that Ms Dhu had stabbed him in the leg with a pair of scissors during an argument, after which he was on his knees with Ms Dhu behind him holding him in a headlock. His account was that he grabbed her jumper and pulled her over himself and that when she landed on the floor she broke her rib on an ornament that was on the floor.[155] He could not recall when that occurred, and believed it was three or four months prior to her death.

239. I am satisfied that Ms Dhu sustained a fracture of her 10th and 11th ribs in April 2014 as a result of Mr Ruffin throwing her over his shoulder, from a kneeling position, and causing her to fall, during the course of a domestic argument. It was a domestic violence incident.

240. After that they both attended at GRH on 21 April 2014 because Ms Dhu had pain and swelling in her ribs. The clinicians at GRH were not told of the domestic argument. Instead, they were informed that Ms Dhu's rib pain was as a result of her having slipped on rocks two days previously.

241. Under cross-examination from counsel for Ms Dhu's father, Mr Ruffin admitted that he did not get his leg wound treated at the hospital even though he had attended with Ms Dhu for treatment to her broken rib. He then clarified that the cut was only *"2 mm"*

[154] ts 112
[155] ts 112

and that the scissors Ms Dhu used were actually *"tiny little scissors"*.[156]

242. The only account of this incident is from Mr Ruffin. Ms Dhu did not make a complaint to police regarding this incident, nor did she ever give an account about Mr Ruffin having thrown her over his shoulder and onto the ground in the manner he described.

243. Ms Dhu is not here to speak for herself. She was of a slender build and much smaller in size to Mr Ruffin. She was 160 centimetres in height and weighed approximately 50 kilograms. It is not now possible to know what actions Ms Dhu took on that day, but having regard to her slight frame, I do not consider she could have effectively held Mr Ruffin in a headlock.

244. I am satisfied that Mr Ruffin's actions in throwing Ms Dhu over his shoulder were not a reasonable response to her inflicting a tiny wound to his leg which did not even require any medical attention, even if she did do that (and I am not satisfied that she did do that).

245. Mr Ruffin was asked by his counsel whether there were any other domestic incidents involving Ms Dhu. He responded: *"we had a couple of arguments here and there, but nothing wild or anything. A few little wrestles, and whatnot...."*[157]

246. Ms Della Roe stated that she was aware that Mr Ruffin was unkind to Ms Dhu and considered him to be possessive of Ms Dhu. She expressed her concern that after Ms Dhu commenced her relationship with Mr Ruffin, she was no longer the bubbly child that she normally was. However, she was not sure whether Ms Dhu's attendance at GRH was as a result of any act on the part of Mr Ruffin.[158]

247. Ms Della Roe referred to an incident after Christmas of 2013 where Ms Dhu came to her house with a black eye and, upon being questioned as to whether Mr Ruffin had caused it, became evasive. Whilst she did not observe Mr Ruffin hit Ms Dhu, she did recall him speaking with her in an angry voice. She also recalled an incident where Ms Dhu reported to her that she and Mr Ruffin had fought in a vacant block in Tamara Street and he was sitting on her and she "*slung him off*."[159]

248. Mrs Carol Roe recalled that in about April 2014 she observed Ms Dhu holding her ribs on one side, but Ms Dhu was evasive when she asked whether Mr Ruffin had hit her. She stated to her that she had fallen over. Mrs Carol Roe also recalled an incident

[156] ts 134
[157] ts 112
[158] ts 23 - 24
[159] ts 25 - 26

similar to the one referred to by Ms Della Roe at the vacant block at Tamara Street. Mrs Carol Roe recalled Ms Dhu's mouth was bleeding and that she said Mr Ruffin had hit her.[160]

249. Mr Robert Dhu recalled that his daughter had told him Mr Ruffin had broken her ribs and that she flogged him or punched him back. He did not know how or by what means Mr Ruffin broke her ribs. He urged her not to put up with it and to see her mother or grandmother.[161]

250. It is clear to me that Ms Dhu's mother, father and grandmother were concerned about her relationship with Mr Ruffin, and harboured serious fears about his treatment of her. They wanted her to separate from him, for her own protection.

251. Mr Ruffin though his counsel submits that there was no direct evidence of any frequent or significant domestic violence incidents between himself and Ms Dhu. However, on his own evidence, there was a significant domestic violence incident that resulted in Ms Dhu sustaining fractures to her ribs.

252. Taking account of Mr Ruffin's own evidence, including that they wrestled on occasion, and the observations of Ms Dhu on the part of her family, very sadly as I have already indicated, this relationship was marred by acts of domestic violence.

253. The DICWC makes extensive submissions concerning the need for Ms Dhu to have been protected by police from incidents of domestic violence.

254. It is axiomatic and beyond question that citizens are to be protected from acts of domestic violence. However, in the context of this inquest, I must have regard to s 25(5) of the Act that provides that I "*must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to* ***suggest*** *that any person is guilty of any offence."* (emphasis added).

255. Unfortunately, in the weeks and months following April 2014 police were not informed of any incidents of domestic violence.

256. Mr Ruffin, by throwing Ms Dhu over his shoulder on or about 21 April 2014, caused her to fall heavily and fracture her ribs. She sustained a fracture of ribs 10 and 11 of her right side, laterally and posteriorly.[162] Ms Dhu also reported that she reinjured those ribs approximately two days (and also two weeks) prior to her arrest. On those occasions, she did not indicate that Mr Ruffin was responsible for her injuries.

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[160] ts 68 - 69
[161] ts 45; ts 57; ts 63 - 64
[162] Exhibit 1, tab s 18 and 40

257. Ms Dhu died as a result of bacteria that entered her bloodstream and lodged at the fracture site of the 10th rib, causing osteomyelitis, a localised infection in the healing rib bone. This type of infection can lay dormant for months, only to reactivate and become painful again.[163]

258. The original fracture of the 10th rib occurred when Mr Ruffin threw Ms Dhu over his shoulder, during an argument, and it did not ever heal.

259. I accept Mr Ruffin's submission, through his counsel, that he did not cause the infection that resulted in Ms Dhu's death. Further, I do not consider that he could have reasonably foreseen that outcome. However, it was as a result of his actions that Ms Dhu fractured her 10th rib. Whilst there were numerous relevant intervening events, not the least her intravenous drug taking, her compromised immune system, and the possibility of a re-fracture, her ultimately fatal infection stemmed from that original fracture of the 10th rib. It forms part of the history of the events leading to her death.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

260. My comments on Ms Dhu's supervision, treatment and care are made in connection with her medical treatment and care at the HHC, and her supervision, treatment and care at the Lock-Up. She was a "*person held in care*" within the meaning of s 3 of the Act at the Lock-Up and she remained in the care of the police at HHC.

261. These comments are required to be made by reason of s 25(3) of the Act. The rationale is obvious. Ms Dhu did not have a choice of medical practitioner, or medical facility. She was not free to go to the HHC when she thought it appropriate. She was not free to seek a second opinion on her medical condition, if she had wanted one after being diagnosed with "*behaviour issues*". In presenting at HHC, she was escorted by police. This heightened the power imbalance and her dependency. The clinicians were tasked with ascertaining whether she was fit to be held in custody. She was not free to present as a patient, seeking medical assistance, formulating her own questions for the doctors.

262. In respect of all of these matters, Ms Dhu was reliant on police from the Lock-Up and clinicians from HHC. Her reliance upon them heightened their duty of care towards her. If the clinicians had determined that she required hospitalisation, in the ordinary course that would have occurred under police guard, at HHC. This

[163] Exhibit 1, tab 40; ts 221 - 225

would have raised yet another set of considerations, which magnified the unusual nature of the presentation.

263. For all of these reasons, arising as a consequence of Ms Dhu's loss of liberty upon incarceration, the actions of the clinicians and the police were examined at the inquest.

264. Regrettably the actions of some of the clinicians at HHC were affected by premature diagnostic closure, and errors were made. Ms Dhu's suffering as she lay close to death at the Lock-Up was compounded by the unprofessional and inhumane actions of some of the police officers there. All of the persons involved were affected, to differing degrees, by underlying preconceptions about Ms Dhu that were ultimately reflected, not in what they said about her, but in how they treated her.

265. I have concluded that Ms Dhu's treatment and care at HHC on 2 and 3 August 2014 fell below the standards that should ordinarily be expected of a public hospital. Further, her medical treatment at HHC on 3 August 2014 was deficient, as a result of premature diagnostic closure.

266. I have concluded that Ms Dhu's supervision, treatment and care at the Lock-Up, particularly on 4 August 2014 fell well below the standards that should ordinarily be expected of the Western Australia Police Service. Further, the behaviour of a number of the police officers towards Ms Dhu was unprofessional and inhumane.

267. My reasons for those conclusions are set out in my comments on supervision, treatment and care under the following headings:

a. Premature Diagnostic Closure, concerning comments on the roles of Dr Lang, Nurse Hetherington, Nurse Hall and Dr Naderi;

b. Unprofessional and Inhumane Treatment, concerning comments on the roles of First Class Constable Matier, Senior Constable Burgess and Mr Bond;

c. Cell Welfare Checks and Record Keeping, concerning comments on Ms Dhu's supervision and her welfare needs;

d. Views Held By Other Police Officers, concerning comments about general views held at the Lock-Up regarding Ms Dhu's symptoms.

268. The details appear below.

PREMATURE DIAGNOSTIC CLOSURE

269. In considering whether Ms Dhu's death was preventable, I have found there were missed opportunities to diagnose her infection on 3 August 2014, when objectively speaking, she did display some signs of infection.

270. With the benefit of hindsight, it is even clearer that she was manifesting the signs of her illness at her presentation on 3 August. However, in making my comments, I recognise the importance of needing to understand the circumstances as they existed at the material time.

271. In his report Dr Dunjey opined that Ms Dhu's care at HHC on 3 August 2014 was affected by premature diagnostic closure, a challenge that all nurses and physicians contend with in cases such as these. Dr Dunjey opined that Ms Dhu's prior visit on 2 August 2014, her diagnosis of "*behavioural problems*" on that occasion, the fact that she was in custody, her prior drug use and her behaviour all led to premature diagnostic closure. In practical terms this meant that clinicians on 3 August 2014 were more likely to form the view that her complaints and her physical signs could all be attributed to her prior chest injury, her drug use and her agitation.[164]

272. At the inquest Dr Dunjey elaborated on the concept of premature diagnostic closure, as follows:

> *"Doctors are trained because we're always behind – we've always got lots of patients to see – to recognise disease patterns. And most people who are in a job – a high-pressure job develop heuristic thinking. They develop a way of looking at stuff and actually adding up clues and quickly arriving at an end point. And it's a useful way of looking at stuff because for the vast majority of cases you see, you will be right, but there's always the odd case where you're not right. And if you're locked in to a diagnosis, it can be difficult for you to let that go and consider a new possibility. I think the difficulty was, in this particular case, that Ms Dhu had arrived the day before. And as a colleague, a doctor that you know, and, you know, possibly respect, has made a diagnosis of agitation, drug withdrawal, behavioural gain. When you look at the case notes from the day before, which is what you do, you can't help but be influenced by that. And sometimes what happens then is that you interpret everything that you see in the light of the previous diagnosis and, you know, particularly if the symptoms make sense, there's no reason to change the way you're thinking and what I am saying is that I think that people have made a diagnosis and seen a pattern that they thought was true the day before and potentially what happened for the people on the second visit was they looked back at those notes and said, you know, "It's the same again," and it makes*

[164] Exhibit 2, tab 49

sense that it's the same again. She's – Ms Dhu has got sore ribs. She is drug withdrawing. She is agitated and therefore you can explain the grunting, the shortness of breath, the tachycardia, the dryness in the light of that prior diagnosis. And what – you know, what you require very often is a really big surprise, something that doesn't fit to make you reconsider."[165]

273. It is a troubling concept, because the heuristic thinking that leads to premature diagnostic closure will likely occur without the person being entirely conscious of the steps they are taking to reach their conclusion. Nonetheless it is a very honest exposition on Dr Dunjey's part and I accept his evidence of it being widespread, and challenging to overcome. One of the purposes of this inquest has been to highlight the risks of premature diagnostic closure and/or the formation of preconceived judgments, in the hope that it will act as a caution, to avoid deaths in similar circumstances.

274. Whilst Dr Dunjey conceded he could make the same mistake, being mindful of the risk, his practice is to put "*roadblocks*" in place to avoid it. He gave examples of those roadblocks in the context of a case such as that of Ms Dhu, namely always trying to get a full set of vital signs, always doing an ECG and a chest X-ray, and generally speaking not discharging patients with tachycardia over 100.

275. With this in mind, I have examined the roles of Dr Lang, Nurse Hetherington, Nurse Hall and Dr Naderi.

The role of Dr Lang

276. Dr Lang qualified as a doctor in 2001. She was, at the time she testified in November 2015, an advanced emergency medicine registrar at HHC, a position she had held since March 2014. She had commenced her training with the Australian College of Emergency Medicine in 2009. For the previous 10 years she had worked extensively as a senior emergency medicine doctor in various hospitals in Queensland and New South Wales.[166] Dr Lang was on the afternoon shift in the emergency department of HHC on 2 August 2014.

277. Dr Lang's evidence initially emphasised that when she treated Ms Dhu on 2 August 2014 she found her to be angry, very agitated, quite loud and a little bit disruptive to the emergency department.[167] This description of Ms Dhu's demeanour is not

[165] ts 277 - 278
[166] ts 419
[167] ts 425

supported by the evidence of Nurses Lindsay and Dunn and Constable Shaw and First Class Constable Buck.[168]

278. Neither the triage nurse (Nurse Lindsay) nor the treating nurse (Nurse Dunn) experienced Ms Dhu to have been disruptive, emotional or angry on 2 August 2014. Constable Shaw and First Class Constable Buck gave evidence to similar effect, with First Class Constable Buck stating that she was compliant and not aggressive.[169]

279. Under cross-examination Dr Lang accepted that her recollection of Ms Dhu being disruptive may be false and that her description of Ms Dhu as being verbally aggressive was an exaggeration.[170] The CCTV captured images of Ms Dhu walking into and out of the HHC, shortly before and after Dr Lang saw her. Those images show a young woman walking slowly, hunched over, and with a serious and subdued demeanour. There is no indication whatsoever of an aggressive stance or attitude on the part of Ms Dhu on the CCTV.[171]

280. An expression of pain is not to be regarded as disruptive. If Ms Dhu was exhibiting signs of distress or even anger at any point, it is clear to me that it was because she was gravely ill and in need of medical attention. There is never any cause for providing a lesser standard of care if a patient is distressed or angry. If the patient does not provide sufficient information to assist with a medical history, extra care is needed to ensure that the focus is maintained on the medical needs of the patient. As Dr Dunjey explained:

> *"....sometimes a patient just won't ever give you a story and you're confronted with a lot of raised emotional temperature and at point your assessment is limited to an examination of the patient and investigations, as you see appropriate, but it has become a veterinary examination at that stage rather than a medical examination because the .... history that you get from the patient and the cooperation is such an important part of dealing with human beings. It's – it's how you really get a feeling for – for what's going on, but – yes. There are – there are absolutely circumstances where you just can't break through and your very strong feeling is that it's not organic, it's not physical disease, it's just a really angry person,* ***but you just need to be careful. You need to put roadblocks in your own way so you don't make the mistake of jumping to a judgment****."*[172] (emphasis added)

[168] Nurse Lindsay had ticked *"Unremarkable"* in the category headed *"Behavioural"* in the *"Primary Assessment "* box of the Emergency Department Notes for Ms Dhu (Exhibit 1, tab 18)
[169] ts 396 – 400; ts 731 - 735
[170] ts 476 - 479
[171] Exhibit 9
[172] ts 337

281. The necessity for putting in roadblocks to avoid jumping to the wrong judgement became a feature of the evidence at the inquest. Whilst Dr Dunjey referred to the risk of clinicians being assaulted by aggressive patients, it is clear that this was not one of those cases. In any event, the police officers were in close proximity. I note and am in accord with his comments that: *"….the general community has the right to expect the doctor will do their absolute best to develop a thick skin and to be as professional as possible and do the best job they possibly can, and, you know, the community does hold doctors to a very, very high standard."*[173]

282. Emergency departments of hospitals will invariably be very busy and patients will often be agitated. Dr Lang's evidence regarding Ms Dhu's conduct ultimately and upon reflection showed some insight. She concluded that Ms Dhu's behaviour was *"completely understandable in a very, very stressful situation. A lot of people will behave the same"*.[174]

283. I do not accept that Ms Dhu was being disruptive at HHC on 2 August 2014.

Dr Lang's medical notes on 2 August 2014

284. Dr Lang made handwritten notes following Ms Dhu's presentation at the emergency department of HHC on 2 August 2014. Those notes were as follows:[175]

> *21 36 Dr A. Lang*
>
> *Behavioural issues*
>
> *Fell two months ago. Had ® rib pain.*
>
> *Taken into police custody this evening.*
>
> *Pain free initially. When informed she would have to spend the night in police detention, she became inconsolable, complaining of acute ® rib pain.*
>
> *Hyperventilating. Exams normally.* [Diagram of chest depicted] *no evidence of acute pathology.*
>
> *(IMP) behavioural gain.*
>
> *Given 5mg Diazepam for agitation.*

285. Dr Lang was questioned about the meaning of her impression of "*behavioural gain"* within the body of her notes and she responded as follows:

[173] ts 336
[174] ts 425
[175] Exhibit 1, tab 18; as interpreted from handwriting

> *"So what was the gain?---Yes. Yes. I think to gain my attention, to gain pain relief, to gain a reaction. I got the impression she wasn't happy to be in the department. She wasn't happy to be in police custody, that the swearing, the reluctance to answer questions, the reluctance to tell me anything about what had happened, the volatility in her emotions, that possibly she was acting out a little bit."*[176]

286. At the inquest Dr Lang's evidence was that she had made a finding that the source of Ms Dhu's pain to her rib area was *"musculoskeletal."*[177] This was the first time that Dr Lang referred to the term "*musculoskeletal*". It was not recorded in her medical notes, and not referred to in her witness statement. There is no evidence that Dr Lang told any other hospital staff member or the police officers who had escorted Ms Dhu to HHC that Ms Dhu did in fact have genuine pain, and that it was musculoskeletal. Her handwritten entry in the box marked "*Discharge Diagnosis*" was *"behaviour issues."*[178]

287. At the inquest, it was important to ascertain whether Dr Lang had actually diagnosed Ms Dhu with anything, and if so whether she communicated it to the escorting police officers. Dr Lang explained that her assessment of Ms Dhu as having "*behaviour issues*" was based on her language, her behaviour, the absence of clinical evidence of pathology and her rapid settling after receiving medication.

288. At the inquest Dr Lang testified that: *"behavioural issues is more an observation than an absolute diagnosis."*[179] She proffered that she did not think she had committed to a diagnosis, although she did record one in her notes.

289. A different view was provided by Dr Dunjey. Upon reviewing the records Dr Dungey considered that *"behavioural/behaviour issues"* was in fact the discharge diagnosis, though it is not a phrase that he would use. In his opinion:

> *"What it's saying is that – it's suggesting that Ms Dhu was cranky and was behaving in a certain way to generate a response, perhaps to get medication of some kind. But what it's saying is – it's suggesting there is not a physical cause for her illness and it's misbehaviour."*[180]

290. In response to being questioned on whether it is a diagnosis, Dr Dungey further explained:

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[176] ts 443
[177] ts 437
[178] Exhibit 1, tab 18
[179] ts 449
[180] ts 290

> *"It's not a physical diagnosis, but sometimes people present to emergency departments and they have a – and I'm not talking in reference to Ms Dhu at the moment, you have patients who turn up who want something from the medical staff. They want a response. They want care provided. They want a sympathetic ear. They want some drugs. These are all different reasons for a person turning up, and sometimes what a person will do is they will get agitated in an effort to get what they are looking for out of a system. What the diagnosis means is, I don't think this person is sick. I think they are behaving in a certain fashion to achieve some other goal. And the doctor hasn't specified what the goal is."*[181]

291. Dr Lang's evidence was that she did not believe Ms Dhu had a broken rib. She formed the view that Ms Dhu was seeking to exaggerate her movements in order to be provided with pain relief. Dr Lang stated that she carefully examined all systems, with careful attention to Ms Dhu's right lateral chest. She did not detect anything to suggest underlying pathology.

292. In Dr Lang's experience, patients with chest wall pathology have limited movement of the thoracic cage and thoracolumbar spine. She noted that upon being examined Ms Dhu sat up very easily. She took account of the manner in which Ms Dhu moved and held her frame. Dr Lang formed the view, in essence, that Ms Dhu was objectively speaking exaggerating her pain:

> *"….pain is a very complex feeling and our emotional response to pain and our psychology of pain affects it all differently. Some people go very quiet. Some people are very stoic. Some people are very sensitive. So my impression was, to the whole situation and to her pain – there was a lot of psychosocial emotional issues that were affecting* ***her perception of pain***."[182] (emphasis added)

293. I accept counsel assisting's submission that hospital medical staff subsequently reading Dr Lang's notes could hardly be criticised for believing this was Dr Lang's conclusion and that it was her impression that there was nothing physically wrong with Ms Dhu that she was able to find.[183]

294. Dr Lang though her counsel points to Dr Naderi's subsequent evidence to the effect that, on Ms Dhu's next presentation on 3 August 2014, he did not rely upon Dr Lang's description of "*behavioural gain*" but instead began his assessment from scratch. Nevertheless, consistent with Dr Dunjey's evidence, and it has to be said, as a matter of common sense, Dr Naderi believed that

[181] ts 290
[182] ts 442
[183] ts 268; Exhibit 2, tab 49

phrase to mean that Ms Dhu had been irritable when seen by Dr Lang.[184]

295. The result is not to be assessed by whether or not Dr Naderi himself relied upon it. There were other clinicians who will have had regard to it.

296. Dr Lang prescribed diazepam, and oxycodone (Endone) for Ms Dhu.[185] Dr Lang maintained that the Therapeutic Guidelines for Analgesia state that oxycodone with Panadol is standard medication for chest wall injury of any sort. She referred to the need for the patient to ventilate (breathe properly) to avoid the risk of pneumonia.[186]

297. Dr Dunjey testified that Endone is a very strong painkiller and, in his opinion, if the conclusion was that Ms Dhu had behavioural issues due to her overemphasising her physical symptoms of pain then it might have been expected that a lesser painkiller would have been prescribed. He said he prescribes Endone "*very very rarely*" as a discharge medication. However, whilst Dr Dunjey would not have prescribed it as a one-off painkiller in these circumstances, he was not critical of Dr Lang for choosing to prescribe Endone.[187]

298. Dr Lang testified that Ms Dhu denied any current respiratory symptoms and further denied any symptoms consistent with acute infection including fever, rigors, sweats, lethargy or malaise.[188] Dr Lang conceded that there should have been a record in her handwritten notes in Ms Dhu's hospital file that there were no respiratory or acute infection symptoms.[189]

299. In evidence Dr Lang herself accepted that her notes were not to the required standard. She conceded: *"I clearly didn't write everything I checked for down. They are terrible notes, I accept that..."* Dr Lang maintained that the deficiency in her notes was purely related to the fact that she was really time poor. She did not seek to justify that, but rather stated it was a reality.[190] Nonetheless, however time poor she was, she clearly would have had the opportunity to write down, either at the time or in the hour afterwards, the words "*musculoskeletal pain*" if she had made that diagnosis.[191]

300. On all of the evidence I consider it unlikely that Dr Lang, on 2 August 2014 actually diagnosed Ms Dhu with musculoskeletal

[184] ts 548
[185] Exhibit 1, tab 18
[186] ts 439
[187] ts 268, 291 and 315
[188] Exhibit 1, tab 21; ts 436
[189] ts 436
[190] ts 435; ts 438
[191] ts 435, 438 and 486

pain. Rather, this diagnosis is given with the benefit of hindsight. On 2 August 2014, Dr Lang's impression was that Ms Dhu was engaging in behavioural gain to obtain painkillers and when she discharged her, I am satisfied that she diagnosed her with behavioural issues.

301. It is undesirable to diagnose a patient with "*behaviour issues*" and it is vital that, if a diagnosis is made, it be recorded.

302. I am satisfied that that Dr Lang's notes, particularly her discharge diagnosis of "*behaviour issues*" had the real potential to contribute to premature diagnostic closure.[192] The reference to "*behaviour issues*" in the discharge diagnosis section suggested there had been misbehaviour, or feigning of symptoms on Ms Dhu's part.

303. On the other hand, if Dr Lang had indeed diagnosed Ms Dhu with musculoskeletal pain on 2 August without recording it at all, then there is a more serious omission in her medical notes, and it elevated the risk of premature diagnostic closure.

304. In either case, and I think the former more likely, by recording "*behaviour issues*" in the discharge diagnosis, Dr Lang's conduct fell short of the standards expected of a doctor working in the emergency department of a public hospital.

Time spent by Dr Lang examining Ms Dhu

305. At the inquest Dr Lang was comprehensively questioned by counsel for Ms Dhu's father about the amount of time she spent examining Ms Dhu on 2 August 2014. From a comparison of the times recorded on the CCTV camera described as *"CAM 11"*[193] and times that were recorded on the hospital records[194] it became apparent that there was a discrepancy in the hospital notes that potentially reflected upon Dr Lang having spent a shorter than indicated time examining Ms Dhu.[195]

306. Despite Dr Lang's denial that she only spent several minutes with Ms Dhu,[196] the evidence of recorded times establishes that that was indeed the approximate length of Dr Lang's examination of Ms Dhu. Dr Lang herself accepted that her examination of Ms Dhu was *"brief"*[197]. I have considered submissions to the effect that it was in fact too brief, but I am not persuaded that it was brief to the point of being deficient.

[192] ts 277 and 278
[193] Exhibit 9
[194] Exhibit 1, tab 18
[195] ts 452 - 463
[196] ts 461
[197] ts 447

307. The evidence of the CCTV establishes that on 2 August 2014 Ms Dhu arrived at the HHC at 9.19 pm and that she departed at 9.39 pm, remaining in the emergency department of the hospital for a total of 20 minutes. Over this time she was assessed by the triage nurse (Nurse Lindsay), the treating nurse (Nurse Dunn), and by Dr Lang, and then discharged.

308. I accept the evidence given at the inquest to the effect that the emergency department wall clocks were not synchronised with each other or the CCTV camera. On her medical notes, Dr Lang appears to have initially recorded that Ms Dhu left the emergency department at 21:30, then crossed it out and wrote 21:45.[198] However, the CCTV at the Lock-Up recorded that by 9.43 pm Ms Dhu had returned.[199]

309. I take into account the evidence of Dr Dunjey who opined that a complete physical examination of the respiratory system, and for the purposes of this assessment, an examination of the cardiac system, gastrointestinal system, and neurological system as conducted by Dr Lang, could be completed in approximately five minutes.[200]

310. The evidence from the medical experts support Dr Lang's contention that the brief time she spent assessing Ms Dhu did not impact on her ability to properly assess her. Dr Lang testified as follows:

> *"I don't feel spending more time with Ms Dhu would have helped me pick up a diagnosis that she had rib osteomyelitis, that she had infected process going on".*[201]

311. Dr Dunjey considered Dr Lang's medical assessment and opined as follows:

> *"Even knowing why Ms Dhu died, and being aware of the kind of signs that might have given early indication of her illness, I cannot fault the care given on this first presentation. She was difficult to assess, but she also didn't manifest any clues to her illness. She had normal vital signs, normal examination of her lungs and no signs on her chest wall. I don't consider most clinicians would have behaved differently to Dr Lang on this occasion".*[202]

312. Dr Speers also considered Dr Lang's medical assessment and opined as follows:

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[198] Exhibit 1, tab 18
[199] Exhibit 5
[200] ts 298
[201] ts 447
[202] Exhibit 2, tab 49

> *"Dr Lang has stated she performed a full examination on 2 August 2014 including the musculoskeletal system. The temperature was recorded as normal. Ms Dhu's pulse and blood pressure were reported to be within normal limits (pulse 72 beats/min) and no evidence of sepsis was apparent. Dr Lang reported that Ms Dhu denied symptoms of infection such as fever, rigors, sweats, lethargy or malaise and there were no clinical signs of pneumonia. Therefore, on 2 August there is no objective evidence that Ms Dhu had an infection with her symptoms being explainable by the traumatic aggravation of a previous rib fracture two days earlier, hence antibiotics were not given."*[203]

313. I have considered whether Dr Lang's diagnosis of behavioural issues was affected by the information provided to her by the escorting police during her examination of Ms Dhu, namely that *"….[she] was told that she would have to spend the weekend incarcerated. And following that information, she started to develop increasing right-sided chest wall pain."*[204] Dr Lang subsequently made a note of this.

314. I accept Dr Dungey's evidence and am satisfied that it was reasonable for police to pass on the information about Ms Dhu and that the obligation is upon the medical staff to prevent themselves from making an erroneous assumption.[205] There is no evidence that Dr Lang was inappropriately influenced by this particular information.

315. I am not persuaded that Dr Lang spent an insufficient amount of time assessing Ms Dhu on 2 August 2014. I accept the evidence of Dr Dunjey and Dr Speers and am satisfied that there was no objective evidence of Ms Dhu having an infection on 2 August 2014.

316. Counsel for Ms Dhu's family submit that Dr Lang assumed relevant information and did not take the time and care to confirm that information with Ms Dhu. Having found on the evidence that there are no deficiencies with Dr Lang's medical assessment of Ms Dhu, this submission is not accepted.

317. Save for the recording of the discharge diagnosis as "*behaviour issues*" there is no deficiency in the medical treatment provided by Dr Lang to Ms Dhu on 2 August 2014.

[203] Exhibit 4, tab 40
[204] ts 430 – 431; ts 1021
[205] ts 334

The role of Nurse Hetherington

318. Ms Hetherington was a registered nurse working in the emergency department at HHC. She graduated in 2006 and was qualified as a triage nurse after completing training in that area through the WA Country Health Service in 2011.[206]

319. On 3 August 2014 Nurse Hetherington was working as a triage nurse in the emergency department of the HHC from 1.00 pm to 9.30 pm. She recalled it was a particularly busy shift due to the public holiday race event in town. She was the triage nurse who attended Ms Dhu at 4.59 pm.[207]

320. Nurse Hetherington did not take Ms Dhu's temperature, did not complete the *"pain score"* section in Ms Dhu's emergency department notes, did not record whether Ms Dhu was re-presenting with similar or same symptoms within 48 hours and gave Ms Dhu a triage score of 4. This was the second lowest priority score and placed her at low acuity. These matters are addressed below.

Nurse Hetherington did not take Ms Dhu's temperature

321. A person's temperature, along with blood pressure, respirations and pulse are the four key vital signs that are generally considered to demonstrate a person's state of health.[208] They are also generally referred to as "*observations*".

322. The issue of taking Ms Dhu's temperature on 3 August 2014 arose in the context of Dr Dunjey's evidence and HHC's own clinical incident review. There was no argument that Ms Dhu's temperature should have been taken by someone at some time during her presentation on 3 August 2014. There was no direct evidence to the effect that it should have been taken by Nurse Hetherington at triage.[209]

323. The undisputed evidence was that a temperature recording at the time of Ms Dhu's presentation on 3 August 2014 would have potentially provided important information in terms of a diagnosis of sepsis. As Dr Speers noted, had a temperature been recorded: *"it would have been harder to attribute the pain to simple trauma if she was febrile"*.[210]

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[206] ts 616
[207] Exhibit 1, tab 18; ts 350, 380 and 617
[208] Exhibit 1, tab 18
[209] Exhibit 2, tab 48; ts 320
[210] ts.232.

324. Similarly, Dr Dunjey observed: *"No temperature was recorded anywhere during this visit which, in the context of septicaemia, may have been a significant omission…"* [211]

325. As to whether a triage nurse should, as a matter of course, take a patient's temperature the court heard varying evidence.

326. Dr Sakarapani gave evidence at the inquest on the procedures at the material time. He was a member of the investigation team that reviewed Ms Dhu's care at HHC. His evidence was that at the material time, the triage nurse would do the first set of observations if time permitted. In his experience, at triage: "*the absolute minimum is the pulse rate in terms of a physiological observation, but any other physiological observation should be guided by the presentation.*"[212]

327. This is consistent with the Guidelines on the Implementation of the Australian Triage Scale in Emergency Department published by the Australian College for Emergency Medicine in November 2013 (the ACEM Guidelines), which states the triage assessment should take no more than two to five minutes with a balanced aim of speed and thoroughness being the essence.

328. On the point of whether taking a temperature is a requirement, the ACEM Guidelines state that:

> "*Vital signs should only be measured at triage if required to estimate urgency, or if time permits. Any patient identified as ATS category 1 or 2 should be taken immediately into an appropriate assessment and treatment area. A more complete nursing assessment should be done by the treatment nurse receiving the patient. The triage assessment is not intended to make a diagnosis.*"[213]

329. The ACEM Guidelines also state that: "*The initiation of investigations or referrals from triage is not precluded if time permits*".[214]

330. Nurse Jones, a registered nurse for 32 years,[215] was employed through a nursing agency at HHC for a three month period in 2014, including August 2014. She gave evidence of nursing practice in this area. She testified that in her experience: "it *is desirable to do a temperature during a triage assessment and we are expected to do that at Hedland Health Campus, as I understood it".*[216]

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[211] ts 274 and 352
[212] ts 386
[213] Exhibit 7, tab 10
[214] Exhibit 7, tab 10
[215] ts 495
[216] ts 496

331. Nurse Lindsay was a registered nurse with 36 years' experience. She was also working at the HHC in August 2014 under the employment of Health Care Australia Nursing Agency.[217] Nurse Lindsay also gave evidence of nursing practice in this area. She was taught to take a full set of observations from a patient at the triage stage, which included temperature.[218] She added that that was normally expected of a nurse at triage and that those observations included taking the temperature, respiratory rate, blood pressure, oxygen saturation and heart rate.[219]

332. Nurse Hall attended to Ms Dhu after Nurse Hetherington. Her recollection was that a full set of observations was done at triage at the material time, though she accepted that it would be reasonable to do a full set of observations at the secondary phase (being the one she was responsible for, as the treating nurse).[220]

333. As Dr Dunjey noted in his report: *"She* [Ms Dhu] *was notably warm to touch and tachycardia and that would normally be enough to measure her temperature"*.[221] I accept Nurse Hetherington's submission though her counsel that Dr Dunjey's criticism that no temperature was taken was not confined to the triage assessment, but instead to Ms Dhu's presentation to the emergency department of HHC (including triage, secondary assessment and medical review).[222] Similarly Dr Sakarapani's evidence was that: "*one set of observations should at least be captured during the patient journey in the emergency department*".[223]

334. Whilst Dr Dunjey's evidence was that even at Royal Perth Hospital, at times a temperature is not taken by the triage nurse but by some-one else[224] the critical issue concerns whether there was a basis, at triage, to take Ms Dhu's temperature, in the circumstances of her presentation.

335. Nurse Jones gave evidence that if, on observation at triage, a patient's skin was warm it would prompt her to take that patient's temperature, even in the absence of tachycardia.[225]

336. It was not in dispute that Nurse Hetherington had ticked *"Warm"* for the *"Circ./Skin"* component in the box headed "Primary Assessment" in the emergency department notes which she completed.[226] However her evidence was that by ticking *"Warm"*

[217] ts 721
[218] ts 728
[219] ts 733
[220] ts 673
[221] Exhibit 2, tab 49
[222] ts 320
[223] ts 379
[224] ts 320
[225] ts 517
[226] Exhibit 1, tab 17

she was simply conveying that Ms Dhu's temperature was *"normal"* to touch. Specifically she explained that: "*Warm is what you would expect when you touch a healthy person. It means that they're well perfused.*" [227]

337. This is the first occasion upon which the expression "*well perfused*" was substantively used by a witness, and it became a feature of the evidence given by some of the subsequent witnesses.

338. I do not accept Nurse Hetherington's explanation that "*warm*" indicated a "*normal*" temperature. If a patient's skin is normal to touch then the caption to tick would be *"Unremarkable."* There is an option for *"Unremarkable"* not only for *"Circ./Skin"* but also for the categories identified as *"Breathing"*, *"Colour"*, *"Pulse"* and *"Behavioural."* Its positioning at the top of the list of options reflects that if this caption is ticked then the assessment that has been made is *"normal"*. The captions that appear under *"Unremarkable"* (including "*warm*" for the circulation/skin) all demonstrate something out of the ordinary.[228]

339. Nurse Hetherington's explanation was that: "*I don't think anyone's circulation can be unremarkable. If you touch someone's skin it's going to be warm or cool.*"[229] I am not persuaded by this explanation. It is self-evident that the emergency department form contemplated "*Unremarkable*" to be selected where the skin temperature was considered to be normal.

340. The implication of having selected *"Warm"* instead of "*Unremarkable*" was that there had been a clear indication to Nurse Hetherington at that point in time that Ms Dhu's temperature ought to be taken.

341. A further indication to Nurse Hetherington that Ms Dhu's temperature needed to be taken is evidenced by the fact that she had noted Ms Dhu was *"tachycardic"* on the emergency department triage form. Nurse Hetherington was aware that a fever can cause that condition.[230]

342. Nurse Hetherington's evidence was she was taught that the only required observation at triage was a pulse and that in Ms Dhu's case there was nothing to indicate to her *"she would have had a temperature"*.[231] She further testified that if someone had given her a history that indicated a febrile illness then she would have taken a temperature.[232]

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[227] ts 628
[228] ts 640.
[229] ts 628
[230] ts 643.
[231] ts 626.
[232] ts 631.

343. I am satisfied that there was sufficient information before Nurse Hetherington to prompt her to take Ms Dhu's temperature at triage on 3 August 2014 because Ms Dhu's skin felt warm and she had assessed Ms Dhu to be tachycardic and dehydrated. Nurse Hetherington's failure to take Ms Dhu's temperature at triage was a missed opportunity.

Nurse Hetherington did not record a pain score for Ms Dhu

344. The triage form of the emergency department notes has a box for the purpose of recording the pain score out of ten. There was no entry in that box. Nurse Hetherington's evidence was that she did not remember asking Ms Dhu what level of pain she was experiencing out of ten (though it was her usual practice to ask patients). She further said that if she did ask, it was likely Ms Dhu was unable to give her a numerical answer that she could record.[233] I can see no basis for Ms Dhu having lacked capacity in this regard, and I reject the suggestion.

345. If a patient refuses to provide a pain score, that information can always be recorded. There may be instances where the very fact of a refusal to provide a pain score, by a patient in apparent pain, may indicate that closer monitoring is warranted.

346. Another matter of concern was Nurse Hetherington's evidence that in her view Ms Dhu's moaning and grunting was *"voluntary."*[234] Again, this raises the question of whether there was an underlying belief or generally held view that Ms Dhu was feigning her symptoms. Nurse Hetherington's explanation for holding this view was because: "*She was able to stop moaning and grunting to speak and also to drink*".

347. Nurse Hetherington was later asked by Counsel Assisting:

> *"So when you call it 'voluntary' if I could just ask you again, does that mean you formed a view about whether it was reflecting her pain or not? --- It could have been. It – or it could not have been. It ---*
>
> *Did you form a view? --- Well, no, I didn't. I made an observation."*[235]

348. Shortly after these questions Nurse Hetherington did in fact agree that she had formed the view that Ms Dhu had *"genuine pain."*[236]

[233] ts 620 - 621
[234] ts 619
[235] ts 636
[236] ts 636.

349. Nurse Hetherington through her counsel submits that the failure to record a pain score was not a failing of some note, in this instance.

350. In all of the circumstances I accept Nurse Hetherington's submission, through her counsel, that whist a pain score was not recorded, important information about Ms Dhu's pain was in fact documented and available for the information of the subsequent practitioners. Nurse Hetherington documented the fact that Ms Dhu was in pain, that she had a sore rib cage and that she was grunting, on the emergency department notes as follows [extract]:

> "*Pt moaning++ Multiple complaints*
>
> *Rib cage is sore – pt states that because she has been sleeping uncomfortably it had gotten worse….Grunting and moaning."*[237]

351. I accept that the emergency department of HHC was very busy at the time Ms Dhu attended. However, in addition to the above record, a pain score would have been desirable as it would have provided Nurse Hetherington and the subsequent clinicians with relevant information about how Ms Dhu herself perceived her pain. All reasonable efforts ought to have been made to seek one.

<u>Nurse Hetherington did not record whether Ms Dhu's attendance was a re-presentation</u>

352. The triage form of the emergency department notes also required a box to be ticked as to whether or not the patient's attendance was a re-presentation with similar or same symptoms within the previous 48 hours. Neither the "*yes*" nor "*no*" box was ticked by Nurse Hetherington.[238]

353. I accept Nurse Hetherington's submission, through her counsel, that the ED Tracker did not give her any information about Ms Dhu's attendance the previous evening.[239]

354. For practical purposes on this occasion the absence of a record to the effect that this was a re-presentation had no bearing on the subsequent examination of Ms Dhu by Dr Naderi. That is because Dr Naderi was already aware that Ms Dhu had previously attended the HHC the night before as he saw her on that occasion when he was on duty.[240] It therefore did not have any bearing on the subsequent medical treatment administered to Ms Dhu by Dr Naderi.

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[237] Exhibit 1, tab 18; ts 625
[238] Exhibit 1, tab 18
[239] ts 618
[240] ts Exhibit 1, tab 18; ts 596

Nurse Hetherington's triage score of 4 for Ms Dhu

355. Triage scores are numbered 1 through to 5, 1 being the highest priority and 5 being the lowest.

356. Nurse Hetherington allocated Ms Dhu a triage score of 4. A triage score of 4 requires a medical assessment within 60 minutes.[241]

357. Dr Dunjey's evidence was that based on his investigations and with the information contained in the emergency department notes, a triage score of 2 would have been appropriate in Ms Dhu's case when she presented on 3 August 2014. He explained:

> *"I think it's a two because it's chest pain. It's accompanied by abnormal vital signs, which is the tachycardia, and the respiratory rate is marginal. If it has been 21, it would have been abnormal. So, you know, even her breathing was a little fast at that stage. So armed with chest pain plus abnormal vital signs plus difficulty breathing, that should make it a two."*[242]

358. Nurse Hetherington's evidence was that when Ms Dhu presented for triage, she did consider giving her a triage score of 3. She disputed Dr Dunjey's assessment and provided the following explanation as to why she would not have given Ms Dhu a triage score of 2:

> *"She did not have chest pain that was consistent with cardiac pain and she did not have respiratory distress. She told me that she couldn't breathe. When somebody can't breathe, they can't actually tell you."*[243]

359. Nurse Hetherington typed the following in the emergency department notes: "*Pt states she has asthma and she cant (sic) breathe – talking in full sentances (sic).*"[244] However, the real issue was that Ms Dhu had difficulty breathing. This state is not necessarily inconsistent with speaking in full sentences. The tenor of this entry, and of the evidence given by Nurse Hetherington in court was that there was a degree of scepticism about Ms Dhu's difficulty in breathing.

360. Nurse Hetherington formed the view that Ms Dhu was tachycardic due to dehydration, recent drug use and agitation. Nurse

[241] ts 279
[242] ts 280 and Exhibit 2, tab 49.
[243] ts 631
[244] Exhibit 1, tab 18

Hetherington's typed emergency department notes also record that Ms Dhu informed her that she had taken half a point of speed two nights before and that she used it intravenously once a fortnight [IVDU]. She later recorded a pulse rate of 126 beats per minute, by handwritten note, after she printed out the emergency department notes and before she placed it in the box for the next clinician (Dr Naderi).[245]

361. Before making her final decision on the triage score, Nurse Hetherington consulted the shift coordinator, a more senior nurse on the shift, who agreed with her. She ultimately settled on the triage score of 4 because oral rehydration treatment had started.[246]

362. Nurse Hetherington through her counsel points to the outcome of the internal clinical incident review that remarked that there had been a misallocation of the triage score and that it should have been a category 3 (as opposed to a category 2):

> *"A pulse rate of 126 and assessment of dehydration at triage indicates a triage score of 3 as per Australian Triage Score"*[247]

363. At the inquest, Nurse Hetherington's triage score of 4 was explored within the context of the risk of under-triage. In connection with the potential impact of under-triage, Dr Dunjey's evidence was as follows:

> *"We were talking before about the way people's minds are influenced by various things they see or hear. When a person gets a 2 they are transported to a monitor area. And when you walk in to see the patient, they are connected to monitors, they have got one to one nursing and the environment suggests to you that there is something potentially wrong with this person and it influences a way a doctor approaches the patient. The assumption is there could be something significantly wrong. When a patient gets a 4, they sit in the waiting room, they are supposed to be seen within an hour. It is often much longer than that. It could be two or three hours before they are seen but it is clear that one of your colleagues has made an assessment that says, 'this patient is not particularly sick', and it can't help but change the way you approach the patient and we talked about the way it can be difficult to cast the shackles off. Once you have committed to an idea, it takes some effort to get you out of that. So it has a – it – whilst there is nothing that I can point to you to in the literature, if you talk to clinicians there is universal agreement that under-triage has an impact in the way people approach patients."* [248]

364. I accept the submission by Ms Dhu's family, through their counsel, to the effect that the allocation of a triage score of 4 indicated a low acuity problem and that a low score can be a source of clinical

[245] Exhibit 1, tab 18; ts 623
[246] Exhibit 1, tab 18; Exhibit 4, tab 59; ts 631 - 632
[247] Exhibit 2, tab 48
[248] ts 280 – 281

bias. However, I am not satisfied that the evidence establishes that the only appropriate allocation on that night was a triage score of 2.

365. Whilst Dr Dunjey acknowledged under cross-examination that he is not an expert in triage,[249] his expertise in emergency department practice is extensive. I accept that triage is a rapid assessment process designed to determine the priority with which a number of competing patients are to be seen by a medical practitioner. However, taking account of Ms Dhu's emergency department notes as a whole, and Dr Dunjey's evidence, Ms Dhu ought to have received a triage score preferably of 2 or at the very least, of 3.

366. I am satisfied that Nurse Hetherington miscalculated the triage score, as a result of which Ms Dhu was placed at a lower acuity than was warranted, and that this had the real potential to contribute to premature diagnostic closure.

The role of Nurse Hall

367. Ms Gitte Hall was a nurse of 33 years' experience. She been an enrolled nurse since 1983 and commenced training as a registered nurse in 2013. In August 2014 Nurse Hall was working in the emergency department at HHC. By that stage she had been working in emergency departments for approximately 10 years.[250]

368. Nurse Hall was working the afternoon shift from 1.00 pm to 9.30 pm on 3 August 2014 as the treating nurse. Her role during that shift was attending to patients who had been allocated to cubicles numbered 5 to 9.[251] Nurse Hall saw Ms Dhu at 6.45 pm.[252]

[249] ts 322 - 323
[250] ts 666.
[251] ts 667.
[252] Exhibit 1, tab 18

Nurse Hall did not take Ms Dhu's temperature

369. Like Nurse Hetherington, Nurse Hall recalled that this shift on 3 August 2014 was particularly busy.[253] Due to time constraints, she did not have the opportunity to look at Ms Dhu's emergency department notes before she saw her, because she was moving directly from another patient to see Ms Dhu.[254]

370. When Nurse Hall treated Ms Dhu it was over 1¾ hours after Nurse Hetherington had commenced Ms Dhu's triage assessment. Though Nurse Hall completed the observations for Ms Dhu's respiratory rate, blood pressure and heart rate, she did not record, or in fact take, Ms Dhu's temperature.[255]

371. Nurse Hall recorded a respiratory rate of 20 breaths per minute, oxygen saturation of 100%, blood pressure of 122/86 and heart rate of 113 beats per minute. There was a box for recording temperature but it was left blank by Nurse Hall. She conceded that she did not take Ms Dhu's temperature. She testified that at the time they only had two thermometers in the emergency department and they were: "*quite hard to get quite often.*"[256]

372. Nurse Hall's evidence was that she considered Ms Dhu's respiratory rate was within the normal range, and that her blood pressure was a little bit elevated for someone of her size, which she attributed to Ms Dhu being a bit anxious. She opined that the pulse rate of 113 is above normal (normal is below 100) but she again attributed the higher pulse rate to Ms Dhu's agitation, noting that she observed her to be "*quite anxious and emotional.*"[257]

373. Because Nurse Hall had not looked at the triage entries on Ms Dhu's emergency department notes, she was unaware of whether Ms Dhu's temperature had actually been taken before she was examined by her.[258] She assumed it had been taken. Nurse Hall's explanation for not taking Ms Dhu's temperature was:

> *"I just presumed that it was done at the front because at the time they were doing – generally doing a full set of obs at the front of triage.*
>
> *So your experience in or around August 2014 was that a full set of observations were done at triage? --- Yes. That's correct".*[259]

[253] ts 667
[254] ts 670
[255] Exhibit 1, tab 18
[256] Exhibit 1, tab 18; ts 672; ts 688
[257] ts 672 - 674
[258] ts 670
[259] ts 673.

374. Nurse Hall's evidence was that she did not consider that Ms Dhu felt *"warm"*, to the extent that it warranted her re-checking the temperature (having assumed it had already been done). She had in fact formed the view that Ms Dhu's skin felt "*warm*" upon touching it when she quickly felt her pulse (after taking her blood pressure) and when she placed the saturation probe on her finger.[260]

375. While Nurse Hall had found Ms Dhu's skin to be warm, she decided that Ms Dhu did not feel febrile, stating:

> *"….she didn't feel hot at all. She just felt normal – like, normal body temperature. You can usually feel with your hand. I know that it's antiquated practice but generally, if you feel somebody, you can actually tell whether they feel like they're febrile or not and the thermometer will just confirm, basically, the numbers that you need to make it accurate, basically."*[261]

376. Like Nurse Hetherington, Nurse Hall maintained that "*warm*" meant that Ms Dhu's skin felt "*normal*" and that she was "*well perfused*". She explained "*well perfused*" as follows:

> *"That she had good circulation; that she didn't have – her hands weren't cold or cool or that she didn't have discolouration of her hands to say that she didn't have enough oxygen or blood flow to that area – that it wasn't constricted – the blood flow wasn't constricted to that area."*[262]

377. At other times in her evidence, however, Nurse Hall used the word *"warm"* to describe a temperature that was not in fact normal, responding in these terms: *She just didn't feel warm – didn't feel abnormal to actually highlight the fact that she – a temperature hadn't been done….* [263]

378. This inconsistency highlights the need for accurate recording, and adherence to proper processes. The risk of misunderstanding and error is amplified when a clinician uses a term such as "*warm*" to mean different things in connection with a person's temperature. Ultimately Nurse Hall settled on the following: "*Generally a person who is febrile is hot to touch."*[264]

379. Nurse Hall agreed with Dr Dunjey's view that a temperature for Ms Dhu should have been recorded at some stage during her presentation on 3 August 2014.[265] Through her counsel Nurse Hall also acknowledges that a thermometer should be used to take

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[260] ts 673 and 707
[261] ts 683
[262] ts 707
[263] ts 690
[264] ts 690
[265] ts 682

a temperature and that this was not done. Dr Dunjey expressed himself as follows, and I adopt his comments:

> *"….I would make the comment that people stopped using the back of their hand recording temperature about a thousand years ago and that's not a very scientific way to measure somebody's temperature and I don't honestly think there's any justification in somebody who's tachycardic for not taking their temperature."*[266]

380. Nurse Hall though her counsel submits that Ms Dhu showed no signs of fevers, chills, rigors, being off her food and feeling unwell, or wanting to lie down. However, Dr Speers previously alluded to these symptoms to explain what he called: "*A more typical presentation of sepsis*". Whilst I accept that Dr Speers' evidence was to the effect that it is difficult to diagnose septicaemia and that a patient rarely displays a "*full house*" of every possible symptom,[267] the import of this evidence is in fact that it becomes even more important to follow proper processes, to put in "*roadblocks*". In this case it included taking the temperature.

381. I am satisfied that as Nurse Hall had identified Ms Dhu to be tachycardic, she ought to have taken her temperature. It also ought to have prompted Nurse Hall to at least check whether Ms Dhu's temperature had been taken at triage. As Ms Dhu's temperature had not been taken at triage that responsibility fell to Nurse Hall.

382. Nurse Hall stated that her practice has now changed:

> *"I've purchased my own heat thermometer which I carry in my pocket and make sure that I routinely do it."*[268]

383. I accept the submission by Ms Dhu's family, through their counsel, that all patients who present for police medical clearance should have a full set of vital sign observations as a matter of course. This includes taking the temperature, with a thermometer.

384. Dr Sakarapani explained that since Ms Dhu's death, a full set of observations, including temperature, is always conducted by the treating nurse during a secondary assessment of the patient.[269] This is consistent with there being a box for recording temperature on the observation chart.

385. Unfortunately in Ms Dhu's case, Nurse Hall failed to take Ms Dhu's temperature, did not check whether it was taken at triage, and left the box for recording temperature on the observation chart blank.

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[266] ts 319
[267] ts 227
[268] ts 683
[269] ts 386

386. I am satisfied that it is highly likely that Ms Dhu was febrile during her presentation at HHC on 3 August 2014. She was in the process of dying from septicaemia and pneumonia.[270] Information concerning her temperature should have been conveyed to Dr Naderi, by way of a record on the observations chart, in the normal course. If, as I expect, Ms Dhu was febrile, the failure by Nurse Hall to convey this information had potential ramifications for the manner in which Dr Naderi subsequently treated her, and had the real potential to contribute to premature diagnostic closure.

The role of Dr Naderi

387. Dr Naderi qualified as a doctor in 1993 and worked in various hospitals, including those in rural areas. He has worked as a medical practitioner in remote Western Australia for approximately 20 years and has treated Aboriginal persons for most of his working life in medicine. He has undertaken training in relation to Aboriginal cultural awareness and Aboriginal Health matters.

388. Dr Naderi was appointed the District Medical Officer in Emergency Medicine in Anaesthesia at the HHC in September 1999. He has worked at HHC since then assuming the role of Director of Clinical Training in 2009.[271]

389. Dr Naderi was on duty in the emergency department of HHC on 3August 2014. Ms Dhu presented to him at 6.45 pm. At the completion of Dr Naderi's examination, Ms Dhu left the hospital at or about 7.10 pm. [272]

Dr Naderi's medical notes on 3 August 2014

390. Dr Naderi made handwritten notes following Ms Dhu's presentation at the emergency department of HHC on 3 August 2014. Those notes were as follows: [273]

"Difficult patient to assess

Presented last night in custody

Complaining of pain. Thought to be behavioural

Again represents still in custody

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[270] Exhibit 2, tab 49
[271] ts 519
[272] Exhibit 1, tab 18 and Exhibit 9
[273] Exhibit 1, tab 18; as interpreted from handwriting

At times she was quietly sleeping then crying in pain all over. Bilateral

Chest/shoulders/ribs etc.

Used drugs prior to this

On examination

Chest clear

Ultrasound → no pneumothorax/no abnormality detected of abdomen

No bruising

Difficult to examine

Impression? Withdrawal symptoms

? anxiety/personality problems

Prescribed Diazepam

Paracetamol

Ok to be in custody."

391. Dr Naderi's examination of Ms Dhu went for approximately 20 minutes, the longest time that any clinician spent with her during her two presentations at HHC. However, by not taking her temperature, by not recognising the implications of her tachycardia, and by not taking an X-ray of her chest, he missed some vital opportunities that would likely have revealed Ms Dhu's serious clinical state. These are addressed below.

<u>Dr Naderi did not take Ms Dhu's temperature</u>

392. Given that neither Nurse Hetherington nor Nurse Hall took Ms Dhu's temperature on 3 August 2014, there was no accurate information concerning Ms Dhu's temperature before Dr Naderi.

393. Dr Naderi did not take Ms Dhu's temperature either. Ms Dhu has passed through the hands of three clinicians, none of whom took her temperature. This is unsatisfactory. By way of explanation at the inquest Dr Naderi suggested the following:

"the problem is the diagnosis comes primarily from the history we're able to obtain, and the history provided to me, there was no suggestion of infection. The examination findings were not of infection. There was no trigger otherwise than automatically measuring a temperature to

need to do it. It is not done – it wasn't done routinely in our hospital at the time."[274]

394. I do not accept that there was no indication of Ms Dhu having an infection. My reasons are outlined below.

395. The treating nurse (Nurse Hall) had recorded a pulse rate of 113 beats per minute on the observations chart in the emergency department notes. Dr Naderi described this as a "*moderately elevated a pulse rate*", but ultimately he accepted that it meant Ms Dhu was tachycardic when he saw her.[275]

396. Dr Naderi did not recall being aware of Nurse Hetherington's subsequent handwritten notation on Ms Dhu's triage notes, recording that Ms Dhu had an even higher pulse rate of 126 beats per minute. Whilst he conceded that she must have written it, he could not say when she had done that. It was his practice to look at the records on the observations chart, and the presenting complaint but not the primary assessment in the triage notes of the emergency department notes. He explained that he does not look at the primary assessment because he prefers to make his own assessment.[276]

397. The pulse rate of 126 was handwritten on the presenting complaint, so in the ordinary course, if it was there Dr Naderi would have seen it. He may also be expected to recall it if he did see it.

398. I accept Dr Naderi's submission, through his counsel, that there is insufficient evidence for finding that he saw the handwritten notation by Nurse Hetherington on the emergency department notes when he read them. Dr Naderi stated that the reading of 126 beats per minute *"didn't make an impression on me"* but that was in the context of his evidence to the effect that he did not recall seeing it.[277] Dr Naderi's evidence was that a pulse rate of 126 beats per minute was "*reasonably high*" and that if he had noticed it, it may have led to a higher index of suspicion.[278]

399. On balance, there is insufficient evidence before me to positively find that Dr Naderi saw the handwritten pulse rate of 126. However, he clearly did see the pulse rate of 113 on the observations chart, so he knew Ms Dhu was tachycardic.

400. Dr Naderi's diagnosis of Ms Dhu (which in his evidence he equated to impression)[279] was recorded in his handwritten notes that were

[274] ts 566
[275] ts 566 - 567
[276] ts 526 and 580
[277] ts 560
[278] ts 560
[279] ts 546

in Ms Dhu's hospital file. His handwritten notes reflect the following: *"? withdrawal symptoms"* and *"?anxiety/personality problems."*[280] I am satisfied these represent his impressions.

401. In the box marked "*Discharge Diagnosis*" he wrote: *"? withdrawal from drugs"* and *"behavioral issues."*[281] I am satisfied that this was his diagnosis in respect of Ms Dhu on 3 August 2014.

402. Dr Dunjey opined that a temperature recording (either very high or very low) would have suggested infection and demanded a more thorough review of Ms Dhu. Clearly it is not now possible to know what Ms Dhu's temperature was upon that presentation. However, having regard to the features of Ms Dhu's presentation on 3 August 2014 and the post mortem findings, it is highly likely that she was febrile. If so, as Dr Dunjey stated:

> *"....it might have changed the trajectory of this case and in any case [temperature] is a standard part of the assessment for a patient such as this. Ms Dhu was warm to touch, tachycardic, and dry when her observations were recorded."*[282]

403. Dr Naderi agreed that a very high or very low temperature would not have sat with a diagnosis of musculoskeletal pain and would have demanded a more thorough review.[283]

404. Dr Speers opined that a temperature recording would have been a very important objective marker of infection, given that Dr Naderi considered Ms Dhu "*difficult to assess*", though he reached this view by also taking into account that the triage nurse noted Ms Dhu's skin as being "*warm*".[284]

405. It was not in dispute that the taking of a patient's temperature is an extremely simple test, which takes less than 30 seconds and provides an accurate assessment as to whether or not the patient has a fever.[285]

406. Dr Naderi gave evidence that he placed his hands on Ms Dhu and felt specifically for temperature and noted that her skin temperature was, according to him, *"normal".*[286] Through his counsel he submits that Ms Dhu was neither pale nor sweaty and in laying his hands on her during the examination, he did not consider her to have a fever and she felt well-perfused.

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[280] Exhibit 1, tab 18
[281] Exhibit 1, tab 18
[282] Exhibit 2, tab 49
[283] ts 559
[284] Exhibit 1, tab 40
[285] ts 565
[286] ts 535 and 536

407. This submission is made in the context of evidence that Ms Dhu had been lying in the back of the police van in air-conditioning for over an hour immediately before Dr Naderi's assessment of her. This submission serves to show how important it is that temperature be taken by thermometer, and that the laying of hands may lead to misleading results.

408. I again endorse Dr Dunjey's admonishment regarding the taking of temperature by hand in this day and age, and his criticism of clinicians for not taking the temperature of a person who is tachycardic.[287]

409. I am satisfied that Dr Naderi knew that no temperature had been taken when he examined Ms Dhu. Had Dr Naderi looked at that primary assessment section of the emergency department notes he would have observed that the caption marked *"Warm"* under *"Circ./Skin"* had been ticked. Whilst he initially testified that for him *"warm"* meant *"there is normal perfusion"* and that *"the skin felt normal to touch"*[288] (which was similar to Nurses Hetherington and Hall) he ultimately conceded that it would have made sense that if the skin felt normal to touch then the caption marked *"unremarkable"* should be ticked.[289]

410. At the inquest Dr Naderi also conceded that in the circumstances, he was the last chance for a temperature to be taken of Ms Dhu on that presentation to the emergency department. He accepted that whilst he formed the view at the material time that Ms Dhu was not clinically febrile, he cannot make that conclusion without taking a temperature with a thermometer. He conceded that he should have taken Ms Dhu's temperature, if it had not been taken before it should have been taken by him, and that it was a failure on his part not to take her temperature.[290] It is to his credit that Dr Naderi makes these concessions as it demonstrates his insight.

411. Dr Naderi's failure to take Ms Dhu's temperature fell short of the standards expected of a doctor working in the emergency department of a public hospital.

412. The relevance of knowing Ms Dhu's temperature was pertinent to the question of whether an X-ray of her chest should have been performed. This is addressed below.

[287] Exhibit 2, tab 49
[288] ts 536
[289] ts 536 - 537
[290] ts 565 and 568

Dr Naderi did not take account of Ms Dhu's recorded pulse rate

413. The emergency department notes from the previous day recorded Ms Dhu's heart rate at 72 beats per minute, a normal rate.[291] By 3 August 2014, the emergency department notes had a handwritten entry recording Ms Dhu's pulse rate at 126 at triage (I am not satisfied that Dr Naderi saw this) and the observation chart recorded Ms Dhu's pulse rate at 113 beats per minute (Dr Naderi saw this).[292]

414. I am satisfied that Dr Naderi failed to appreciate the significance of the reading of 113 beats per minute at the time of his examination of Ms Dhu. As Dr Dunjey stated in his report:

> *"This lady was clearly unwell on this visit. She was dead less than a day later, and one clue as to her septic state was her tachycardia. There appears to be some dispute about her recorded pulse rate of 126 on the front of the case notes on the 3 August 2014, but not about the reading of 113 in the clinical table on the inside of the notes. There is absolutely no question that this is abnormal, particularly when the same patient had a normal pulse rate of 76 bpm the day before.*
>
> *There are many causes for a raised pulse rate and some are serious (as in this case) whilst other cases are less concerning. Because there are potential serious causes, I (and a lot of other specialists Emergency Physicians) won't discharge someone into the community with a pulse rate of over 100 unless we have made a clear diagnosis of a benign, self-limiting condition. There is no evidence base for this practice but it is based on clinical common sense and is something I teach to my trainees. I would have kept this lady until a diagnosis was clear or until I had evidence that she was returning to normal. In Ms Dhu's case, her hemodynamic parameters would have continued to worsen with a period of observation."* [293]

415. I take account of Dr Naderi's knowledge of the pulse rate of 113 beats per minute, and Dr Dunjey's evidence that he would not discharge someone into the community with a pulse rate of over 100 unless he has made a clear diagnosis of a benign, self-limiting condition. In the circumstances I am satisfied that on the basis of a pulse rate of 113 beats per minute Dr Naderi ought to have ordered further investigation.

416. Dr Dunjey's evidence was that the only truly objective evidence that she was ill was her pulse rate, because she was not shocked: "*these diseases progress so quickly that she may not have looked that bad because young people compensate for the illness. The*

[291] Exhibit 1, tab 18
[292] Exhibit 1, tab 18
[293] Exhibit. 2, tab 49

tachycardia in this case is her body attempting to compensate and you compensate well."

417. Unfortunately, Dr Naderi considered there may be other reasons for her tachycardia, and they were based upon considerations that gave rise to premature diagnostic closure:

> *"....with the agitation, chest pain, being in custody, having waited an hour and a half to be seen, maybe the remnant of the influence of drugs, all of them, and – and the fact that she was dehydrated – there – there are a lot of reasons to contribute to the tachycardia."*[294]

418. I accept the submission by Ms Dhu's family through their counsel, that having regard to her pulse rate, it was an error that Ms Dhu was discharged. This is supported by Dr Dunjey's evidence. He explained it in the following manner: "*....there has very clearly an error been made, but it's an error which a lot of doctors would make.*" The reason he gave is that: "*Patients who are septic, their illness is underappreciated."*[295]

419. However, Dr Dunjey's evidence did point to an area of relevance for me:

> "*You need the process to overcome the deficiencies that every – the process of physical examination, taking history, is not perfect, and we need steps in a process to stop us making understandable errors, and, yes, I mean, I – if you want me to summarise, you know, amazingly, when you look back at how ill this poor lady was the next day, in retrospect you think, "How on earth could somebody miss this?" But the fact is, at the stage that the doctor examined the patient, the fact that he made this error does not make him a terrible doctor, and, as I've said, I see this same error made in my own institution on a fairly regular basis. This is hard medicine and it doesn't mean that he's, you know, terrible or has missed something out, it's just hard. So, yes, it's about process preventing the error being made."*[296]

420. The fact that other doctors make the same error does not change the fact that it is an error. I accept Dr Dunjey's evidence that this area of medicine is "*hard medicine*" and that there is a tendency to underappreciate the severity of this type of illness, for that reason.

421. Nevertheless I am satisfied that Ms Dhu's tachycardia, combined with the fact that she was very likely to be febrile, should have given rise to elevated concerns about her health and should undoubtedly have mandated further investigation. Processes such as a temperature reading and chest X-ray would have prevented error.

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[294] ts 550
[295] ts 286 – 289
[296] ts 313

Dr Naderi did not take an x-ray

422. This was Ms Dhu's second presentation with pain in the rib area. She told Dr Naderi she had fallen on stairs two weeks prior and that she had pain in her ribs. She did not tell Dr Naderi about the rib injury in April 2014, nor of her presentation to GRH that month. She spoke normally and coherently and she was alert and orientated, consistent with Nurse Hetherington having allocated her a Glasgow Coma Scale score of 15 at triage.[297]

423. Whilst Nurse Hetherington's record on the presenting complaint at triage on the emergency department notes reflects that Ms Dhu informed her she had asthma and difficulty breathing, and that she was grunting and moaning, Dr Naderi's evidence was that Ms Dhu showed no signs of respiratory difficulty nor did she have any grunting or moaning when he saw her. Dr Naderi was informed by Ms Dhu that her breath was "*catching*", which to him meant that it was a pain restricting the depth of her inspiratory movement, rather than not being able to get any air in. He referred to it as a pleuritic pain.[298]

424. Ms Dhu also pointed to the right lower side of her ribs and told Dr Naderi they were bruised and swollen. Dr Naderi auscultated, percussed and palpated her chest, particularly where she pointed, being the anterior inferior chest wall (that is, the front lower chest wall) but he did not find any clinical sign of bruising, swelling, nor any focal tenderness; he found no pain response on the part of Ms Dhu. He listened to her chest on both sides and did not find any abnormalities.[299]

425. Dr Naderi agreed that grunting by a person was a sign of sepsis, but he did not find her to be grunting when he saw her.[300] He also agreed that tachycardia was a symptom of infection.[301] He accepted that he had read in the emergency department notes for 3 August 2014 that Ms Dhu had complained *"she can't breathe"*, but he did not find her to be in respiratory distress. He was also aware that her oxygen saturation was 100% in room air.[302]

426. Dr Naderi performed an ultra-sound on Ms Dhu's chest area, in order to rule out pneumothorax and haemorrhage in Ms Dhu's lungs. He did not find any abnormality, including in her upper abdomen and liver. He was qualified in the use of ultrasound.[303]

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[297] Exhibit 1, tab 24
[298] ts 529 and 580 - 582
[299] ts 581 - 582
[300] ts 601
[301] ts 566
[302] ts 543 and 581
[303] ts 313

427. At the inquest I heard evidence on the question of whether an X-ray ought to have been performed. Dr Naderi did turn his mind as to whether an X-ray was warranted, but decided not to do so because he did not think Ms Dhu had any clinical signs of pneumonia. From his perspective, Ms Dhu showed an elevated pulse rate, with normal respiration and saturation rates and accordingly it would be difficult to justify doing an X-ray. There would have been no difficulty with engaging a radiographer to undertake an X-ray as there was one on call for HHC.[304]

428. Though he agreed that generalised pain was a symptom of sepsis,[305] Dr Naderi did not agree that his handwritten notes in which he described Ms Dhu as being *"in pain all over"* meant that she actually had overall pain. In answer to a question from counsel for Ms Dhu's father, Dr Naderi stated:

> *"The all over pain you're talking about – I considered she did not have all over pain the way she described it. She – I know the wording is there, but the way she described it, she had pain in specific areas of the chest, shoulder – left shoulder and then only one left thigh. It wasn't as generalised. I have written 'all over', but my recollection and understanding was that she was talking about specific areas that was* [sic] *sore as a result of her fall rather than a generalised pain."* [306]

429. As to Dr Naderi's decision not to perform a chest X-ray, Dr Dunjey opined as follows:

> *"Whilst it is not possible to be absolutely certain, it is highly certain that a chest x-ray performed on this visit would be abnormal. The autopsy performed on Ms Dhu after her death, the next day, show bilateral pneumonia, pleural effusions (fluid around the outside of both lungs) and abscess formation. It is just not credible to believe that all of these changes appeared in the 18 hours between her second and third presentations. An abnormal chest x-ray showing disease in her lungs would have forced a reconsideration of the diagnosis given, and would be considered a standard investigation for chest pain. In this particular case, the presence of shortness of breath, grunting respirations, tachycardia and a second presentation with chest pain* ***demanded*** *further investigation. This was a critical missed opportunity."* [307]

430. In evidence Dr Dunjey noted that this was a second presentation with the same problem within 24 hours (namely chest pain, being the pain in the rib area). From his experience: "*100% of the time we would do a chest x-ray on a patient like this*". In evidence at the inquest Dr Dunjey did not think there was any doubt a chest X-ray

[304] ts 543 - 545
[305] ts 584
[306] ts 584
[307] Exhibit 2, tab 49

would have been abnormal, and that it was: "....*one of these little road blocks the doctors have to put up in front of themselves so they don't make a mistake.*"[308]

431. Dr Dunjey considered ultrasound would be more sensitive and appropriate if the doctor is certain that the problem is wholly and solely related to a traumatic event, but the other clues, such as the tachycardia and the aching all over suggested this was not a problem localised to the chest and that there was something else going on. He agreed that the fact that Ms Dhu was an intravenous drug user would place her in a higher category for a number of other pathologies.[309]

432. I accept Dr Dunjey's opinion, and consequently do not accept Dr Naderi's view where he stated: *"I firmly believe if I had done the chest x-ray at the time, it would have not shown pathology."* [310] However, it is to his credit that Dr Naderi did ultimately agree that, in hindsight, it would have been better to perform a chest X-ray.[311]

Comment [RF1]:

433. It follows that I am not persuaded by Dr Naderi's opinion evidence to the effect that he believes the micro abscesses of the visceral pleural surfaces occurred peri mortem, as a result of multi organ failure and disseminate intravascular coagulation.[312]

434. I accept the submission by Ms Dhu's family through their counsel, that a chest X-ray would have been a standard of care for assessment of chest pain in a patient such as this.

435. I am satisfied that Dr Naderi ought to have ordered a chest X-ray and that if taken, it would most likely have been abnormal, and if so, would have changed the course of Ms Dhu's treatment.

436. Dr Speers opined that had antibiotics been given at that stage, they would have been potentially life-saving for Ms Dhu.[313]

437. By not taking an X-ray, Dr Naderi's conduct fell short of the standards expected of a doctor working in the emergency department of a public hospital.

[308] ts 283
[309] ts 284
[310] ts 543
[311] ts 569
[312] ts 543 and 544
[313] Exhibit 1, tab 40; ts 231

Dr Naderi did not record that his diagnosis was musculoskeletal

438. Dr Naderi's evidence was that he thought Ms Dhu had a rib injury and that she may or may not have a fractured rib. Through the ultrasound he ascertained she did not have complications such as haemopneumothorax. He testified that his primary diagnosis was that the source of her pain was musculoskeletal, meaning that he considered her rib injury to be a musculoskeletal condition, which in the broader term refers to bruising, rib fractures, injury to muscles and/or bones.[314]

439. Dr Naderi was firm in his evidence and in his statement that his diagnosis, at the very least, included musculoskeletal as the cause of Ms Dhu's pain.[315] However, he did not record it as a diagnosis. In fact he did not make any record of Ms Dhu having musculoskeletal pain in her emergency department notes at all.[316] A plain reading of his notes indicates that his diagnosis (albeit with question marks) was that Ms Dhu had behavioural issues and was suffering from drug withdrawal.

440. Dr Dungey was questioned on what diagnosis he, as a clinician, considered that Dr Naderi had made of Ms Dhu. He opined as follows, having regard to Dr Naderi's notes:

> *"So there are two conditions there. Query withdrawal from drugs is suggesting that a person may be becoming physically unwell because an illicit drug they are using is coming out of their system. Their body is physically craving that drug and it produces a range of symptoms which can include tachycardia, vomiting, diarrhoea, etcetera. So that's one diagnosis. The second diagnosis is behavioural issues. And I think what – to me what that's suggesting is, that the doctor has looked at Ms Dhu and felt that she was embellishing her physical symptoms. She was – and plus or minus she is a difficult patient to deal with, because she is cranky."*[317]

441. Dr Naderi himself acknowledged that a doctor reading his notes would be entitled to conclude that he did not consider that Ms Dhu had a musculoskeletal cause for her pain.[318]

442. Unfortunately Dr Naderi's treatment of Ms Dhu was influenced by *"premature diagnostic closure"*. An example of this was Dr Naderi's conclusion that Ms Dhu's tachycardia was because of her distressed state rather than the fact she was very gravely ill.

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[314] ts 546
[315] ts 546, 549 and 570; Exhibit 1, tab 25
[316] Exhibit 1, tab 18
[317] ts 290
[318] ts 570

443. At the inquest Dr Naderi conceded there was a level of influence, having regard to Dr Lang's diagnosis of "*behaviour issues*" the previous day. He explained it as follows:

> *"It is hard not to be influenced by what is said before. I think that has been in evidence of experts in the past, that it opened up a whole set of pathways, but I still made an attempt at taking history myself and examining and coming with my own conclusions."* [319]

444. In the circumstances, on 3 August 2014 Dr Naderi ended up by agreeing, essentially, with Dr Lang. The overall impression is that neither doctor believed Ms Dhu was genuinely unwell, let alone seriously so. The only reasonable inference was that they thought Ms Dhu's complaints were exaggerated, or not entirely genuine.

445. I make a similar comment regarding the absence of a reference to a diagnosis of a musculoskeletal condition within Dr Naderi's medical notes, as I have made in respect of Dr Lang. That is, it is undesirable to diagnose a patient with "*behavioural issues*" and it is vital that, if a diagnosis is made, it be recorded. At the inquest Dr Naderi conceded that the notes of his examination of Ms Dhu were inadequate and inaccurate.[320]

A missed opportunity to treat Ms Dhu

446. Dr Dungey upon a review of the records reported that:

> *"Ms Dhu was a very challenging case for the staff at Hedland Health Campus. Her incarceration, prior drug use, behavioural on first visit and prior chest injury provided distractions that prevented staff from seeing how ill she really was. On her first visit to the hospital, on 2 August 2014, there were no clues to her life-threatening illness and no issues with the treatment she received. On her second visit on 3 August, she was already very ill and in the process of dying from septicaemia and pneumonia, but attending staff had undergone premature diagnostic closure for all the reasons listed. This is completely understandable in the context and is known to occur in medical practice. There were several points at which her serious illness may have been recognised, but these steps were omitted or forgotten by staff at HHC on that day."*[321]

447. I am satisfied that Dr Naderi did genuinely spend time endeavouring to assess whether Ms Dhu had a medical condition.

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[319] ts 583
[320] ts 577
[321] Exhibit 2, tab 49

At the inquest I found him to be truly remorseful about the catastrophic outcome for Ms Dhu, undoubtedly affected by the fact that, in hindsight, he was the last person who may potentially have been able to make a difference for her.

448. I accept that this was "*hard medicine*" as previously described by Dr Dunjey, and that misdiagnosis of staphylococcal septicaemia is common. It is also clear that Ms Dhu's deterioration was rapid.

449. However, there were roadblocks, that is processes, that should have been put in place (temperature reading, chest X-ray, an assessment of the implications of her tachycardia). If those steps had been taken, I am satisfied that it would have become apparent that Ms Dhu had an infection, and she would not have been discharged into police custody. She would have remained at HHC, under careful monitoring. Despite her already grave condition, antibiotics would potentially have been life-saving for her at that stage. The outcome of such treatment cannot now be known. By this stage it is likely that her sepsis, was well-established and she was probably bacteraemic.[322] However, there was a missed opportunity to treat Ms Dhu on 3 August 2014. Those roadblocks, or processes, were all, ultimately, Dr Naderi's responsibility.

Changes to Dr Naderi's practices since Ms Dhu's death

450. Dr Naderi described Ms Dhu's death as a tragic event that has had an effect on the way he practices. He now finds himself over investigating and finds it difficult to let go of patients, preferring to keep them in hospital until all abnormal observations are capable of being explained.[323]

451. Dr Naderi through his counsel informs the Court that he now endeavours to write his notes as close to the event as possible, and to include more details and reasoning behind his thought processes.

452. Since Ms Dhu's death Dr Naderi has organised educational material, updated HHC protocols and arranged discussions around sepsis diagnosis to further his own and other doctors' training in the area. He has addressed the topic of sepsis diagnosis in new doctors' orientation materials, compiled tutorials on the topic, been involved in running sepsis simulations at HHC and has mentored a District Medical Officer who is undertaking research on sepsis in remote areas and patient transfers to tertiary centres.

[322] Exhibit 1, tab 40
[323] ts 562

453. I am satisfied that Dr Naderi has shown insight into his conduct, and has taken steps to avoid a situation arising in similar circumstances.

UNPROFESSIONAL AND INHUMANE TREATMENT

454. Ms Dhu remained in custody at the Lock-Up until she was close to death. On the morning of 4 August 2014, the police officers responsible for her care and welfare believed she was feigning her symptoms. As a result, they delayed taking her back to HHC. At the inquest, it was profoundly disturbing to witness CCTV evidence of Ms Dhu being treated, by some of the police officers, as if she were an object, as if she were invisible, and without regard for her dignity as a fellow human being.

455. Article 10(1) of the *International Covenant on Civil and Political Rights* provides that: "*All persons deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person.*" There is no doubt in my mind that this reflects the contemporary values of the Australian community.[324]

456. The events at the Lock-Up on 4 August 2014 will serve as a constant reminder of the dangers of failing to acknowledge the inherent right of every person in detention to be afforded humane and dignified treatment. When respect is lost for that right, for whatever reason, the risk of mistreatment is high. A steadfast adherence to that tenet was needed that day, but was sadly lacking.

457. Throughout the morning of 4 August 2014 Ms Dhu was developing septicaemia. Her infection was far advanced with septic shock and by mid-morning she was only hours away from death. Despite the two previous hospital attendances, an ambulance should have been called for Ms Dhu in the earlier part of the morning on 4 August 2014. By approximately 7.35 am Mr Bond was aware she had vomited; by approximately 10.00 am Mr Bond was aware she sought to go to hospital.

458. Had Ms Dhu been taken to HHC several hours earlier on the morning of 4 August 2014, her chances of survival, even with full resuscitation and intravenous antibiotics were slim, and on all of the evidence before me, it is unlikely that she would have survived.[325] However, she ought to have been afforded every reasonable and proper opportunity for medical care, and that included the calling for an ambulance at an earlier stage on 4 August 2014.

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[324] *Royal Women's Hospital v Medical Practitioners Board of Victoria* (2006) 15 VR 22 at [77]

[325] Exhibit 1, tab 40; Exhibit 2, tab 49

459. The evidence does not establish that the police caused or contributed to Ms Dhu's death. Nevertheless, there were failures in Ms Dhu's supervision, treatment and care at the Lock-Up on 4 August 2014 that are irreversible. Ms Dhu, who was dying, was unable to be comforted by the presence of her loved ones. She very sadly spent her final hours at the Lock-Up with persons who misunderstood the acceleration of the infective process, thought she was feigning her symptoms, and in the process, disregarded her welfare and her right to humane and dignified treatment.

460. The roles of the police officers are examined below.

The role of First Class Constable Matier

461. First Class Constable Matier has been a police officer in the Western Australian Police Service since May 2011. He was stationed at the SHPS in April 2014 and as of August of that year, he was 24 years of age. He, like Constable Sharples, was a relatively inexperienced police officer at the time. As at August 2014, he was a Constable. First Class Constable Matier did not work on 2 or 3 August 2014 and commenced work on Monday, 4 August 2014 at the SHPS at 7.00 am when he was assigned the responsibility as lock-up keeper.[326]

462. First Class Constable Matier received his verbal handover from Detective Senior Constable Nunn. He was made aware that Ms Dhu had been to HHC twice and that she had been declared by the doctors to be fit to be held in custody. He was not told, nor did he ask the reasons for Ms Dhu's attendance at HHC. He was made aware that there was Panadol if Ms Dhu needed it.

463. Shortly after First Class Constable Matier commenced his shift, he heard the shift supervisor, Mr Bond make comments to the effect that Ms Dhu was feigning her symptoms, that she was "*faking it.*"

464. In the hours that followed First Class Constable Matier had contact with Ms Dhu at critical times. That conduct was visually (and at times audibly) recorded on the CCTV cameras at the SHPS and then at HHC.[327] First Class Constable Matier's conduct reflects that he chose to rely on Mr Bond's assessment of Ms Dhu's behaviour, instead of taking account of what was happening before his very eyes.

465. At the inquest First Class Constable Matier was candid in giving his evidence about his treatment of Ms Dhu on 4 August 2014, and

[326] Exhibit. 1, tab 17
[327] Exhibits 5, 9 and 10

he did not try to minimise his role. However, it is to be borne in mind that his actions were recorded. His behaviour towards Ms Dhu was of one who appeared to not be consciously aware that he was dealing with another human being. His conduct on 4 August 2014 not only reflected poorly on him but also the Western Australia Police Service. The details are set out below.

First Class Constable Matier treated Ms Dhu in an unprofessional and inhumane manner on 4 August 2014

466. Ms Dhu was in the process of dying after First Class Constable Matier had assumed the responsibilities of lock-up keeper on 4 August 2014. Initially, he became aware that Ms Dhu was calling out for assistance. Later, as he observed Ms Dhu, her health deteriorated, and she manifested increasing signs of incapacitation.

467. However, First Class Constable Matier resolutely adhered to the view that Ms Dhu was feigning her symptoms, and in the process failed to assess and react to the patent risks to her welfare.

468. The audio from the CCTV camera in the charge room recorded an exchange between First Class Constable Matier and a detainee at approximately 10.20 am on 4 August 2014.[328] After noises can be heard coming from the direction of the cells (which would appear to be Ms Dhu's distressed cries), First Class Constable Matier asks the detainee: "*Has she been screaming all night?*" This is an obvious reference to Ms Dhu. When the detainee replies "*yeah*", First Class Constable Matier is heard to say "*… think she is trying to get out*". The detainee then states "*she's really in pain*" and First Class Constable Matier responds with "*yeah*" but continues looking at some paperwork on the counter in front of him and talking with the detainee.

469. It is apparent from this exchange that a few hours into his shift, First Class Constable Matier had developed an indifference to Ms Dhu's wellbeing. Sadly, it was magnified as the morning progressed. His responses to the detainee's comments reflect that by this stage he believed Ms Dhu was crying out as a ploy, with the aim of being released from custody. He ignored the other detainee's concern about her condition.

470. First Class Constable Matier through his counsel accepts that he did not immediately take action after the detainee in effect informed him that Ms Dhu was displaying symptoms of pain throughout the night, but submits that he was alone in the charge

[328] Exhibit 11

room on a busy shift and was awaiting Mr Bond's attendance regarding a bail matter.[329] That may explain the inaction, but not the underlying indifference, which reflected his true state of mind and persisted until Ms Dhu's presentation at HHC.

471. Shortly afterwards at 10.28 am, First Class Constable Matier did make a reference to "*hospital*" in connection with Ms Dhu, but Mr Bond appeared and cut him off with the words: "*That would be the third time she's been to hospital, she's fit to be held.*"[330]

472. At the inquest First Class Constable Matier gave evidence to the effect that he saw no point in questioning Mr Bond. Through his counsel he submits that in retrospect he should have circumvented Mr Bond. It is clear that First Class Constable Matier would not have had authority to circumvent Mr Bond under normal circumstances.

473. However, if First Class Constable Matier had understood and believed that Ms Dhu's life was at risk, he ought to have immediately picked up the telephone and dialled for an ambulance, without awaiting further authority. With the benefit of hindsight, First Class Constable Matier now recognises that he ought to have called for an ambulance.

474. The segments of footage from the Cell 3 camera between 11.09 am and 11.52 am[331] depict Ms Dhu's rapid and serious deterioration in her health. Her body began to go numb, she could no longer stand, and her attempts to pull herself up into a seated position ended with her falling onto her back, without breaking her fall.

475. At approximately 12.14 pm on 4 August 2014, Mr Bond decided that Ms Dhu ought to be conveyed to the HHC for a third time. It is difficult to believe how no police officer became alarmed, or at least worried for Ms Dhu at this point. At 12.33 pm, with no sense of urgency, Senior Constable Burgess and First Class Constable Matier entered Cell 3 for the purpose of conveying Ms Dhu to HHC.

476. First Class Constable Matier through his counsel concedes he displayed a lack of empathy towards Ms Dhu. He also concedes that he still should not have displayed the conduct that he did, even to a well detainee. However, whilst he disputes it, I am persuaded by the evidence before me that more than a lack of empathy, First Class Constable Matier demonstrated a disregard and complete indifference to Ms Dhu's condition.[332]

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[329] ts 1478
[330] Exhibit 3, tab 17
[331] Exhibit 5
[332] Exhibit 5 and footage from 12:33:44pm – 12:39:13pm on 4 August 2014

477. First Class Constable Matier through his counsel suggests that a wheelchair or stretcher would have afforded a much better conveyance. However, there is no doubt in my mind that when a detainee is so unwell as to be unable to stand up and walk, an ambulance must be promptly called for. A detainee who has essentially collapsed may be further injured if incorrectly placed upon a wheelchair or stretcher by police, who are not medically trained personnel.

478. First Class Constable Matier through his counsel submits that he did not realise that Ms Dhu could not walk. Upon entering Ms Dhu's cell at approximately 12.33 pm with the aim of conveying her to HHC, he handcuffed her as she lay on the mattress on her back. Inexplicably, he was of the belief that Ms Dhu was a flight risk. He still believed she was feigning her injuries.

479. By handcuffing Ms Dhu, he believed she could walk, or possibly run. He based this upon Mr Bond's earlier comments and the fact that Ms Dhu was declared to be in a fit condition to be held in custody on two previous occasions. However, First Class Constable Matier had no information that suggested Ms Dhu had been anything other than compliant during the previous two hospital attendances. I am led to the inescapable conclusion that First Class Constable Matier was going through the motions, without any thought or regard for Ms Dhu.

480. Through his counsel First Class Constable Matier concedes that his belief that Ms Dhu was a flight risk sounds unreal, in hindsight. Sadly, his behaviour in handcuffing Ms Dhu stands as a shameful example of blindly following what he referred to as "*general practice*"[333] at the time, without the application of common sense or common humanity.

481. First Class Constable Matier found it awkward removing Ms Dhu from her cell. Initially he grabbed her around the waist to lift her to her feet, and when this did not work, he placed her back on the mattress. In what is a disturbing series of images on the CCTV,[334] First Class Constable Matier then placed his hands under each of Ms Dhu's arms and dragged her, face up, along the floor of her cell up to the cell door, where he propped her against his legs, in a semi sitting position.

482. He then asked Ms Dhu if she could walk and he recalled that she said: "*No, I can't move my legs.*" Inexplicably First Class Constable Matier was not entirely convinced that she had lost the use of her legs.[335] He still believed she was faking her injuries. In his

[333] ts 1499
[334] Exhibit 5
[335] ts 1497

evidence and through his counsel he suggested that he tried to drag her "*gently*"[336] along the cell floor and through the cell door.

483. I will say unequivocally and without reservation that it is not possible to minimise this behaviour by suggesting that a detainee has been "*gently*" dragged across a floor. The act of dragging a person across a floor has no gentle aspect whatsoever. Detainees who are incapacitated, or who appear to be incapacitated, such as Ms Dhu, are not to be dragged along the floor. It is particularly inappropriate to do so where medical assistance is being sought.

484. After First Class Constable Matier propped Ms Dhu up against his legs, he continued to hold her upper body and Senior Constable Burgess took Ms Dhu by her feet. Together they carried Ms Dhu along the corridor, to the sally port and lifted her into the secure pod at the back of the police vehicle. It is disheartening to observe, on the CCTV, that as they did so, the police folded her legs so that she could fit into the space before the door was closed.

485. On being placed into the secure pod of the police vehicle Ms Dhu was able to tell First Class Constable Matier "*I can't move*".[337] She did not have use of her legs, and she had negligible observable movement in her arms.[338] First Class Constable Matier still believed she was feigning her symptoms.

486. Mr Ruffin had observed these events from his cell. He called out to police in an aggressive manner, to complain about their treatment of Ms Dhu. The audio footage of the charge room camera at 12.37 pm reflects that First Class Constable Matier shouted out loudly to Mr Ruffin: *"Oh shut up"*.[339] This was just before he got into the police vehicle to convey Ms Dhu to hospital.

487. First Class Constable Matier's evidence was that he found Mr Ruffin's comments "*extremely distressing*".[340] Granted that he was young and relatively inexperienced, nonetheless First Class Constable Matier should not have shouted in that manner at Mr Ruffin, and he should have heeded Mr Ruffin's exhortations to stop treating Ms Dhu in that manner.[341]

488. They left for HHC by 12.39 pm, arriving there a matter of minutes afterwards. CCTV footage from the HHC depicts the manner in which First Class Constable Matier and Senior Constable Burgess conveyed Ms Dhu from the police vehicle, by wheelchair, into the reception area of the emergency department.[342] Even at this stage

[336] ts 1497
[337] Exhibit 4, tab 18; ts 1507
[338] ts 1506 - 1507
[339] Exhibit 5
[340] ts 1560
[341] ts 121 -1 122; ts 1505
[342] Exhibit 9

First Class Constable Matier's evidence was that he still "*had doubts*" about whether he believed Ms Dhu was being genuine about her condition.[343]

489. As Ms Dhu was being lifted out of the back of the police vehicle outside HHC First Class Constable Matier again heard her repeat the words: "*I can't move, I can't move.*"[344] This appears to have had no effect on him and he did not display any sense of urgency as he lifted her into a wheelchair and together with Senior Constable Burgess, conveyed her into the emergency department at HHC. Through his counsel First Class Constable Matier accepts that his behaviour in conveying her into the hospital was with disregard to her fatal condition.

490. When they arrived at the front counter of the emergency department, Nurse Jones spoke with First Class Constable Matier. Nurse Jones' evidence was that when she asked the police officers *"what's going on"* or words to that effect, the male police officer replied *"She's just putting it on. She's faking it"*.[345] In his evidence First Class Constable Matier denied saying those exact words, saying his words were along the lines of *"This is Ms Dhu. She has been here twice before. I don't know if she's faking it or not"*.[346]

491. I consider it more likely that Nurse Jones' recollection is the more accurate of the two. In any event by the time Ms Dhu is seated, incapacitated, in the wheelchair with her head flopped backwards, there is no cause whatsoever for mentioning that she is or might be feigning her incapacitation. The suggestion ought not to have been made at all by First Class Constable Matier, and it risked delaying the raising of the alarm. In the circumstances, Nurse Jones acted quickly. However inexplicably, First Class Constable Matier again repeated this in the presence of the resuscitation team. By now it was likely more of a hope, than a belief.

492. First Class Constable Matier's treatment of Ms Dhu was clearly unprofessional. I am not satisfied that First Class Constable Matier acted in that manner because he was angry with Ms Dhu, though he was frustrated with her (and he conceded that). There is a difference, because acting in anger is completely untenable, whereas frustrations can and do occur, both for understandable reasons and wrong reasons. In this case, First Class Constable Matier was wrong to be frustrated.

493. At the inquest Constable Matier accepted that it is difficult, objectively, for a person to understand the basis upon which he believed that Ms Dhu was exaggerating or feigning her injuries by

[343] ts 1508 - 1509
[344] ts 1508 - 1509
[345] ts 498
[346] ts 1517

the time he was conveying her to HHC. With the benefit of hindsight, he accepted that his treatment of Ms Dhu was inhumane, without due compassion for her suffering.[347]

494. First Class Constable Matier should not have continued to rely on his supervisor's comments about Ms Dhu feigning her illness. As lock-up keeper, he observed her deterioration first hand. He was responsible for her welfare. He was unwise to consider the question resolved by reason of two prior attendances at HHC, particularly where he did not know the details. He failed to consider her welfare needs.

495. Unfortunately, First Class Constable Matier inflexibly adhered to his preconception that Ms Dhu was feigning or embellishing her symptoms. His inflexibility in this regard leads me to conclude that regrettably, Mr Bond's comments must have resonated with First Class Constable Matier's own preconceptions concerning Ms Dhu.

496. I am satisfied that First Class Constable Matier's treatment of Ms Dhu on 4 August 2014, and particularly from the time when he approached her to remove her from her cell, and continuing to the point where he suggested to the resuscitation team that she was feigning her illness, was unprofessional and inhumane. His conduct reflects badly on the Western Australia Police Service.

The role of Senior Constable Burgess

497. Senior Constable Burgess graduated as a police officer in July 2005. She was promoted to the rank of Senior Constable in January 2014. She was posted to the SHPS in or about May 2012 and remained there until April 2015. She did not work on 2 or 3 August 2014, but did work the morning shift at the SHPS on 4 August 2014 from 7.00 am to 3.00 pm.

498. Senior Constable Burgess' contact with Ms Dhu was confined to shortly after midday on 4 August 2014 to less than 45 minutes later when Ms Dhu was presented to the front reception area at the emergency department of HHC. Throughout this time, Senior Constable Burgess continued to believe that Ms Dhu was feigning her symptoms. Her behaviour towards Ms Dhu reflected an obstinate adherence to this belief.

499. It was only by chance that Senior Constable Burgess had any contact with Ms Dhu on this day. Her duties at the relevant time were that of a community police officer. She therefore did not have

[347] ts 1520

any responsibilities relating to the Lock-Up. At about midday on 4 August 2014 she had completed her duties and before she went home she inquired whether there was any other work that had to be performed. That inquiry was directed to Mr Bond, the shift supervisor at the time.[348]

500. The performance by her of the duties assigned by Mr Bond set in train a series of events that indelibly marred Ms Dhu's final hours. The details are set out below.

Senior Constable Burgess treated Ms Dhu in an unprofessional and inhumane manner on 4 August 2014

501. At approximately 12.00 noon on 2 August 2014, Mr Bond assigned Senior Constable Burgess the task of attending to Ms Dhu to offer her a shower. When he instructed her in this task, he informed her that Ms Dhu had been to the HHC twice, and he referred to Ms Dhu as a "*junkie*" who was coming off drugs. He also informed her that Ms Dhu was "*faking*" her injuries and that she was walking around at an earlier stage that day.[349]

502. Mr Bond spoke in a disrespectful and inappropriate manner about Ms Dhu and I address his conduct later in this finding. Whilst Mr Bond conveyed his disregard towards Ms Dhu when he instructed Senior Constable Burgess, I do not accept that it was reasonable or understandable for Senior Constable Burgess to adopt his attitude and display a similar disregard to Ms Dhu, merely because he was her supervisor. I take into account that she was neither as young, nor as inexperienced, as First Class Constable Matier.

503. Senior Constable Burgess gave evidence to the effect that in her experience Mr Bond was not to be crossed or questioned too much, as he was likely to become intemperate.[350] However, within this context, crossing him would have meant failing to attend to Ms Dhu to offer her a shower.

504. I do not accept that Senior Constable Burgess' subsequent behaviour towards Ms Dhu can be ameliorated or adequately explained by her submission, through her counsel, that her very first impression of the situation was an emphatic instruction from Mr Bond that Ms Dhu was not to be taken seriously.

505. Senior Constable Burgess accepted Mr Bond's advice that Ms Dhu was withdrawing from drugs, which as it transpired was incorrect. There is no criticism of Senior Constable Burgess' acceptance of information at that stage that Ms Dhu was withdrawing from

[348] ts 1571
[349] ts 1572
[350] ts 1573

drugs. However, that state of mind did not entitle her to disparage or disregard Ms Dhu.

506. When Senior Constable Burgess went to Ms Dhu's cell with Senior Aboriginal Police Liaison Officer Edwards, she warned her to be careful because she believed Ms Dhu was a person coming off drugs and that she may behave in an unpredictable manner.[351]

507. When Senior Constable Burgess attended the cell at 12.06 pm, Ms Dhu complained to her that her leg was numb. During that exchange, Ms Dhu was lying on her back on the mattress and her arms were moving from side to side. She looked towards Senior Aboriginal Police Liaison Officer Edwards who was standing at the doorway with Senior Constable Burgess and said: *"Help me. I can't feel my legs"*. Senior Aboriginal Police Liaison Officer Edwards described it as a murmur.[352]

508. Senior Constable Burgess, together with Senior Aboriginal Police Liaison Officer Edwards, realised that it would not be possible to arrange for Ms Dhu to have a shower. Senior Constable Burgess formed the view that Ms Dhu was unwell, though not seriously so. She returned to Mr Bond to advise him that Ms Dhu needed to go to hospital.[353]

509. Upon receiving this information, Mr Bond became angry. Some of that anger was directed towards Senior Constable Burgess. He disputed her interpretation of the situation and told her he would attend at the cell himself. The two police officers and Senior Aboriginal Police Liaison Officer Edwards returned to Ms Dhu's cell, but Mr Bond then walked off to get some gloves.[354]

510. The CCTV footage that follows is alarming. It shows that at 12.11 pm on 4 August 2014, Senior Constable Burgess attempted to pull Ms Dhu up to a sitting position, as she was lying on her back on the cell's mattress. With her right hand, whilst holding a magazine in her left hand, Senior Constable Burgess took hold of Ms Dhu's right hand and yanked upwards and forwards twice, in a manner which was bound to fail. Predictably, she lost her grip of Ms Dhu's arm which caused Ms Dhu to fall backwards and strike the back of her head on the concrete floor. Ms Dhu did not break her fall and did not cry out in pain. Senior Aboriginal Police Liaison Officer Edwards was present when Ms Dhu fell backwards, but Mr Bond was not.[355]

[351] ts 1575
[352] ts 1418 and 1577
[353] Exhibit 4, tab 9; ts 1576 and 1583
[354] ts 1579
[355] Exhibit 5: 12:11:24pm – 12:17:57pm

511. At the inquest Senior Constable Burgess maintained that she tripped or stumbled, leading her to lose her balance and thereby release her grip on Ms Dhu's arm. In fact from the CCTV she appeared to almost slip and had to plant her feet more firmly on the ground, because she was not expecting that Ms Dhu would be inert. She believed Ms Dhu had a sore or numb leg, but she thought Ms Dhu was feigning her incapacity to get up.[356]

512. Senior Constable Burgess believed Ms Dhu was making things difficult for her by lying down on the mattress and essentially, pretending to be unwell.[357] She thought Ms Dhu could get up to have a shower, but was refusing to do so.

513. Senior Constable Burgess based her preconception as to Ms Dhu's welfare needs on Mr Bond having told her that Ms Dhu was feigning her injuries. She did not exercise any independent judgement. She did not continue to assess all of the risk related information concerning Ms Dhu. She did not take account of how Ms Dhu appeared when she saw her, preferring instead to continue to accept Mr Bond's version.

514. Such preconceptions are inevitably attended by the risk of error, such as happened here. Whilst I accept Senior Constable Burgess' evidence to the effect that she did not act out of anger towards Ms Dhu,[358] which as I have said would be untenable, I am satisfied that she was frustrated with Ms Dhu. At the inquest Senior Constable Burgess explained: "*I genuinely thought she was going to assist me and sit up with me because she was only complaining of a sore leg*".[359] In fact, Ms Dhu had complained of a numb leg, which has a more serious complexion.

515. I accept that Senior Constable Burgess genuinely, but mistakenly, thought Ms Dhu would also shift her weight to assist in getting up to a seated position. It was however a careless judgment. Senior Constable Burgess made that mistake because she lacked empathy and consideration for Ms Dhu, and relied on a preconception that was no longer reasonable once she had seen her. She had not intended to drop or hurt Ms Dhu, but regrettably she did not care enough to avoid it.

516. After Ms Dhu fell backwards, she was partially on the mattress, but her head was on the concrete floor. Senior Constable Burgess again pulled her up by the same arm, this time holding the magazine under Ms Dhu's head, and moved Ms Dhu across towards the wall on the right hand side, in order to reposition her on the mattress.

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[356] ts 1586
[357] ts 1587 - 1588
[358] ts 1588
[359] ts 1586

517. Shortly after Ms Dhu was repositioned on the mattress, Mr Bond walked into the cell. Despite her evidence to the contrary, I am not persuaded that Senior Constable Burgess told Mr Bond that she had just dropped Ms Dhu and/or that Ms Dhu had fallen backwards and hit her head, when he came into the cell. I prefer Mr Bond's evidence on this matter and I have taken into account the responses that police officers gave shortly after they were questioned by the IAU, the nature of the entries into Senior Constable Burgess' police notebook and the oral evidence at the inquest.[360]

518. At the inquest Senior Constable Burgess denied being rough with Ms Dhu: *"Would you accept that you yanked on her arm in a rough manner? --- I can see it looks like I did, but no, I don't. It wasn't rough."* [361]

519. Senior Aboriginal Police Liaison Officer Edwards, who was there, observed it as being rough,[362] which is consistent with how it appears on the CCTV. Very sadly, neither Senior Constable Burgess, nor Senior Aboriginal Police Liaison Officer Edwards, moved to check the back of Ms Dhu's head for injury, nor did either person make inquiry of Ms Dhu as to whether she was hurt or in pain as a result of falling backwards.

520. I have considered Senior Aboriginal Police Liaison Officer Edwards' role and I have accepted her evidence to the effect that throughout these events, she was overwhelmed and shocked, and not thinking straight.[363] I am not persuaded that Senior Aboriginal Police Liaison Officer Edwards had the authority or capacity to intervene with Senior Constable Burgess and she most certainly had no authority or capacity to question Mr Bond.

521. Senior Constable Burgess however was vested with authority and had a clear responsibility to care for Ms Dhu, who was reliant on a professional and appropriate response from her. I am satisfied that Senior Constable Burgess acted in an unprofessional manner by employing a completely incompetent and unsafe method to lift Ms Dhu, and by being rough with her. Her conduct was contumelious and it was compounded by her inexplicable failure to immediately check to ascertain whether Ms Dhu had been hurt by the fall.

522. At the inquest Senior Constable Burgess gave evidence to the effect that immediately after the fall she checked whether there was blood on the concrete, which does address the issue of whether

[360] ts 1590; 1646; 1657 – 1660; 1748; Exhibit 4, tabs 19.1 and 19.2
[361] ts 1585
[362] ts 1433
[363] ts 1432, 1437, 1443

there was evidence of a fall, but does not address the issue of whether Ms Dhu has been hurt:

> *"I didn't check the back of her head. What I did do is when I moved her again out of that position, I looked at the concrete to see if there would be blood or anything like that and noticed there wasn't, and because she didn't respond to the knock on the head and brought her attention – or her attention and my attention back to the leg, I left the head."*[364]

523. Senior Constable Burgess also conceded that she made no attempt to safely get Ms Dhu into a sitting position, and that she should have got behind Ms Dhu and lifted her up underneath her arms.[365] That is if indeed lifting Ms Dhu would have been appropriate at the time.

524. Shortly before Senior Constable Burgess pulled her up and whilst she was lying on her back, Ms Dhu appeared vulnerable and fragile on the CCTV. She was moving her arms about and her demeanour is of someone who is vexed and trying to communicate something, without success. It ought not to have been followed by any attempt to lift her whatsoever. Senior Constable Burgess ought to have endeavoured to understand what Ms Dhu was trying to communicate. I have no doubt that Ms Dhu was trying to convey information that ought to have led to the immediate calling for an ambulance.

525. I accept counsel assisting's submission that if in fact Senior Constable Burgess was genuinely contrite at what occurred and had been concerned that Ms Dhu had struck her head on the concrete floor then she would have apologised. Senior Constable Burgess was questioned as follows:

> *"I am saying to you that you pulled her up in that manner because you believed she was faking it? --- I don't – I disagree.*
>
> *After she – you accept that she struck her head on the concrete section rather than the mattress of the floor? --- Yes.*
>
> *You didn't apologise to her, did you? --- No.*
>
> *Why not? --- I don't know.*
>
> *Is that because you thought it was her fault? --- No. Definitely not. That was my fault.*
>
> *Entirely your fault? --- Yes.*
>
> *With no apology? --- The reason why I may have been distracted from it is because when she fell back she didn't acknowledge the hit on*

[364] ts 1626
[365] ts 1586

the head. She went immediately straight back to 'my leg is numb', repeating that. So I remember looking. Going, 'Okay, she hasn't acknowledged this,' and then I was distracted again back to the leg.

Is that your explanation for not apologising to her? --- That's maybe a reason why but I'm – I'm sorry I didn't apologise to her. I should have [indistinct]."[366]

526. Senior Constable Burgess' evidence was that she did not see the full fall of Ms Dhu when she hit her head.[367] The CCTV shows that back of Ms Dhu's head very clearly struck the concrete floor. After Senior Constable Burgess lost her grip on Ms Dhu's hand, Ms Dhu fell backwards from an almost sitting position. She did not lose consciousness and after the fall, she was able to continue to speak. Ms Dhu continued to complain about numbness to her body.

527. At the inquest, forensic pathologist Dr White gave evidence about having examined the back of Ms Dhu's head, post mortem. Dr White did not find any bruising or lump to the back of the head when she conducted a full external examination. Nor did she detect soft tissue injuries, swellings or abnormalities in that area upon further examination. Dr White did find bruising to the left frontal scalp (left forehead), which could not have occurred as a result of a blow to the back of the head, and in her opinion did not have any significance in terms of the cause of Ms Dhu's death. There were no underlying fractures.[368]

528. The neuropathologist Dr Fabian did not find any significant abnormalities of the brain and there were no macroscopic features of traumatic brain injury.[369]

529. I am satisfied that the backwards fall that occurred when Senior Constable Burgess lost her grip on Ms Dhu's hand did not contribute to Ms Dhu's death.

530. Through her counsel, Senior Constable Burgess accepts that there should have been more attention to Ms Dhu's head and that there should have been an apology to Ms Dhu with regard to her head.

531. At 12.14 pm, Mr Bond, Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards left Ms Dhu's cell.[370] At about this stage Mr Bond made the decision to have Ms Dhu conveyed to HHC for the third time, for medical assessment. However, a further 25 minutes elapsed until police left SHPS with Ms Dhu to convey her to HHC.[371] There ought to have been a

[366] ts 1586 and 1587
[367] ts 1674
[368] ts 91 - 93
[369] Exhibit 1, tab 38
[370] Exhibit 5
[371] Exhibit 5 and Exhibit 10

timely response. The lack of urgency displayed by Senior Constable Burgess in conveying Ms Dhu to HHC is inexplicable.

532. It is to be borne in mind that within those 25 minutes Senior Constable Burgess had ample time to make a record in the Custody system to the effect that she had dropped Ms Dhu, causing Ms Dhu to hit her head on the concrete floor, but she did not do so. Regrettably she failed to take responsibility for the incident. At the inquest she conceded she should have entered it onto the Custody system. Her evidence to the effect that she thought Mr Bond would enter the details of her having dropped Ms Dhu onto the Custody system was unsatisfactory:

> *"Did you say to Mr Bond, "The reason why I'm telling you this is so that you can enter it into the record system"?---No.*
>
> *Why not?---Because I thought he would get the hint and understand I'm telling him this and he would make a notation to himself, "Yes, that's important. I will add it."*
>
> *Well, giving a hint might be one thing. But I just don't know why it is that you didn't tell him?---Because I didn't think I needed to."* [372]

533. At 12.33 pm on 4 August 2014, Senior Constable Burgess assisted First Class Constable Matier in removing Ms Dhu from her cell for the purpose of conveying her to HHC. In describing the events that follow, I take account of the fact that Senior Constable Burgess was the more senior of the two police officers involved.

534. Senior Constable Burgess would have been able to clearly observe that Ms Dhu could not use her legs to stand up and walk, even with assistance, to the police vehicle. Ms Dhu had minimal use of her arms, and First Class Constable Matier had handcuffed her, and was dragging her along the cell floor towards the sally port. Instead of becoming alert to Ms Dhu's parlous state, Senior Constable Burgess continued to believe she was feigning the extent of her symptoms. This was despite having formed the view that Ms Dhu required medical assistance because her leg was numb.[373]

535. Senior Constable Burgess actions in lifting Ms Dhu's feet, whilst First Class Constable Matier held her under the shoulders, and carrying her along the corridor, instead of calling for an ambulance or raising the alarm, is incomprehensible. When they arrived at the sally port, the manoeuvres used to place Ms Dhu into the secure pod at the back of the police vehicle reflect adversely on Senior Constable Burgess.

[372] ts 1673
[373] ts 1576

536. There was a total lack of appropriate precaution for Ms Dhu, who was clearly unable to take care of herself, and was entirely reliant on the police officers. I have already outlined how Ms Dhu's legs were folded so the door of the secure pod could be shut. Senior Constable Burgess did not go into the back of the pod herself to ascertain how much room there was for Ms Dhu or what position she was lying in.

537. As already outlined above with respect to First Class Constable Matier, the conduct of Senior Constable Burgess and First Class Constable Matier upon arriving at HHC shortly after 12.40 pm as depicted on CCTV footage is extremely concerning. Notwithstanding the obvious parlous state that Ms Dhu was in, they both behaved in an entirely nonchalant and indifferent manner. Senior Constable Burgess attached no significance to what was right before her very eyes.

538. Disturbingly, when Ms Dhu was placed in the wheelchair outside the HHC and her head flopped back, it caused no alarm bells to ring for Senior Constable Burgess.[374] She made no attempt to assess her welfare at that point. At the inquest she agreed with counsel assisting's questions to the effect that she thought this was just all a put on, and acting, by Ms Dhu.[375]

539. Senior Constable Burgess' displayed a troubling lack of urgency upon arrival at HHC, clearly sharing First Class Constable Matier's views that Ms Dhu was feigning her symptoms. This attitude persisted up to the point when the two police officers presented Ms Dhu at the front reception desk of the Emergency Department and handed her into the care of HHC.

540. At the inquest Senior Constable Burgess accepted that with the benefit of hindsight she displayed a lack of empathy, exhibited no compassion towards Ms Dhu and exercised no professionalism towards her.[376]

541. As stated in the Assisting Commissioner's Warning Notice letter to Senior Constable Burgess dated 7 October 2014, the manner in which Ms Dhu was removed from her cell and taken to the police vehicle:

> *"strongly questions your compassion, empathy and professionalism towards an ill detainee. Your actions in this regard significantly call into question your integrity, conduct, competence and professionalism".*[377]

[374] ts 1618
[375] ts 1618 - 1619
[376] ts 1627 - 1628
[377] Exhibit 4, tab 39

542. I accept counsel assisting's submission that this description can be extended to include from the time Senior Constable Burgess attempted to yank Ms Dhu from her prone position on the mattress to when she was presented at the front reception desk of the Emergency Department at the HHC.

543. The Assistant Commissioner's Warning Notice issued to Senior Constable Burgess recognised that her conduct was "*well below the standard expected of [you] by the community of Western Australia and by the WA Police.*"[378]

544. Senior Constable Burgess through her counsel accepts that she showed complete indifference to Ms Dhu when they arrived at the HHC, but points to a range of reasons as to why she was in a state of disbelief as to the gravity of the situation. Her reasons include being told by Mr Bond that Ms Dhu was "*faking it*", and being aware that Ms Dhu had been to HHC twice before. However, Senior Constable Burgess was under an obligation to continually assess all risk related information relevant to the situation that confronted her.

545. Senior Constable Burgess' obstinate adherence to the preconceived notion that Ms Dhu was either feigning or embellishing her symptoms, even in the face of Ms Dhu's lack of reaction when she dropped her, leads me to conclude that regrettably, Mr Bond's comments must have resonated with her own preconceptions concerning Ms Dhu.

546. I am satisfied that in her treatment of Ms Dhu on 4 August 2014, from the time she dropped her at 12.11 pm up until the time Ms Dhu was taken into the care of the HHC at approximately 12.45 pm Senior Constable Burgess behaved in a manner that was unprofessional, having regard to her duties as a police officer. Her treatment of Ms Dhu, who was in a catastrophic state of health, was inhumane. Through her counsel Senior Constable Burgess accepts this. Her behaviour reflects badly upon the Western Australia Police Service.

The role of Mr Bond

547. At the material time Mr Bond was a police officer holding the rank of Sergeant with the Western Australian Police Service. He served from 1996 until he voluntarily resigned in 2015, and is referred to in this finding as Mr Bond.

548. At the end of June 2014, Mr Bond was posted to the SHPS. The only duty he performed at the SHPS was shift supervisor. He worked the afternoon shift on 3 August 2014 from 1.00 pm to 9.00

[378] Exhibit 4, tab 39

pm and then the morning shift on 4 August 2014 commencing at 7.00 am.[379]

549. Mr Bond was therefore the shift supervisor on two occasions when Ms Dhu was in custody. The police officers he supervised were required to execute his proper and reasonable instructions. Inevitably, being in a leadership role, his attitude and behaviour towards detainees would have the tendency to influence the attitude and behaviours of the police officers that he supervised.

550. On occasions during both of his shifts on 3 and 4 August 2014, Mr Bond heard Ms Dhu crying. At the inquest he did not recall having asked her what was wrong, and offered the explanation that detainees cry quite a lot, in his experience.[380] It reflects a distinct lack of empathy.

551. It is important for a supervisor to function as a positive role model for more junior staff, and it is well known that good modelling has the capacity to improve behaviour. Bad modelling, such as that demonstrated by Ms Bond, is to be rigorously avoided. However, I am not persuaded that it can be used as an excuse to justify other people's bad behaviour, where it concerns the treatment of another human being. Bad modelling can go some way to explaining it.

552. Mr Bond was the most senior of the police officers who had responsibility for Ms Dhu's welfare on the morning of 4 August 2014. In order to comment upon Mr Bond's role on that date, it is necessary to take account of views that he formed on his shift the previous day. The details are set out below.

Mr Bond treated Ms Dhu in an unprofessional and inhumane manner on 4 August 2014

553. When Mr Bond took over as shift supervisor on 3 August 2014, he received a verbal handover from Acting Sergeant Tindall, pursuant to the procedure at the material time.

554. Acting Sergeant Tindall did not recall the content of his handover to Mr Bond on 3 August 2014 but he was confident that it would have included a briefing on Ms Dhu. It would also likely have included mention of Ms Dhu having sore ribs. He believed he may

[379] ts 1692
[380] ts 1727

have told other officers that it was suspected that Ms Dhu was suffering from drug withdrawals.[381]

555. Mr Bond's evidence was that when he came on shift on 3 August 2014 he was told that the doctor had said "*she's just coming off drugs and here's your fitness to hold*"; and that the diagnosis from the hospital, although it was not written on the Fitness to Hold Form, was that she was coming off drugs.[382]

556. Due to the absence of any written handover by Acting Sergeant Tindall to Mr Bond, and inconsistencies in the recall of certain witnesses, I cannot now determine what Mr Bond was told about Ms Dhu when he became shift supervisor at about 1.00 pm on 3 August 2014. However, it is likely that he was told by a police officer that Ms Dhu was considered, by the clinicians who saw her at HHC on 2 August, to be withdrawing from drugs.

557. At 4.52 pm on 3 August 2014, in accordance with Mr Bond's decision, Ms Dhu was conveyed to HHC for the second time, and she was returned to the Lock-Up at 7.12 pm. At the inquest Mr Bond agreed that once Ms Dhu had returned from HHC for the second time, he was of the view that she was faking her complaint.[383] The Fitness to Hold Form signed by Dr Naderi, which he sighted, did not give any indication of whether Ms Dhu had been diagnosed with any ailment, nor whether she had received any medical treatment.[384]

558. I take into account the fact that Dr Naderi's discharge diagnosis on 3 August 2014 contained a query as to whether Ms Dhu was withdrawing from drugs, and noted "*behaviour issues*". The evidence is not sufficient for me to be positively satisfied that the gist of this information was passed from any particular HHC staff member to one or other of the escorting police officers and back to Mr Bond.

559. However it is likely that in the various interchanges that occurred between HHC staff members and escorting police officers a common belief was reached to the effect that Ms Dhu's ailments were attributable to drug withdrawal, and that Mr Bond became aware of it.

560. From conversations he had with Ms Dhu and Mr Ruffin, Mr Bond was aware that Ms Dhu had used amphetamines, though he could not be sure of the quantities and frequency.[385] I am satisfied that by the end of his shift at approximately 9.00 pm on 3 August 2014

[381] Exhibit 4, tab 33; ts 1231 – 1233; ts 1250 - 1251
[382] Exhibit 3, tab 16; ts 1697 – 1698; ts 1708; ts 1712
[383] ts 1711
[384] Exhibit 1, tab 26; ts 1711
[385] ts 1787 - 1789

Mr Bond formed the view that Ms Dhu's symptoms were attributable to drug withdrawal, and that that was the reason why she had twice been returned from HHC with no apparent diagnosis. Unfortunately, once Mr Bond formed this view, he became intractably attached to it.

561. Mr Bond's next shift commenced at 7.00 am on 4 August 2014. Mr Bond was informed by Senior Constable Lee Burgess that Ms Dhu was vomiting, at approximately 7.35 am on 4 August 2014. Instead of objectively considering this new information and assessing her risk, Mr Bond firmed up on his view that Ms Dhu was withdrawing from drugs and therefore feigning the symptoms that had led her to be taken to HHC on the two previous occasions.[386]

562. Regrettably, Mr Bond, in his capacity as shift supervisor, also told First Class Constable Matier, the lock-up keeper, that Ms Dhu was *"faking it"*. At the inquest Mr Bond agreed that he possibly mentioned that to First Class Constable Matier because: *"The reason I would have mentioned that is he needs to know what I knew at the time or what I believed"*.[387] On all the evidence before me, I am satisfied that he did tell him that Ms Dhu was "*faking it*".

563. It was inappropriate for Mr Bond, having regard to his position as a supervisor, to convey this to First Class Constable Matier. He had no credible diagnosis from HHC to the effect that Ms Dhu was withdrawing from drugs, or credible information that she was feigning her symptoms. There was rumour or innuendo to that effect, and it continued to be passed on. The obvious risk, which was borne out, was that it would predispose others to ignore changes in her symptoms.

564. The fact that Ms Dhu was twice returned from HHC did not absolve those charged with her care from continuing to assess her welfare needs. There was no information on the Fitness to Hold Forms that would assist with understanding Ms Dhu's health condition.

565. It may equally and properly be inferred that if a detainee is twice taken to hospital and returned, and still complains of ill health, even closer monitoring is warranted.

566. At 9.54 am Ms Dhu pushed her cell call button for the last time.[388] On this occasion she spoke on the intercom to First Class Constable Matier, who was in the presence of Mr Bond. During this conversation Ms Dhu told First Class Constable Matier that

[386] ts 1719
[387] ts 1475 and 1720
[388] Exhibit 3, tab 17

she could not feel her legs and that she wanted to go to hospital. Mr Bond did not hear what Ms Dhu said, but agreed that he told First Class Constable Matier: *"No, she's not going to hospital"*.[389]

567. At the inquest, Mr Bond explained his actions by stating: "*There was nothing new. I had nothing new to send her to the hospital."* Mr Bond did not however ask First Class Constable Matier about the content of his discussion with Ms Dhu.[390]

568. At 10.28 am Mr Bond was heard stating to First Class Constable Matier in the charge room *"that would be the third time she's been to hospital. She is fit to be held."*[391] These instances are indicative of his intractable adherence to his views about her feigning her symptoms. At the inquest Mr Bond maintained that he would have required some verification or corroboration of what Ms Dhu was saying to him about the extent of her ailment, because he had formed the view that she was not being completely honest with him.[392]

569. At 10.34 am, Mr Bond conducted a physical cell check of Ms Dhu and found her to be responsive and breathing. It was a cursory check, and he instructed her to clean up her cell, believing that she had spilt coffee on the floor.[393] It would not have been possible for Ms Dhu to comply with that instruction. Her legs were numb, and she was in the process of dying.

570. Earlier that morning, Ms Dhu had vomited on three occasions, without being observed by a police officer.[394] The liquid on the floor was assumed by police to be coffee. However, it was more likely Ms Dhu's vomitus.[395]

571. By mid-morning on 4 August 2014, Mr Bond had become frustrated with Ms Dhu. Despite his denials at the inquest,[396] his body language on the CCTV and the tenor of his evidence persuades me that he had reached a point of frustration that subverted any objectivity.

572. First Class Constable Matier conducted his final, and cursory, physical cell check of Ms Dhu at approximately 11.00 am.[397] After that First Class Constable Matier was directed by Mr Bond to take a witness statement from someone who had attended the station, which took between 40 and 50 minutes. Mr Bond gave evidence

[389] ts 1724
[390] ts 1724 - 1725
[391] Exhibit 3, tab 17
[392] ts 1738
[393] ts 1731
[394] Exhibit 3, tab 17
[395] Exhibit 1, tab 2
[396] ts 1732
[397] Exhibit 3, tab 17

that after that last cell check by First Class Constable Matier, he: "*took over basically from there*".[398]

573. By 11.09 am on 4 August 2014, Ms Dhu lay down on the mattress on her back and did not stand again after this time. Mr Bond conducted a number of physical cell checks in relation to Ms Dhu. Between approximately 11.23 am to 11.32 am Mr Bond entered Ms Dhu's cell twice and on two other occasions he stood outside her cell and spoke with her.[399]

574. When Mr Bond entered Ms Dhu's cell at 11.23 am, in response to Ms Dhu informing him that her hands were "*going blue*", he examined her hands. He performed a "*finger pinch testing*" (capillary nail refill test) and concluded that nothing appeared any different than normal. He subsequently made a record on the Custody system to this effect.

575. At the inquest Dr Dunjey opined that the capillary nail refill test was an understandable action by a lay person, but that it would have been very difficult for an untrained person to have identified that Ms Dhu's hands were cyanotic.[400] Mr Bond was an untrained person in that regard.

576. At the inquest Mr Bond's evidence was that when he saw Ms Dhu at approximately 11.32 am there was nothing that he observed of her that would suggest she needed urgent medical treatment.[401] This is incomprehensible in light of the fact that some ten minutes later she struggled to get into a sitting position and then fell backwards, without breaking her fall. By this stage, Ms Dhu was in an established state of septic shock.

577. At about midday on 4 August 2014, Mr Bond asked Senior Constable Burgess to go and give Ms Dhu a shower. At the inquest he conceded that he thought he told Senior Constable Burgess that Ms Dhu was coming down off drugs and that he possibly called her a *"junkie"* and that he may have expressed his concerns by telling Senior Constable Burgess that she was *"faking it"*.[402]

578. When Senior Constable Burgess returned with Senior Aboriginal Police Liaison Officer Edwards after attending Ms Dhu's cell, and told Mr Bond that Ms Dhu needed to go to hospital, [403] he became angry. Convinced that Ms Dhu was feigning her symptoms, he decided to go to her cell.

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[398] ts 1734
[399] Exhibit 3, tab 17
[400] ts 329
[401] ts 1737
[402] ts 1739
[403] ts 1743

579. It was 12.10 pm on 4 August 2014, and unfortunately, by this stage Mr Bond's mind was not sufficiently open to the possibility of Ms Dhu being seriously unwell, and regrettably his intention was to look for indications that supported his preconceptions regarding Ms Dhu.

580. The CCTV footage of Mr Bond with Senior Constable Burgess and Senior Aboriginal Police Liaison Officer Edwards in Ms Dhu's cell at 12.14 pm shows him apparently conducting another pinch test, and then gesturing towards Ms Dhu's prone body, in a clearly aggressive manner.[404] He displayed an unprofessional attitude.

581. At the inquest Mr Bond's evidence was that he was saying to her at this point in time: *"This will be the last time you go to hospital".*[405] I am satisfied that this is the point at which Mr Bond made the decision to have Ms Dhu taken to HHC for the third time. He was still angry[406] and he had doubts about whether she required medical attention.[407]

582. Mr Bond did not direct that Ms Dhu be taken to HHC as a matter of urgency and another 25 minutes elapsed before Senior Constable Burgess and First Class Constable Matier left with Ms Dhu for the HHC.

583. In the meantime at 12.19 pm, in an unrelated matter, Mr Bond spoke to a young detainee about Ms Dhu in a derogatory manner that was both regrettable and unprofessional. By reference to Ms Dhu, he said to the young detainee: "*You take drugs? 'Cause I'll go and show you something, that's what happens when you take drugs. You end up like this woman in here. Good deterrent not to take drugs.*"[408]

584. Despite all of his observations, Mr Bond still expected Ms Dhu to be able to *"at least assist the police officers in getting herself to the police vehicle".*[409] Mr Bond should have called for an ambulance to urgently attend SHPS to convey Ms Dhu to HHC. He did not do that because he still believed Ms Dhu was feigning her symptoms, and I have regard to the following:

a. his comments to Constable Sharples at 12.18 pm on 4 August 2014 that: *"She can't feel her body, her whole body is numb. She can't sit up. She can't feel her legs.* ***You name it.***" (emphasis added); and

[404] ts 1745 and Exhibit 5
[405] ts 1746
[406] Exhibit 10
[407] ts 1765
[408] Exhibit 3, tab 17
[409] ts 1760

b. his final entry into the Custody system at approximately 12.30 pm on 4 August 2014: "*Detainee appears to be suffering withdrawals from drug use and is not coping well with being in custody*"

585. The HHC was situated a few minutes' drive from the SHPS. Mr Bond's evidence was that he *"certainly believed he could get [her] to the hospital quicker than any ambulance could get to the police station"*.[410] Whilst I accept that the volunteer ambulance service may not have been readily available, a further 25 minutes elapsed before the police officers left SHPS with Ms Dhu. Had the ambulance officers come to Ms Dhu in her cell, they would have discerned her parlous state.

586. Through his counsel Mr Bond accepts that he held a preconceived notion that:

a. Ms Dhu was faking or embellishing her symptoms; and/or

b. As she was withdrawing from drugs her complaints should not be accepted at face value.

587. Regrettably, due to the preconceptions that he held Mr Bond failed to identify the serious deterioration in Ms Dhu's physical condition.

588. Through his counsel Mr Bond accepts that he influenced his staff and that as supervisor, he was responsible for the running of the SHPS and everything that went on at the SHPS. Specifically, he accepts that:

a. He conveyed the views he held about Ms Dhu's condition and the veracity of her complaints to other police officers who were interacting directly with her;

b. He usually spoke in a forthright and unambiguous manner; and

c. As a supervisor his expressed opinions, and his manner of carrying out his duties, are likely to have significant influence on his staff.

589. Given his seniority, it was incumbent upon Mr Bond to be mindful of his ongoing duty of care towards Ms Dhu, irrespective of unsubstantiated reports and certainly without regard to rumours and/or innuendo. All he had before him were two Fitness to Hold Forms, with scant details, and information from Ms Dhu to the effect that she had used amphetamines recently.

[410] ts 1766

590. Through his counsel Mr Bond submits that he made an heuristic judgement, namely that the facts before him fitted with his experience. He points to the effect on his judgement of what he understood to be the medical advice from HHC.

591. Whilst Mr Bond has pointed to a number of other persons who held similar views concerning Ms Dhu, some of which were passed onto him, he was obligated to continually assess all risk related information in connection with Ms Dhu. Had Mr Bond set aside his preconceptions, it is likely that he would have identified that Ms Dhu's physical condition was deteriorating and that she required urgent medical assistance at an earlier stage on 4 August 2014, just by looking at her and listening to her.

592. Through his counsel Mr Bond draws my attention to Dr Dunjey's evidence, in support of his submission to the effect that his views were fortified by the fact that Ms Dhu had been twice cleared fit for custody. Dr Dunjey made this comment in the context of an example of a junior doctor mistakenly relying on a more senior doctor, despite the junior doctor's own observations of a patient to the contrary: "*Their minds are closed because of the opinions they have been given by somebody who is alleged to be smarter and more experienced than they are.*"[411]

593. I have no doubt that it is to Mr Bond's ongoing regret that he placed too much emphasis on the two doctors' Fitness to Hold Forms and not enough attention on what he saw and what he heard on the morning of 4 August 2014. Unfortunately, the two Fitness to Hold Forms played into his own preconceptions and he became blind to Ms Dhu's suffering and her welfare needs.

594. Despite being aware of the two Fitness to Hold Forms, Mr Bond was not absolved from the need to have conscientiously and properly continued to observe Ms Dhu and to have retained an open mind regarding her health status.

595. Through his counsel Mr Bond accepts eight specific shortcomings, namely:

a. at 9.54 am he ought to have promptly interrogated First Class Constable Matier to thoroughly investigate the reasons for Ms Dhu's request to return to hospital;

b. at 10.28 am he again ought to have promptly interrogated First Class Constable Matier to thoroughly investigate the reasons for Ms Dhu's request to return to hospital;

c. he ought to have followed up why Ms Dhu was crying;

[411] ts 326 - 327

d. it was unprofessional and inappropriate for him, at the time of instructing Constable Burgess, to:

(i) refer to Ms Dhu as a junkie; and

(ii) express his concerns regarding her conduct as "*faking it*";

e. it was unprofessional and entirely inappropriate for him, at the time of visiting Ms Dhu's cell with Constable Burgess, to:

(i) gesture aggressively;

(ii) speak in the manner that he did; and

(iii) possibly use an expletive;

f. he ought to have instructed Constables Burgess and Matier to act urgently;

g. with what he now knows about the benefits of ambulance paramedics, he should have called an ambulance even if the time to get Ms Dhu to the hospital may not have been quicker; and

h. it was entirely unprofessional to have made the remarks that he did to the juvenile in the charge room.

596. At the inquest Mr Bond accepted, with the benefit of hindsight, that his treatment of Ms Dhu was inhumane, and he repeats this through his counsel.[412]

597. I am satisfied that Mr Bond displayed a high level of unprofessionalism and his treatment of Ms Dhu on 4 August 2014 was inhumane. His behaviour was exacerbated by the fact he was the shift supervisor and the most senior police officer on duty at the relevant time. His conduct did not meet the expectations required of him by Western Australia Police Service or the community, and reflects badly upon the Western Australia Police Service.

CELL WELFARE CHECKS AND RECORD KEEPING

598. At the material time the SHPS procedures regarding cell welfare checks and record keeping were governed by Part 10 of the

[412] ts 1764

Western Australia Police Manual, concerning Lock-Up Procedure (the Lock-Up Manual).[413] The relevant portions are as follows:

a. LP-10.1 provided that: "*A member shall regularly visit each detainee to ensure the safety and welfare of that detainee and to determine any reasonable needs*"

b. LP-10.1 also provided that: *"When medical attention or advice is sought relating to the welfare of a detainee, a notation is to be made on the detainee's running sheet and on Custody detail in the following points:*

    1. *The time when the medical attention or advice was sought;*

    2. *The name of the medical facility and staff member giving the advice or diagnosis;*

    3. *The advice or diagnosis given by the medical staff member."*

c. LP- 10.3 provides that "*members conducting cell checks shall record the time of each check and their observations of each detainee*".

599. The evidence at the inquest established that on a number of occasions, the procedures for recording the outcome of certain observations made of Ms Dhu during requisite cell checks, and the outcome of Ms Dhu's hospital attendances, were not entered into the handwritten running sheet, or the electronic Custody system pertaining to Ms Dhu.

600. The importance of keeping accurate records becomes self-evident when a person is detained over a number of days and nights, particularly in the case of Ms Dhu, who was taken to HHC and returned as being fit to be held in custody, twice. Proper record keeping enables the police officers responsible for her welfare to gain some insight into her condition, and to identify whether, over a period of time, she is expressing or displaying signs of deterioration that may necessitate further medical attention. When shifts change, the incoming police officers have access to relevant longitudinal information, to put their observations into context.

601. The fact that the Fitness to Hold Form is signed by a medical practitioner addresses a detainee's condition at that point in time. By signing it, the medical practitioner is representing that the detainee does not require hospitalisation, or other urgent medical treatment. A signed Fitness to Hold Form is not to be regarded as a representation to the effect that a detainee is, and will remain, in good health. A detainee's health may subsequently deteriorate, or a detainee may develop a new and unrelated medical condition. For this reason it is important that police officers responsible for a detainee's welfare remain vigilant.

[413] Exhibit 17.1

602. It is particularly apposite in the case of detention within a regional lock up, because any further recourse to medical assistance needed to be organised by escort to the hospital in a police vehicle, or by calling an ambulance. In South Hedland, both of those options would have been likely to take time due to the police vehicle and/or volunteer ambulance service (and the related personnel) not necessarily being readily available.

603. At the material time, the requirement to "*regularly visit*" each detainee (that is, conduct a cell check) was interpreted as a requirement for an hourly cell check (under LP-10.1) together with a requirement to record the time of each cell check and the observations of the detainee on the handwritten running sheet and electronic Custody record for that detainee (under LP-10.3).

604. The SHPS also published its local Lock-Up procedures, referencing LP-10.1 and 10.3, and providing further guidance on the conduct of cell checks, including the requirement for the entry of specific information concerning the observations of the detainee (short entries such as "*OK*" or "*all correct*" were deemed insufficient) and the requirement for the police officer to physically visit the lock-up area and if necessary, enter the cell to check on the detainee's welfare.[414]

605. Most of the cell checks for Ms Dhu were completed and recorded having regard to an interval of approximately one hour, but there were instances where even under this paradigm, cell checks were missed and/or resultant observations were not fully or properly recorded.

606. Just over two weeks after Ms Dhu's death, Part 10 of the Lock-Up Manual was amended, and LP-10.1 contained a new requirement for "*high risk*" detainees to be "*monitored continuously*" for the first 30 minutes after admission, and then monitored every 10 minutes thereafter.[415] I have no doubt that under the new procedures, Ms Dhu's proper assessment would have been "*high risk*", and more frequent monitoring would have been mandated.

607. More frequent monitoring would have led police to identify signs of imminent and severe deterioration in Ms Dhu's health, such as the following which were, regrettably, unwitnessed:[416]

a. On numerous occasions between approximately 9.00 am and 10.15 am on 4 August 2014, Ms Dhu vomited into a styrofoam cup;

b. Shortly after 10.15 am on 4 August 2014, Ms Dhu stood up and appeared to be disoriented, before going to the toilet;

[414] Exhibit 2, tab 53
[415] Exhibit 17.2
[416] Exhibit 5

c. Shortly after 11.00 am on 4 August 2014 Ms Dhu lay down on her mattress on her back, and did not manage to stand up after this time, despite two attempts to do so, outlined below;

d. At approximately 11.45 am on 4 August 2014, Ms Dhu managed, after struggling to do so, to momentarily sit up, but almost immediately fell backwards, striking the back of her head on the concrete, without breaking her fall;

e. At approximately 11.50 am, Ms Dhu struggled to a sitting position and for a brief period managed to hold herself up with her arms, before again falling backwards and striking the back of her head on the concrete, without breaking her fall.

608. The fact that Ms Dhu was not able to summon the energy to break her fall, or react in pain when she fell backwards the first time, if it had been witnessed, would have mandated the calling of an ambulance, or the seeking of immediate medical attention for her. The repeated vomiting, if it had been witnessed, should have raised similar concerns and at least mandated the seeking of immediate medical attention.

609. Independent expert Dr Speers was questioned about the implications of Ms Dhu falling backwards in the manner that she did. He opined that: "*the fact that Ms Dhu could not even sit up and fell backwards means that there was already very advanced shock present*". He explained that she was losing her blood supply to the brain, with the result that there would not be the normal protective mechanism of breaking a fall by putting an arm out, because the brain would not be alert enough to do it.[417]

610. Within the same series of amendments to the Lock-Up Manual on 22 August 2014, LP-10.03 stipulated a more rigorous and detailed observation of the detainee during cell checks, and required greater specificity in the recording of the details of the detainee's welfare on the running sheet and the Custody system.

611. In accordance with the IAU recommendations, the Lock-Up Manual was also amended, LP-04.03, to highlight that conducting risk assessments is an ongoing process and that any change should be immediately recorded on the Custody system. Where a detainee undergoes medical treatment, it required that their risk status be reassessed. The information concerning risk may come from the detainee, police or other sources.[418]

<u>Recording medical attention or advice</u>

[417] ts 246 - 247
[418] Exhibit 4, tab 62

612. Whilst most of the police officers were aware of an obligation to enter data concerning Ms Dhu's hospital attendances on the Custody system, the detail of the data that needed to be entered was not well known. It was accepted that the obligation to make the entries (or ensure the entries were made) rested with the lock-up keeper and with the shift supervisor. Ms Dhu was escorted to HHC on two occasions and the following entries were made after her return:

a. *2 August 2014*

613. An entry was made into Ms Dhu's electronic Custody record by Constable Shaw (one of the escorting officers) at 9.30 pm and two fields were populated with data as follows:

- On the Custody Management field, it was recorded that Medical Treatment was provided at the HHC.
- On the Medical Treatment field by way of additional information, it was recorded:

  "Taken to Hedland Health Campus for pain relief (complaint of pain to old broken rib injury). Panadol administered to her and FIT FOR CUSTODY letter obtained." [419]

The Fitness to Hold Form signed by Dr Lang[420] related to this entry.

No entry was made in Ms Dhu's lock-up running sheet regarding her visit to the HHC on 2 August 2014.[421]

b. *3 August 2014*

614. An entry was made into Ms Dhu's electronic Custody record by First Class Constable George (in his capacity as lock-up keeper) at 7.00 pm and two fields were populated with data as follows:

On the Custody Management field, it was again recorded that Medical Treatment was provided at the HHC.

On the Medical Treatment field by way of additional information, it was recorded that treatment was provided by a doctor (not named) and the following appeared:

"*500mb Paracetamol, 1 – 2 tablets every 4 – 6 hours when required, first lot taken at 1900 hours*"[422]

[419] Exhibit 3, tab 7
[420] Exhibit 1, tab 22
[421] Exhibit 3, tab 17
[422] Exhibit 3, tab 7

The Fitness to Hold Form signed by Dr Naderi[423] related to this entry.

No entry was made in Ms Dhu's lock up running sheet regarding her visit to the HHC on 3 August 2014.[424]

615. By reference to the obligations set out in LP-10.1 there has been non-compliance with the following:

a. The names of Dr Lang and Dr Naderi, respectively were not recorded;

b. The advice or diagnosis given by Dr Lang and by Dr Naderi is not recorded, save for the instructions concerning administration of Panadol on 3 August 2014;

c. There is no entry at all in Ms Dhu's handwritten running sheet.

616. The police officers responsible for making or ensuring the entries related to the HHC attendances were properly made were as follows:

a. On 2 August 2014 - lock-up keeper Constable Sharples and shift supervisor Sergeant Patchett; and

b. On 3 August 2014 – lock-up keeper First Class Constable George and Mr Bond.

617. The police officers who escorted Ms Dhu to HHC were as follows:

a. On 2 August 2014, First Class Constable Buck and Constable Shaw; and

b. On 3 August 2014, Fist Class Constable Beckett and First Class First Class Constable Eastman.

618. Evidence was taken at the inquest concerning the obligation on the part of the escorting police officers (the custodians) to seek and obtain information from the treating clinicians at HHC concerning the advice or diagnosis given. Whilst ideally the medical practitioner would inform the custodians of the advice or diagnosis, this is not what happens in practice and there are difficulties surrounding the transmission of such information, because of patient confidentiality.

619. The other manifest difficulty is that the Fitness to Hold Form at the material time made it optional for the medical practitioner to provide written information concerning medical treatment. It would not be unreasonable for those involved to extrapolate that the process does not contemplate an obligation on the part of the

[423] Exhibit 1, tab 26
[424] Exhibit 3, tab 17

medical practitioner to disclose medical treatment or diagnosis, either in writing, or orally.

620. It becomes challenging for an escorting police officer to require a medical practitioner to disclose his or her advice or diagnosis if the clinician has elected not to complete that optional part of the Fitness to Hold Form. Generally, this part of the Form was often not completed.

621. In evidence First Class Constable Buck (escorting Ms Dhu to and from HHC on 2 August 2014) referred to her understanding that a medical diagnosis in relation to a detainee raises *"a privacy issue"*.[425] First Class Constable Buck also said she would not have been comfortable asking the medical practitioner to make a note of the diagnosis if it had not initially been written down on the form.[426] This is not an unreasonable position to take under the circumstances.

622. First Class Constable Beckett (escorting Ms Dhu to and from HHC on 3 August 2014) also gave evidence that he did not think he would be able to approach a doctor who had treated a detainee to ask questions about the details of the Fitness to Hold Form if the doctor was busy seeing another patient.[427]

623. I am satisfied that under the procedures in force at the time, and especially having regard to the fact that the Fitness to Hold Form did not obligate the medical practitioner to provide a notation of medical treatment and/or diagnosis, there is no reasonable basis upon which the escorting officers could have required Dr Lang and/or Dr Naderi to provide that information.

624. Whilst ideally and with the benefit of hindsight the escorting police officers could have asked the question, my concern is that on those occasions, had the diagnoses been given, Ms Dhu would not have been assisted. It is to be borne in mind that the discharge diagnoses were as follows:

a. On 2 August 2014 Dr Lang recorded a discharge diagnosis of "*behaviour issues*"; and

b. On 3 August 2014 Dr Naderi recorded a discharge diagnosis of "*1. ? w/d from drugs*" and "*2. behavioural issues*".

625. Whilst both doctors gave evidence at the inquest that, despite having made no concurrent notation, they believed Ms Dhu was suffering musculoskeletal pain, the medical notes speak for themselves. I am satisfied that if the treating doctors had been

[425] ts 1027
[426] ts 1028.
[427] ts 1331

asked by the escorting police officers on the relevant evenings, and if they had elected to respond, their answers would have been along the lines of the discharge diagnoses that they themselves recorded in Ms Dhu's medical notes. This would only have served to reinforce the views that Ms Dhu was feigning her symptoms.

626. When lock-up keeper First Class Constable George received the Fitness to Hold Form signed by Dr Naderi back at the Lock-Up on 3 August 2014, with no record of medical advice or diagnosis, he was faced with a document bearing limited information. He did not ring HHC to seek further details. First Class Constable George gave the following evidence:

> *"... did it cross your mind at all at the time that you ought to follow this* [i.e. why Ms Dhu was at the hospital and what treatment was provided] *up with the doctor? --- No, it didn't.*
>
> *You don't recall or you wouldn't have bothered? --- I don't recall, but I've never heard of anyone doing that. That's not standard practice."* [428]

627. I am satisfied that it is unlikely that First Class Constable George would have been provided with information concerning Ms Dhu's treatment or diagnosis over the telephone, for reasons of patient confidentiality. Further, for the reasons set out above, Ms Dhu would not have been assisted by the provision of information by HHC staff to the effect that she was withdrawing from drugs and/or had behavioural issues.

Making and recording cell check observations

628. The police officers were aware of the obligation to regularly visit Ms Dhu in her cell, for the purpose of ensuring her safety and welfare (LP-10.1). They were also aware that they needed to record the time of each check, and their observations of Ms Dhu (LP-10.3).

629. It was generally understood that if a detainee appeared to be asleep, a cell check could not be conducted remotely by CCTV, because the vision was not adequate for the purpose of determining the rise and fall of a detainee's chest. When the Lock-Up Manual was updated on 22 August 2014, the limitations of the CCTV in this regard, whilst obvious to any reasonable person, were nonetheless spelt out.

630. At the material time on a number of occasions, the procedures regarding the frequency of cell checks and the recording of

[428] ts 878

observations from those cell checks, were not complied with in respect of Ms Dhu.

631. Ms Dhu had been classified as a "*low risk*" detainee and the obligation to "*regularly visit*" her was interpreted as requiring hourly visits to her cell. It is to be borne in mind that this hourly interval is only a guide, and if a low risk detainee appears unwell, the circumstances clearly change and far more frequent monitoring will be indicated.

632. The obligation to undertake cell welfare checks has to be interpreted by reference to what is appropriate for that detainee. The frequency is to be assessed by reference to the specific needs of the detainee. An hourly interval is to be seen as a minimum standard. The obligation to ensure the safety and welfare of a detainee will not be met by complying with a minimum standard when the detainee appears unwell.

633. The importance of undertaking the function regularly and conscientiously cannot be underestimated. The detainee has no independent means of recourse to medical assistance and is reliant upon the police officers in this regard.

634. Properly conducted and recorded cell check observations assist in identifying whether a detainee's health is deteriorating. Supervisors and lock-up keepers are rostered on shifts. As the handover is made to the next responsible police officer, the availability of cell check observations on the Custody system will shed light on the history of a detainee's ailments.

635. For example, between 2 and 4 August 2014, amongst numerous electronically recorded observations indicating that Ms Dhu was either awake and sitting, or awake and lying down are the following: "*stated she was in pain and pointed to her rib area*", "*still complaining of pain to the rib area*", "*making a moaning noise*", "*prisoner complaining of sore ribs*", "*two paracetamol given*", "*complaining of all over body pains*", "*Ms Dhu awake moaning*".[429]

636. This history reflects that despite two hospital attendances, Ms Dhu remained unwell. Unfortunately, the police officers relied primarily upon the outcome of the hospital attendances, where two doctors over two days signed forms to the effect that Ms Dhu was in a fit condition to be held in custody.

637. It is understandable that the police officers would defer to the opinions of the two doctors, at the time of the medical attendance. However, the dangers of the police officers preferring to rely on the outcomes reflected on the two Fitness to Hold Forms (scant as they

[429] Exhibit 3, tab 17

are on detail) as opposed reacting to what was happening before their very eyes, have become self-evident.

638. The Custody system is a uniquely effective mode of communicating relevant information between police officers, and providing a longitudinal perspective on a detainee's state of health. However, in order for it to operate in furtherance of one of its intended purposes, which is to assist in ensuring the safety and welfare of a detainee, the records need to be accurate and appropriately detailed.

639. On 3 August 2014 Senior Constable Murphy entered a record for a physical cell check at 6.01 am on 3 August 2014, stating "*Detainee is sleeping lying down on his/her back*".[430] However, Senior Constable Murphy did not visit Ms Dhu's cell. It was not a "*physical*" cell check. Instead, she conducted a "*remote*" cell check by looking at CCTV footage of the camera in Ms Dhu's room.[431]

640. At the inquest Senior Constable Murphy's evidence was that she made an inadvertent error by clicking on the incorrect option on the drop down menu.[432] There is an obvious difficulty with properly ascertaining whether a detainee is breathing, by means of remote CCTV checking. At 11.17 pm the previous night (2 August 2014) Senior Constable Murphy had recorded Ms Dhu as "*making a moaning noise.*" There was no cell check of Ms Dhu between 4.08 am and 6.01 am on 3 August 2014.[433] These cell checks, and records, were inadequate.

641. At approximately 4.30 pm on 3 August 2014, First Class Constable George heard moaning from Ms Dhu's cell, he attended upon her and she informed him she was finding it difficult to breathe and that she had asthma. At her request, at 4.37 pm he subsequently provided her with a brown paper bag, to assist with her breathing. First Class Constable George relayed that to his supervisor, Mr Bond, which resulted in Ms Dhu being conveyed to HHC.

642. However, First Class Constable George did notmake a record, in Ms Dhu's Custody system, of the fact that he had heard her moaning in pain, that she had complained about difficulty breathing, and that he had provided her with a paper bag to assist with her breathing. At the inquest he acknowledged that he ought to have made these records.[434] The records he made were inadequate.

[430] Exhibit 3, tab 17
[431] ts 1092
[432] ts 1092
[433] Exhibit 3, tab 17
[434] ts 868

643. In the early hours of the following day, 4 August 2014 at 12.30 am, Detective Senior Constable Nunn recorded that he gave Ms Dhu "*2 tablets of Panadol*".[435] However, Ms Dhu had also told Detective Senior Constable Nunn that she had "*sore bones*" and shortly afterwards he heard her moaning.[436] He did not record these facts and at the inquest he conceded that he ought to have done so.[437] The records he made were inadequate.

644. Detective Senior Constable Nunn did not inform First Class Constable Matier of those facts either, when he handed over his lock-up keeper duties to First Class Constable Matier at 7.00 am on 4 August 2014. First Class Constable Matier gave evidence that, understandably, he would have expected to be informed, as this was relevant to his duties in taking care of Ms Dhu.[438]

645. However, when First Class Constable Matier was informed by Detective Senior Constable Nunn during handover on 4 August 2014 that Ms Dhu was declared to be in a fit condition to be held in custody, and that there was paracetamol if she needed it, First Class Constable Matier did not ask what the paracetamol was for, nor did he examine the Fitness to Hold Forms.[439]

646. First Class Constable Matier's evidence was that he was not aware that Ms Dhu had a broken rib until after she passed away.[440] However, if he had looked at the Custody system entries for 2 August 2014, he would have seen a number of references to a rib injury and related pain.[441]

647. At approximately 7.35 am, Ms Dhu called out to Senior Constable Lee Burgess, who was walking past her cell, to inform him that she had been sick. He informed Mr Bond, who at the inquest accepted that Senior Constable Lee Burgess was referring to the fact that Ms Dhu had vomited.[442]

648. Mr Bond did not make a record of Ms Dhu having vomited in the Custody system and at the inquest he accepted that he ought to have done so. The only reason he could think of for not recording it was that he believed Ms Dhu's vomiting was still consistent with what he understood her diagnosis to be, namely that she was still coming down from drugs.[443] That state of belief did not absolve

[435] Exhibit 3, tab 17
[436] Exhibit 4, tab 31; ts 1373
[437] ts 1375 - 1377
[438] ts 1458
[439] ts 1458 - 1459
[440] ts 1461
[441] Exhibit 3, tab 17
[442] ts 1680 – 1681; 1715
[443] ts 1716

him from the duty of recording the fact of Ms Dhu's vomiting. His recording was inadequate.

649. At 7.45 am on 4 August 2014, approximately 10 minutes after Mr Bond was informed that Ms Dhu had vomited, First Class Constable Matier (who had commenced his duties at 7.00 am) brought Ms Dhu her breakfast. On that occasion Ms Dhu told him that she was feeling unwell. First Class Constable Matier, who did not know she had recently vomited, suggested to her that she might feel better if she ate something.[444]

650. If the notation that Ms Dhu had vomited been recorded, and if First Class Constable Matier checked that, it would have become clear that she was unwell, and medical attention, as opposed to breakfast would have been appropriate. One of the functions of the Custody system is to allow for appropriate dissemination of relevant information regarding detainees, particularly having regard to the fact that the police officers operate on shifts, and care of detainees is routinely handed over and/or shared between police officers.

651. Whilst First Class Constable Matier then proceeded to make a record on the Custody system of having supplied Ms Dhu with a meal, he did not record her complaint of ill health. At the inquest he conceded that he ought to have done so.[445] His recording was inadequate.

652. At 8.45 am on 4 August 2014, First Class Constable Matier did record the fact that Ms Dhu was moaning on the Custody system, and at 9.00 am, he recorded that he provided her with "*1 tablet of Panadol*". On this occasion he also provided her with a styrofoam cup.

653. Shortly before First Class Constable Matier provided Ms Dhu with the Panadol, when he was speaking with her, Ms Dhu had difficulty getting up from her mattress, and she was unsteady on her feet. From the CCTV footage it is apparent that she appeared to be endeavouring to communicate with him, and experiencing some frustration. First Class Constable Matier's evidence was that she again told him she was feeling unwell.[446]

654. Inexplicably, Ms Dhu's appearance on that occasion did not cause First Class Constable Matier to have concerns about her health. When Ms Dhu is speaking with First Class Constable Matier, he is observed to raise his hands in the air in a "*what can I do?*" fashion, which through his counsel he accepts was perhaps unprofessional. It was unprofessional.

[444] ts 1465
[445] Exhibit 3, tab 17; ts 1465
[446] Exhibits 6 and 13.9

655. By way of explanation First Class Constable Matier proffers that Ms Dhu had been declared to be in a fit condition to be held in custody on two occasions, and that he overhead his shift supervisor Mr Bond stating that Ms Dhu was "*faking it*".[447]

656. I have submissions before me to the effect that a Constable will not lightly override a Sergeant. Those submissions are not apposite to this situation. Common humanity demanded that First Class Constable Matier make an objective observation and exhibit some empathy and concern for a young woman who can barely stand on her feet.

657. As Ms Dhu's health deteriorated on the morning of 4 August 2014, so did the tenor of the entries into the Custody system, so as to culminate in a series of entries, made by Mr Bond, that unequivocally reflect the erroneous belief that Ms Dhu was feigning her symptoms:

a. At 11.40 am, following a physical cell check: "*Ms Dhu lying on her back. Claimed her hands were going blue. Hand inspected. Nothing appeared any different than normal. Detainee is awake, lying down.*"

b. At 12.25 pm, following a physical cell check: "*Detainee complaining that she can't feel her legs and the rest of her body is going numb. Detainee is lying down.*"

c. At 12.30 pm, the general observation is made: "*Detainee appears to be suffering withdrawals from drug use and is not coping well with being in custody.*"

658. As Ms Dhu's body began to go numb, observations were recorded in a matter of fact manner, with no indication of elevated concern about the implications of the spreading numbness.

659. The recording of the cell check observations between 2 and 4 August 2014 was on occasion inadequate, as I have outlined above. The inadequacies are not to be viewed as mere irregularities in record keeping. Failures to record instances of moaning and complaints of feeling unwell risks minimising the symptoms of a detainee's illness. As happened in Ms Dhu's case, such failures had the real potential to unfairly undermine the credibility of her complaint.

660. Of more concern, on numerous occasions when police officers recorded Ms Dhu moaning, or heard her complain about her health, there was no appropriate and focussed questioning of her, so as to endeavour to understand the nature of her complaint.

[447] ts 1475 - 1476

661. Properly recording the observations of a detainee after a cell check is important. Of even greater importance is the obligation to actually be responsive to the observations.

662. Unfortunately, save for the HHC attendances, there was insufficient effort made to endeavour to understand Ms Dhu's complaints and to respond to them as she was expressing them. The inevitable conclusion I have reached is that to varying degrees, most of the police officers responsible for her welfare believed she was feigning her symptoms.

VIEWS HELD BY OTHER POLICE OFFICES CONCERNING MS DHU'S SYMPTOMS

663. A striking feature of the evidence at the inquest concerned the number of other police officers who formed the view that Ms Dhu was exaggerating or feigning her symptoms, in addition to First Class Constable Matier, Senior Constable Burgess and Mr Bond.

664. Not all of the police officers at SHPS disbelieved Ms Dhu, and Constable Sharples was a notable exception in this regard. Unfortunately however, the preponderance of such views had the cumulative effect of obfuscating the severity of her life-threatening condition. Counsel for the police officers remaining in the employment of the Western Australia Police Service concedes that the notion of drug withdrawal was most likely in the back of everyone's minds.

665. Whilst counsel for the police officers remaining in the employment of the Western Australia Police Service also points to HHC staff members within the group of those responsible for Ms Dhu's welfare, the views held by police officers warrants careful consideration. As I have said, despite receiving two Fitness to Hold Forms, the police are not absolved from the need to have conscientiously and properly continued to observe Ms Dhu and to have retained an open mind regarding her health status.

666. The details of the views held are set out below.

Constable Sharples – 2 and 4 August 2014

667. Though Constable Sharples was by far the most inexperienced police officer who was responsible for the care of Ms Dhu, it was readily apparent from all the evidence that this young woman displayed the most compassion and empathy towards her.

668. On 2 August 2014, Constable Sharples sought and obtained permission to deal with Ms Dhu one-on-one, by taking her out of her cell and sitting her in the charge room whilst they awaited the availability of a police vehicle to convey her to HHC. This was despite the usual procedure requiring two-on-one when detainees are moved from the cell.[448]

669. It is clear from the CCTV footage between approximately 8.40 pm and 9.15 pm on 2 August 2014, that Ms Dhu is in pain. Constable Sharples was courteous, solicitous, empathetic and genuinely concerned to comfort Ms Dhu. Constable Sharples made appropriate inquiry about how her rib injury arose, and encouraged her in a range of steps designed to minimise her discomfort whilst awaiting conveyance to the HHC.

670. Two days later, on 4 August 2014, in the minor role that Constable Sharples played in the conveyance of Ms Dhu from her cell to the police vehicle she was the only police officer who displayed any sense of urgency.[449]

671. It is evident to me that Constable Sharples believed Ms Dhu and considered her to be in pain and unwell and to the extent that she was able, addressed her welfare needs.

Sergeant Patchett – 2 August 2014

672. At 7.50 pm on 2 August 2014, Constable Sharples informed Sergeant Patchett that Ms Dhu was complaining of sore ribs. A couple of minutes later, Sergeant Patchett went to Ms Dhu's cell and spoke with her. He informed the court as follows: "*I went down and spoke to Ms Dhu to verify and validate her issues, whether she was feigning an illness or whether she was legitimately sick or injured.*"[450]

673. Sergeant Patchett's evidence was that he wished to establish "*whether she was coming down off something, whether she needed some medication of some description to ease her anxiety*".[451]

674. Ms Dhu informed Sergeant Patchett that her sore ribs were as a result of an assault a couple of weeks previously and also that she had used amphetamines the preceding day. Sergeant Patchett did not at that stage follow up with questioning on the allegation of assault, preferring instead to address the more immediate issue of her health problems. Upon his inquiry of Ms Dhu, he formed the

[448] ts 970
[449] Exhibit 5
[450] ts 938
[451] ts 940

view that her pain was genuine and commenced arrangements for her transfer to HHC.

675. On the Custody system Sergeant Patchett entered the following details for Ms Dhu, at approximately 8.00 pm on 2 August 2014, an hour and a half before she was conveyed to HHC: "*Spoken to by Sgt PATCHETT to clarify and verify injury as POI is a known amphet user….maintained status re injury and pain. Detainee is awake, lying on his/her front."*[452]

676. Sergeant Patchett's initial reaction was to verify whether Ms Dhu was indeed injured, and he specifically took account of the fact that she used amphetamines. Neither of these steps were unreasonable within themselves. He did proceed to make arrangements to have her conveyed to HHC for medical treatment on 2 August 2014, after being informed, and accepting, that she was in pain.

First Class Constable George – 3 August 2014

677. When First Class Constable George arrested Ms Dhu on the afternoon of 2 August 2014, he had formed the view that she appeared to be a user of methylamphetamine, from his personal observation of her and his experience of dealing with drug users. He did not recall seeking clarification from her on that point. He based it upon her behaviour and the slightly deteriorated appearance of her hair, skin and teeth.[453]

678. At approximately 4.00 pm on 3 August 2014 First Class Constable George heard moaning coming from the cell of Ms Dhu and it appeared to him Ms Dhu was in pain.[454]

679. When First Class Constable George returned with a paper bag, Ms Dhu said something about wanting to be taken to hospital.[455] First Class Constable George then conveyed that request to Sergeant Rick Bond, the on-duty shift supervisor, and it was arranged for Ms Dhu to be taken to the HHC. Ms Dhu was conveyed there, departing the lock-up at 4.52 pm.[456]

680. However, upon Ms Dhu's return from HHC at 7.12 pm on 3 August 2014, First Class Constable George, who was not aware that the CCTV camera in the sally port area of the SHPS had audio, made some inappropriate comments in the presence of Ms Dhu as she

[452] Exhibit 3, tabs 7 and 17
[453] ts 859
[454] ts 866
[455] ts 867
[456] Exhibit 3, tab 17; Exhibit 5

got out of the police vehicle.[457] First Class Constables Beckett and Eastman were also present.

681. As Ms Dhu was walking to the door leading into the SHPS a male voice is heard stating: *"Paracetamol, Paracetamol? After all that"*. This is then followed by an exclamation: *"Hah"*.

682. First Class Constable George accepted that he was the police officer saying the above words[458]. However, his evidence in relation to the *"Hah"* comment was that he did not remember that, and that he did not hear it on the footage.[459]

683. I am satisfied that First Class Constable George made all these utterances. There is no evidence to suggest that the "*Hah*" was uttered by anyone other than First Class Constable George. It is audible on the footage and relates contextually to the words that preceded it.

684. First Class Constable George through his counsel submits that those remarks were a reflection of his disbelief that, after a two hour wait at the hospital, Ms Dhu was prescribed Panadol. He maintains that he uttered the words out of frustration, as opposed to a desire to denigrate Ms Dhu.

685. First Class Constable George's remarks, heard in their context, are not to be regarded as an indication of his concern for Ms Dhu's health, nor do they suggest any disagreement on his part with the HHC's administration of Panadol. I do not accept that they were uttered in shock and surprise at how she had been treated at HHC.

686. First Class Constable George's comments were made in a mocking tone and suggested his disbelief regarding the seriousness of Ms Dhu's health condition, which was consistent with the view he held at the time to the effect that she was feigning her illness.[460]

687. I accept counsel assisting's submission that it would have undoubtedly conveyed to Ms Dhu that this police officer believed she was feigning (or at the very least exaggerating) her complaints of pain.

688. There is a power imbalance between a lock-up detainee and those police officers in charge of the lock-up. For First Class Constable George to make the remarks that he did within the presence of Ms Dhu could only have served to reinforce that imbalance to Ms Dhu.

[457] Exhibit 3, tab 9
[458] ts 879
[459] Exhibit 5
[460] ts 881 and 888

689. Remarks such as these made by First Class Constable George may well impact upon a detainee's willingness to making further complaints and are wholly inappropriate. While there is no evidence that Ms Dhu refrained from making further complaint about her health as a result of the remarks, the risk is serious enough for me to state, unequivocally, that detainees are not to be mocked when they complain of illnesses or seek medical assistance.

First Class Constable Eastman – 3 August 2014

690. On 3 August 2014 when First Class Constable Eastman (together with First Class Constable Beckett) returned Ms Dhu to SHPS, she was aware that one of the nurses at HHC who had attended to Ms Dhu believed that she was having withdrawals or coming down from drugs.[461]

691. When later questioned, First Class Constable Eastman was "*fairly sure*" that she passed this information on to shift supervisor Mr Bond after she had attended to another job.[462] Through her counsel First Class Constable Eastman accepts that she passed this information onto First Class Constable Beckett and also that this information may have been offered to Mr Bond.

692. At the inquest First Class Constable Eastman was later asked the following questions by counsel assisting:[463]

> *"Did you personally think that Ms Dhu was behaving in the way that she was because she was coming down or withdrawing from drugs? --- No.*
>
> *You didn't believe that? --- I wasn't sure what was going on with her."*

693. It is not now possible for me to determine the context in which those comments were passed on at the Lock-Up. However, the general effect of the comments is consistent with the concession made by counsel for all of the employed police and already referred to, namely that the notion of drug withdrawal was most likely in the back of everyone's minds.

Detective Senior Constable Nathan Nunn

694. I have already addressed Detective Senior Constable Nunn's failure to record Ms Dhu's moaning and complaint of sore bones at the

[461] ts 1272
[462] Exhibit 3, tab 8; ts 1288
[463] ts 1287

paragraphs above. The evidence at the inquest reflected that Detective Senior Constable Nunn considered that Ms Dhu may have been feigning her symptoms. At the inquest he agreed that his perception could have been that Ms Dhu was "*putting it on*" but he could not recall with confidence what his perception was at the material time.[464]

695. At the material time, Detective Senior Constable Nunn provided relevant answers on this point in his interview with the IAU officers. It concerned information as to the contents of the conversation he had with Sergeant Russel Cowie regarding this incident. In his IAU interview he stated:

> *"I think it was only once that I noticed her moaning when I went down there, and that's the reason I remember. It was because she wasn't moaning, and I actually made a point of saying it to the – to Sergeant Cowie. I said she wasn't – she wasn't moaning when I went down there, until she saw that I was walking past her cell to do a check, and then she started moaning. But she didn't say anything to me, and she saw me down there and looking."* [465]

696. It is evident that Detective Senior Constable Nunn thought Ms Dhu moaned because she saw him in the vicinity and from that, he extrapolated that she was likely to be able to control her moaning, and that it was therefore not genuine.

CHANGES SINCE MS DHU'S DEATH

697. Assistant Commissioner Duane Bell gave evidence at the inquest. He has been a serving police officer with the Western Australia Police Service for over 38 years and has responsibility for judicial services. It is clear from the Assistant Commissioner Bell's evidence at the inquest that the Commissioner of Police and the Western Australia Police Service have been proactive in either implementing changes or are examining the making of changes to ensure that the conduct of police officers at the Lock-Up, and particularly on 4 August 2014 is not repeated.

698. The nature of these changes and my recommendations for further improvement are addressed under the headings:

a. Improvements to Lock-Up Procedures;

b. Cultural Competency Training; and

c. Medical handover of Detainee.

[464] ts 1374 - 1375
[465] Exhibit 4, tab 31

IMPROVEMENTS TO LOCK-UP PROCEDURES

699. Since Ms Dhu's tragic death there have been improvements to lock-up procedures, primarily through changes to the Lock-Up Manual. In addition to the more rigorous and more frequent monitoring of detainees mandated by the changes to the lock-up procedures on 22 August 2014[466] and referred to in the paragraphs above, there have been developments in the training in lock-up procedures, in the recording of shift handovers, and in the staffing of the lock-up keeper role that are designed to facilitate a better focus on the welfare needs of detainees. There are addressed below.

Past Training in Lock-Up Procedures

Inadequate training of police officers in lock-up procedures

700. The evidence at the inquest established that there was some knowledge of the provisions of Part 10 of the Lock-Up Manual[467] concerning lock-up procedures, and scant knowledge of the SHPS Lock-Up procedures,[468] which on the material aspects referenced the state-wide manual.

701. The individual police officers had received some training concerning lock-up procedures at the Police Academy. Constable George described the training as "*one small part of a great many things [he], as a police recruit, needed to learn.*"[469] Constable George knew that there was a requirement to record the name of the doctor and the diagnosis given, on the Custody system.[470]

702. Constable George did not record his observations of Ms Dhu that led him to provide her with paper bag to assist with her difficulty breathing because on his evidence, he was under "*time and work pressure*".[471] It was not as a result of being unaware of the obligation.

703. First Class Constable Matier also gave evidence about training he had received in lock up procedures, both at the Police Academy and on the job. On 4 August 2014, he did not make a record of Ms Dhu's complaints of ill health, or of Mr Bond's decision to convey

[466] Exhibit 17.2
[467] Exhibit 17.1
[468] Exhibit 2, tab 53
[469] ts 921
[470] ts 926
[471] ts 926

her to HHC, on the Custody System, and he conceded he knew that he ought to have done so.[472]

704. First Class Constable Matier had recorded that Ms Dhu was moaning earlier on the morning of 4 August 2014, so it is clear he knew of the obligation.

705. Detective Senior Constable Nunn gave evidence about receiving training in lock-up procedures at the Police Academy and described a constantly evolving process of instruction including by way of updates or broadcasts. As a general observation he believed there was quite a lot to learn over the training period and in terms of keeping up with changes.[473]

706. Detective Senior Constable Nunn's explanation for not recording observations, such as Ms Dhu stating she had "*sore bones*" were based upon what he described as the dynamic nature of the lock-up keeper's role and the number of other functions that take the lock-up keeper's attention away from the role. He too made records into the Custody system and it is clear he knew there was an obligation to do so.[474]

707. Whilst Mr Bond did not record information that he had been given about Ms Dhu having vomited on 4 August 2014, he could not account for failing to do so and he accepted that it was not as a result of being ignorant of the requirement to do so.[475]

708. I am satisfied that the individual failures to properly record observations of Ms Dhu were not as a result of a lack of awareness of the obligation. The police officers knew of the obligation but failed to comply, primarily because they believed Ms Dhu was feigning her symptoms, or they did not consider it to be sufficiently important to comply. Had such records been properly kept, it may have alerted police officers to the fact that she was not feigning her symptoms due to the sheer accumulation of observations that would have been recorded on the Custody system.

709. This was not as a result of a failure of training in the awareness of the obligation. Rather, it reflects an occasionally careless attitude towards compliance with lock-up procedures, exacerbated by intermittent interruptions due to the lock-up keeper being tasked with other duties, and undoubtedly affected by an underlying belief that the symptoms were not genuine.

710. Whilst I am satisfied that the SHPS police officers knew of the obligation to record their observations of Ms Dhu after a cell check,

[472] ts 1556 - 1557
[473] ts 1356 - 1357
[474] ts 1375 - 1376
[475] ts 1811

most of those police officers did not know the precise matters that needed to be recorded when medical attention was sought. In the main, they were unaware of the requirement to record the advice or diagnosis, and the name staff member giving it.

711. Through his counsel the Commissioner accepts that, given various police officers gave evidence to the effect that they were unfamiliar with the precise requirements for recording the medical advice or diagnosis given, and the name of the staff member giving it, a finding that the training of officers was inadequate is open.

712. Whilst more rigorous training would have assisted in this area, and compliance with recording the details of medical attention is essential in order to properly manage a detainee's welfare needs, in the circumstances of this case it is an inescapable fact that had the details of medical advice or diagnosis been sought and given, they would have reinforced the view that Ms Dhu was feigning her symptoms.

713. The doctors' discharge diagnoses recorded that Ms Dhu had behaviour issues and was possibly affected by drug withdrawal. I do not accept any suggestion that different advice would have been given on those dates, even though it is now contended that it was understood by those doctors that Ms Dhu was suffering from musculoskeletal pain. There is no record of musculoskeletal pain in Ms Dhu's medical notes.

714. The evidence at the inquest reflected a need for a more focussed system for training police officers in the area of compliance with lock-up procedures, in particular training that addresses the underlying reasons for compliance. A better understanding of the underlying reasons may avoid the carelessness that was evident from the evidence given at the inquest. This is addressed below.

Changes to Training in Lock-Up Procedures

715. At the inquest, Assistant Commissioner Bell explained that mandatory refresher training in lock-up procedures was conducted for some 5000 police officers after August 2014. These were the non-commissioned police officers, being officers in operational roles ranked Sergeant and below.[476]

716. The training was delivered by means of an electronically based system known as "*Blackboard*" that operates throughout Western Australia. Embedded within the system is the ability of those in management roles to for check compliance. He explained:

[476] ts 1844

"every officer has to log in. So we can audit that they've registered, they've sat through the material, and they have to get right to the end and click buttons, so we know they've seen each screen, so that they've accepted that they've read it as well, and understood it." [477]

717. The rationale for utilising the electronic training system to build upon the knowledge imparted at the Police Academy is based in part upon the sheer size of Western Australia. The ability exists to utilise this technology for the purposes of effectively reaching out into the more remote areas and also for ensuring that police officers who are working on shifts are able to take part.[478]

718. Police Academy training remains the first point for the delivery of the training. It is partly theoretical but is now predominantly practical. Assistant Commissioner Bell referred to the scenario-based training in lock-up procedures that has been introduced at the Police Academy, for the new police recruits.[479]

719. Like many of the police officers from the SHPS who gave evidence, Assistant Commissioner Bell's evidence was that the vast majority of learning was "*on the job*" learning or practical experience.

720. On this basis, it is vital that those police officers who are in a supervisory role demonstrate a diligent and rigorous compliance with the lock-up procedures and equally demand the same from those whom they supervise.

721. Notwithstanding the obvious benefits of the electronic training, which ought to continue with regular refreshers, I am persuaded that some further face-to-face training is warranted. This is addressed in more detail in the paragraphs concerning the training for the dedicated lock-up keepers.

722. The benefit of face-to-face training is that it enables the educator to better impart the information, to more effectively communicate its importance and to more readily discern whether there are those within the audience who are unlikely or unwilling to adhere to the requirements. It is difficult if not impossible to detect any cynical participation in training exercises that are undertaken electronically.

Record of handover between shifts

723. Some of the evidence at the inquest concerning the detail of information passed between police officers at the handover between

[477] ts 1843
[478] ts 1938
[479] ts 1924

shifts was inconsistent. At the material time, there was no requirement that a written record be created of the information conveyed at handover. This led to police officers relying on their memories of what was said at handover, to a significant degree, and not unsurprisingly, accounts diverged at the inquest.

724. Consistent with the IAU recommendations, a new provision was introduced into the Lock-Up Manual that mandates a more rigorous recording of information when there is a handover of responsibility for the detainee between shifts, LP-10.05.[480]

725. The Shift Supervisor and Lock-Up keeper are each required to ensure that a detailed shift handover occurs in accordance with the local Standard Operating Procedures. The minimum requirements to be recorded on the Custody system include details of and medical concerns, medication requirement and suspected mental health or other safety concern for each detainee.

726. Properly executed, this will ensure the handover information is readily accessible to the police officers on all subsequent shifts, which assists in the management of the detainee's care and welfare. Further there is a permanent record of the information that was imparted that is amenable to future review.

Conveyance of detainees by ambulance

727. At the material time, the St John Ambulance Service operated in Port Hedland and the station was located approximately 800 metres from the SHPS and one kilometre from the HHC. It operated daytime and night-time shifts. During the daytime, it operated two crews. Full-time paid paramedics and volunteer ambulance officers worked together to staff the two ambulances.[481]

728. On 4 August 2014, according to the St John Ambulance records, there would have been an ambulance with crew available to convey Ms Dhu to HHC after 11.30 am, due to another case having taken up to that time. The response time target for a Priority 1 call was 11 minutes, within a 10 kilometre radius of the town centre. For a Priority 2 call it was 15 minutes.[482]

729. Unfortunately, the commonly held view by police officers was that, given the proximity of the SHPS to the HHC, it was more efficient to convey Ms Dhu to HHC by police vehicle, due to it being located approximately 200 metres away. No doubt this was also

[480] Exhibit 4, tab 62.1 and Exhibit 17.3
[481] Exhibit 4, tab 58; ts 766 - 768
[482] ts 768 - 769

influenced by the incorrect perception that Ms Dhu was feigning her injuries.

730. This commonly held view based upon proximity did not however take into account the fact that the ambulance crew would be able to administer resuscitative measures upon arrival at SHPS. There will undoubtedly be occasions where time is of the essence and/or the moving of a detainee into a police vehicle is contra-indicated.

731. Very sadly any resuscitative measures applied by paramedics on the morning of 4 August 2014 would have been unlikely to revive Ms Dhu. However, she ought to have been afforded that opportunity. A conveyance to HHC by ambulance would have avoided the unprofessional and inhumane manner in which she was conveyed there in the secure pod at the back of the police vehicle.

732. On 22 August 2014 amendments to the lock-up procedure manual shifted the focus onto the use of an ambulance for conveyance of a detainee for medical treatment. The provision now stipulates that a detainee found to be suffering from a serious injury/illness shall be conveyed to a place for medical treatment by ambulance wherever possible, LP-04.04.01.[483]

733. The previous version had expressly allowed for conveyance by an unmarked police vehicle or most expedient use of transport if a detainee was suffering from an injury/illness that was not of a serious nature. That option has since been removed.

734. In accordance with the IAU recommendations, wheelchairs are to be made available in police lock-ups to enable the humane handling of persons in custody who are unwell. The delivery of wheelchairs to the seven major metropolitan lock-ups and the 24 hour regional lock-ups is underway.[484]

735. Every lock-up now has a defibrillator and training is provided in its usage, on a yearly basis.[485]

Dedicated Lock-Up Keeper Pilot

736. After Ms Dhu's death, the IAU review recommended that every major police centre be staffed with a dedicated lock-up keeper on every shift whilst a person is in custody. This was supported in

[483] Exhibit 17.2
[484] Exhibit 4, tab 62.1
[485] ts 1894

principle, but remains under consideration and subject to assessment.[486]

737. At the inquest Assistant Commissioner Bell explained that the Western Australian Police Service is piloting a "*dedicated lock-up keeper*" role on every shift whilst a person is in custody in a regional area. This is distinct from the previous "*designated lock-up keeper*" role, where the incumbent was charged with other duties.[487] A dedicated lock-up keeper, as the description indicates, is not charged with any duties other than those of lock-up keeper.

738. The lock-up keeper is the police officer with the allocated responsibility to run the lock-up during a particular shift. The primary focus of the lock-up keeper is the custodial care of detainees. The duties of the lock-up keeper include, upon commencing duty, personally visiting the cells and taking over responsibility for the detainees, and recording handover of responsibility.[488]

739. In respect of each new admission the lock-up keeper must, amongst other things, speak to the detainee and arresting officers to establish whether the detainee requires medical attention, and ensure that appropriate records are made of medical conditions.[489]

740. The lock-up keeper must ensure that every detainee is treated in a humane and dignified manner, having regard to the need for security. Amongst other things the lock-up keeper must also ensure that the Custody system and appropriate records are completed in respect of each detainee. The shift supervisor must ensure that the lock-up keeper is aware of their responsibilities.[490]

741. At the inquest Assistant Commissioner Bell's evidence was that the dedicated lock-up keeper role has been piloted in Kalgoorlie and that there remains in principle support for that role, subject to some practicalities that he described as follows:

> *"For example, if there are no persons in custody, what does that person do? How do we optimise that? So, for example, that's why we're looking at major centres, as – as this talks about, and how we might then transport people in custody from outlying stations to that central hub, which then reduces the number of sites, reduces the number of people you need to put into this role, and also changes how we provide care."*[491]

[486] Exhibit 4, tab 62.1
[487] ts 1887
[488] Exhibit 17.2
[489] Exhibit 17.2
[490] Exhibit 17.2
[491] ts 1888

Recommendation 1 – formalisation of dedicated lock-up keeper roles

I recommend that at every police station where detainees are held, there must be a dedicated lock-up keeper. Alternatively that a minimum of two officers are rostered for custodial care duties at any time.

Recommendation 2 – training for dedicated lock-up keeper roles

I recommend that a mandatory training course on the roles and responsibilities of lock-up keeper/supervisor be developed and introduced across Western Australia and that a component of the training be undertaken face-to-face. Successful completion of the course ought to be mandatory before an officer can be assigned lock-up keeper/supervisor duties.

CULTURAL COMPETENCY TRAINING WAPOL

Past Training in Cultural Competency

742. The evidence established that prior to Ms Dhu's death, police recruits undertook cultural awareness training at the Police Academy, and before 2011 this was by means of a cultural awareness training module. Since 2011, that training had been extended to include cultural competency, delivered in a more practical training course. However, that training course was not ongoing.

743. When the police officers moved to regional areas, they also received on-the-job training by way of contemporary and community-specific information. This was not a formal training program, and would clearly have been reliant on the skills and attitudes of their supervisors in those regional areas.

744. At the inquest, Assistant Commissioner Bell suggested that a reason as to why a number of police witnesses were unable to recall much of the detail of their cultural competency training was due to that training being integrated within the curriculum since 2011, rather than being delivered as a stand-alone module.[492]

745. From 2011 the emphasis in the training shifted from "*awareness*" to "*competency*" in cultural matters, and was delivered to trainees by means of practical scenarios designed to assess fitness for the role. This was a step in the right direction. It is one thing for a person to be aware of cultural matters, but quite another for a person to act in a culturally competent manner when the situation calls for it.

746. The training since 2011 and prior to Ms Dhu's death did not address the particular health concerns of Aboriginal persons. At the inquest Assistant Commissioner Bell conceded that while there was reference material available on the subject, it was not brought together in a consolidated way. Nor was that material used in any training in respect of persons held in custody.[493]

747. Given that police officers stationed in the Port Hedland area (and other regional areas) would be interacting with Aboriginal persons and be responsible for their care in a custodial environment, and given what was already known about the health status of Aboriginal persons, in hindsight their training ought to have included information concerning Aboriginal persons' higher rates of common medical illnesses and susceptibility to illnesses.

748. I accept Professor Thompson's evidence to the effect that it "*is not realistic to expect custodial staff to monitor regularly and interpret pulse, temperature, respirations and blood pressure measurements.*"[494] The police are not medically qualified personnel and the training ought not to aim to equip them with skills that are more appropriately applied by clinicians.

749. However, the purpose of training police officers in the health status of Aboriginal persons is to impart an understanding of the social determinants of ill health and to thereby, hopefully, avoid preconceptions being made to the effect that apparently unusual, aberrant or atypical behaviour must be due to intoxication or drug withdrawal. Training in this area is inextricably connected with cultural competency.

750. Through his counsel the Commissioner of Police accepts that there was a deficiency in the training of police in relation to Aboriginal health concerns.

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[492] ts 1842
[493] ts 1841
[494] Exhibit 4, tab 60

751. Whilst this deficiency in training did not contribute to Ms Dhu's death, more focussed training in this area may have softened the attitudes shown to Ms Dhu during the last hours of her life. Even though by this stage medical assistance was not likely to revive Ms Dhu, it may have caused police officers to more readily seek it, and may have made her last hours more comfortable.

752. At the inquest, I received evidence concerning the future training in cultural competency, which is set out below.

Changes to Training in Cultural Competency

753. Assistant Commissioner Bell explained that after Ms Dhu's tragic death, in addition to the mandatory refresher training in lock-up procedures that I have referred to above, the Western Australia Police Service also reviewed their cultural competency training and added some components.

754. First, and most importantly, having identified and accepted the deficiency in the training of police in relation to the health concerns of Aboriginal persons, the Western Australia Police compiled a document entitled "*Awareness of Aboriginal Issues for Custodial Staff and Police Watch-House lock ups.*"[495] This document came into being in August 2015.

755. The instructions in respect of the health concerns of Aboriginal persons are comprehensive. They cite the Royal Commission into Aboriginal Deaths in Custody and call for monitoring and oversight, vigilance and understanding on the part of police officers who are responsible for managing Aboriginal people who will come into police custodial settings. They address the following material matters:

a. Social and behavioural determinants of health;

b. Geographical location and distribution of Aboriginal and non-Aboriginal population;

c. Information on the mental and physical health status of Aboriginal persons generally, and of Aboriginal prisoners;

d. Mental health, respiratory diseases, cardiovascular diseases, diabetes, chronic kidney disease, cancer and injury and poisoning;

e. Life expectancy and mortality rates for Indigenous persons;

f. Contact with the criminal justice system, with statistical information that includes the following:

[495] Exhibit 16

- although Indigenous adults make up only 2.2% of the Australian adult population, they accounted for 27.4% of all prisoners as at 30 June 2013;
- the imprisonment rate of Indigenous adults was 13 times as high as the rate for the Non-Indigenous adult population as at 30 June 2014; and

g. Duty of care in police custodial settings.

756. This information and instruction regarding the health concerns of Aboriginal persons has since been used in the induction training for police recruits at the Academy, and was also part of the mandatory refresher training in lock-up procedures that all non-commissioned police officers have undergone. It is now recognised that instruction in the health concerns of Aboriginal persons properly forms part of the cultural competency training that is integrated throughout the entire training program.

757. Given the high rates of imprisonment of Indigenous adults, and the significant health concerns that they face, it is vital that this information be rigorously imparted to police officers as part of their induction at the Police Academy, that it be reviewed and updated as required, that it be available as an on-line resource, and that regular re-fresher training in this area be arranged.

758. Secondly, and also importantly, the Western Australia Police Service are reviewing the cultural competency content of the induction packages that are used for police officers who are transferred to a new police station. The aim is to ensure that the police officers receive contemporary and community-specific information, and that the training be consistently applied across the State.

759. As I have outlined already in the paragraphs above it is vital that cultural competency training also be undertaken face-to-face so that trainers have the opportunity to assess competence in this area and if necessary, recommend appropriate interventions to ensure that police officers not only learn culturally relevant information, but that they also demonstrate the requisite attitudes and skills.

Recommendation 3 – cultural competency training

I recommend that the Western Australia Police Service develops its cross-cultural diversity training to address the following:

1. **That there be mandatory initial and ongoing cultural competency training for its police officers to assist in their dealings with Aboriginal persons and to understand their health concerns;**
2. **That Aboriginal persons be involved in the delivery of such training;**
3. **That successful trainees should be able to demonstrate cultural competency – that is a well-developed understanding of Aboriginal issues and the skills to deal effectively with Aboriginal communities; and**
4. **That the initial training and at least a component of the ongoing training is to be delivered face-to-face.**

Recommendation 4 – training tailored to local community issues

I recommend that the Western Australia Police Service develops its training for police officers who are transferred to a new police station to address the following:

1. **That it be a standard procedure for all police officers transferred to a location with a significant Aboriginal population to receive comprehensive cultural competency training, tailored to reflect the specific issues, challenges and health concerns relevant to the location;**
2. **That members from the local Aboriginal community be involved in the delivery of such training, and that it be ongoing to reflect the changing circumstances of the location; and**
3. **That the initial training and at least a component of the ongoing training is to be delivered face-to-face.**

MEDICAL HANDOVER OF DETAINEE

760. The system for medical assessment of detainees and their handover to police once declared by a doctor to be fit to be held in custody was unsatisfactory, and lacked integration. The details are set out below.

The previous Fitness to Hold Forms

761. The Western Australia Police Fitness to Hold Forms as they existed in August 2014 gave the treating doctor an option as to whether or not to complete the details of medical treatment provided to the detainee. There was no requirement for the treating doctor or other clinician to provide written (or verbal) information as to whether or not the detainee had been diagnosed with a medical condition.[496]

762. Regrettably, the processes surrounding the Fitness to Hold Forms in 2014 did not adequately enable police officers to comply with the requirements of the Lock-up Management Procedures. When the treating doctor left the section dealing with medical treatment blank (or when detail was scant), and when they imparted no other information as to diagnosis, the escorting police officers were left in a difficult position.

763. Essentially, if the escorting police officers were not voluntarily provided with information concerning the advice or diagnosis given by a HHC medical staff member, they would not be able to comply with LP-10.1, that required a notation of that information to be made on the detainee's running sheet and on the Custody system.

764. If that part of the Fitness to Hold Form was left blank, or if it contained insufficient details, understandably, the escorting police officers were reluctant to ask the treating doctor to provide further details. They had no right to demand it. In practice, once the escorting police officers were provided with a Fitness to Hold Form signed by the HHC treating doctor, they accepted that the detainee was in a fit state to be held in custody.

765. Apart from the obvious proscriptions flowing from patient confidentiality considerations, and the fact that the form itself gave the doctors an option in any event, the treating clinicians were busy with other patients in the emergency department of the HHC.

766. The Commissioner of Police through his counsel accepts that the fact that that section of the Fitness to Hold Form in which doctors can note medical treatment was referred to as "*optional*" was a deficiency that needed to be rectified.

767. After Ms Dhu's tragic death the Western Australia Police Service reviewed the Fitness to Hold Form, identified deficiencies, and sought within the limits of their remit, to rectify them. Unfortunately, the previous Fitness to Hold Form had left some

[496] Exhibit 1, tabs 22 and 26

police officers under the impression that if a doctor signed the form, it signified that the detainee was healthy.

768. In fact, a detainee may have been deemed fit to be held in custody, without being in a sound state of health. This calls into question the issue of whether an individual ought to be detained in a regional lock-up over a number of days when not in a sound, or even reasonable, state of health, and I address this later in my finding.

769. In connection with the improvements to the Fitness to Hold Form, Assistant Commissioner Bell's evidence was that the form was altered to change the mind-set of police officers and medical professionals so that the emphasis is now not merely on whether a detainee is fit for custody, but rather on what their medical needs, if any, might be:

> *"It is not about being fit in custody. It is about understanding what's the care for that person when they come back to us, what should we look for, what changes should we look for, that would alert us to something and we would re-present at a hospital or seek medical assistance, to take some of that ambiguity out, and subjectiveness."*[497]

770. The changes are addressed below.

The new Medical Summary and Treatment Reports

771. The form is now in two parts representing the expanded procedure[498] for the handover of critical information about a detainee between escorting police officers and health clinicians, as follows:

a. First is a "*Medical Summary*" form, used by the escorting police officers for the purpose of conveying salient information about the detainee to the treating health clinician. It functions as a medical handover document. It comprises a print out from the Custody system that consists of the detainee's personal data and details of his/her health and welfare status, including the detainee's responses to welfare questions answered during admission, information about diseases or injuries or medical issues, as well as medically related events, including medication requirements, last meal given, previous medical treatment provided, and medication given. Properly utilised, the form will avoid the risk of escorting police officers overlooking relevant information in the course of a verbal handover to the treating health clinician.

[497] ts 1878
[498] Exhibit 2, tab 54 and Exhibit 4, tab 62: this procedure is consistent with the IAU recommendations

b. The next component is the "*Medical TreatmentReport*" which replaces the Fitness to Hold Form. This new form is to be handed to the treating health clinician by the escorting officers. It contains details concerning the detainee, including estimated time remaining in police custody, current health status and observations, within the information to be conveyed to the treating health clinician. There is then a section (not marked as "*optional*") for the health clinician to make a written record of the medical assessment of the detainee and the treatment provided, plus instructions for the further treatment of the detainee whilst in police custody.

772. The content of the hospital/medical assessment on the Medical Treatment Report is to be entered as medically related information on the Custody system, and it will then become automatically available on the Medical Summary Form in the event that further medical treatment is sought.

773. The new system is consistent with Professor Thompson's suggestion to the effect that the approach to seeking and providing medical input be reframed away from seeking a "*fitness for custody*" clearance to a focus on medical assessment, attention and care.[499]

774. Whilst this procedure for the handover of information represents a significant improvement to the previous one conducted in accordance with the Fitness to Hold Form, the following difficulties are not resolved:

a. the escorting police officers are not able to require the health clinicians to complete the Medical Treatment Report, and are reliant on voluntary completion;

b. the treating health clinicians on the other hand are understandably concerned about potential legal ramifications for breaching patient confidence, in the absence of consent; and

c. the result is that there is a risk that detainees who are unwell, but not to the extent of requiring hospitalisation, will continue to be kept in police lock-ups, in a setting where the lock-up keeper and/or shift supervisor does not know the detainee's diagnosis, nor the signs or symptoms that ought to trigger the seeking of further medical advice.

775. At the inquest Assistant Commissioner Bell explained that there is now a 24 hour seven day a week nurse stationed at the Perth Watch House, who may be contacted by telephone should police officers from a regional location wish to seek medical advice. The procedure for seeking the advice of the internal nurse was introduced in part because the regional police officers did not feel that they could go back and ask the hospital for further

[499] Exhibit 4, tab 60

information once they had returned the detainee to their custody, from the hospital. This new system was described as being not unlike the 24 hour healthdirect health advice line for the community.[500]

776. At the inquest Assistant Commissioner Bell confirmed that even under the new system, escorting officers may potentially leave the hospital with a detainee, and with no documentation whatsoever about the fact that the detainee was ever taken there or discharged, a matter that concerns him because, as he correctly identified:

> *"the person is in the State's custody. We have a duty of care to that person. We feel there's information we need about what care regime they need and also what to look for to re-present, and we don't feel we can fulfil our duty of care without that information from the health professionals."*[501]

777. Even if such medical information were to be provided by the medical clinicians direct to the centrally located 24 hour Perth Watch House nurse, that nurse is still in a potentially difficult position when regional police officers make contact to seek information and advice.

778. The present situation, where police officers are now required to make a record on the Custody system of a refusal by a medical professional to sign a medical treatment report,[502] may highlight the importance of seeking the medical information, and may shed some light on the extent of the impasse, but does not solve it.

779. Detainees themselves may not be in a position to provide informed consent to disclosure of medical information, and they may not be in a position to comprehensively relay the diagnosis and treatment required to the police officers. One of Professor Thompson's suggestions for improvement concerned the negotiation of confidentiality restrictions, recognising that: "*the person in charge of the [prisoner] is essentially their guardian for the duration of their incarceration under their care.*"[503]

780. At the inquest I received evidence about discussions held between the Commissioner of Police and the Director General of Health with the aim of addressing these issues. The court was informed that it is hoped that a position may be reached whereby medical staff who treat detainees will provide the information that police officers need in order to fulfil their duty of care to those detainees who are not so

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[500] ts 1884; Exhibit 4, tab 62.1: IAU recommendations
[501] ts 1909
[502] Exhibit 4, tab 62.1: IAU recommendations
[503] Exhibit 4, tab 60

unwell that they need to stay in hospital, but who have health concerns that need to be addressed while in custody.

781. Assistant Commissioner Bell gave evidence at the inquest about high level discussions he was having on the issue. The Chief Medical Officer is the Department of Health's representative. Through its counsel, the Department confirms it is more than willing to continue to engage with the Western Australia Police Service to strengthen procedures that support the health and well-being of detainees and provide the Western Australia Police Service with sufficient information to manage their care whilst in police custody.

782. At the inquest I heard evidence to the effect that some doctors are still not completing (or otherwise providing) all of the information sought under the "*Hospital/Medical Assessment*" section of the Medical Treatment Report. The discussions between the Western Australia Police Service and the Department of Health remain a work in progress and hence my following recommendation:

Recommendation 5 – provision of medical information to police

I recommend that Parliament consider whether legislative change is required in order to allow medical clinicians to provide the Western Australia Police Service with sufficient medical information to manage a detainee's care whilst in police custody. Allied to this is a consideration of the safeguards concerning that information.

ALTERNATIVES TO IMPRISONING FINE DEFAULTERS

The legal framework for Ms Dhu's detention

783. Ms Dhu was held in police custody at the Lock-Up for a total of approximately 45 hours, between 2 and 4 August 2014. She was detained pursuant to four Warrants of Commitment that had been issued on 13 May 2014[504] because she had failed to pay a number

[504] The Warrants of Commitment were issued pursuant to s 53 of the *Fines, Penalties and Infringement Notices Enforcement Act* 1994 and in accordance with section 57 of the *Sentencing Act* 1995

of fines that had been imposed on dates between 2009 and 2011, following proceedings in the Magistrates Courts.

784. The fines related to her convictions for offences of disorderly behaviour, obstructing public officers, assaulting a public officer, failure to comply with request to give police personal details, and breach of bail. The disorderly behaviour offences related to swearing in a public place. The obstruction offences related to waving her right finger in a police officer's face and not moving away from him when warned to do so, and later making contact and attempting to break free. The assault offence related to kicking a police officer whilst being handcuffed (in connection with one of the obstruction offences).[505]

785. The offence of assaulting a public officer was unquestionably a serious matter. The other offences stemmed from behaviour that could be described as low-level offending. The undesirable trajectory that had been identified by the *Royal Commission into Aboriginal Deaths in Custody* (1991) was to a degree borne out in Ms Dhu's case more than 20 years later:

> *"….too often the attempt to arrest or charge an Aboriginal person for offensive language sets in train a sequence of offences by that person and others – resisting arrest, assaulting police, hindering police…."*[506]

786. As at 2 August 2014, when Ms Dhu was arrested, she owed a total of $3,662.34 in unpaid fines (together with costs and enforcement fees) (the "fines") and she had no realistic means of paying the fines. When Mr Bond contacted Ms Dhu's father by telephone on 4 August 2014, to ascertain if he could pay the fines, so that she could be released from custody, not unsurprisingly, Mr Dhu was unable to pay the fines on the spot either.[507]

787. Under *Fines, Penalties and Infringement Notices Enforcement Act 1994* (FPINE Act) where an unpaid fine imposed upon an offender is registered with the Registry for enforcement, the Registrar may issue a notice of intention to enforce payment of the amount owed, with a due date that is not earlier than 28 days from the date of issue of the notice. Where 28 days elapse without the amount being paid, the Registrar may issue an enforcement warrant.[508]

788. In addition to an enforcement warrant, the Registrar may also issue an order to attend for work and development, which must be served personally by the offender. Where a work and development order is served, the enforcement warrant ceases to be in force. The

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[505] Exhibit 1, tab 15; See ss 74A(2)A, 172(2) and 318(1)(d) *Criminal Code*, s 51(2) *Bail Act* 1982, and s 16(6) *Criminal Investigation (Identifying People) Act* 2002.

[506] RCIADIC *Report of the Inquiry into the Death of David John Gundy*, per Commissioner Wootten

[507] ts 42 - 43

[508] Sections 42 and 45 FPINE Act

Registrar also has the option of issuing a work and development order ahead of other enforcement measures where certain criteria are met, in particular where the offender is unlikely to have the means to pay.[509]

789. In Ms Dhu's case the four Warrants of Commitment issued, which commanded that she be arrested and imprisoned for the period stipulated on each warrant, and specified that each period be concurrent on any other term or period of imprisonment that Ms Dhu was to serve. Applying the formula in the FPINE Act,[510] and allowing for concurrency, this resulted in Ms Dhu being required to serve a total of four days' imprisonment. This was recorded by Mr Bond and it would have resulted in her release date being 5 August 2014.[511]

790. The concurrency provisions had come into effect in March 2008. By reason of Ms Dhu's largest fine being $1000 (plus costs and enforcement fees of $225), the concurrency provisions meant that, at a rate of $250 per day, she would be required to serve sufficient time in prison to pay off the largest fine, being the four days.

The over-representation of Aboriginal women in prison for fine default

791. In 1991 the *Royal Commission into Aboriginal Deaths in Custody* report stated:

> "*Aboriginal people die in custody at a rate relative to their proportion of the whole population which is totally unacceptable and which would not be tolerated if it occurred in the non-Aboriginal community. But this occurs not because Aboriginal people in custody are more likely to die than others in custody but because the Aboriginal population is grossly over-represented in custody. Too many Aboriginal people are in custody too often.*"[512]

792. The *Royal Commission into Aboriginal Deaths in Custody* addressed the issue of the disproportional impact of fines on Aboriginal people in the Western Australian context, noting the following:

> *"Fines operate in a manner which is obviously unjust towards poor people, since the impact of any monetary penalty is directly proportionate to the defendant's income. Taking no account of the level of income of the offender means that poor people are punished*

[509] Sections 47 and 47A FPINE Act
[510] Section 53(7) FPINE Act
[511] Exhibit 1, tab 15
[512] RCIADIC, Volume 1 [1.3.3]

more harshly than the affluent for the same offences, because the fine has a much greater effect on their modest means. The fact that the court may not, and usually does not, insist upon immediate payment, and grants time for the fine to be paid, does not affect the offender's obligation to pay the fine.

The practice of imprisoning those who do not or cannot pay fines imposed on them, without proper regard to their ability to do so, emphasises the injustice of existing sentencing policies to poor people, among whom Aborigines figure so prominently."[513]

793. Since that time, s 53 of the *Sentencing Act* 1995 (the Sentencing Act) was enacted, which provides as follows:

> *"53. Considerations when imposing fine*
>
> *(1) Subject to Division 1 of Part 2, if a court decides to fine an offender then, in deciding the amount of the fine the court must, as far as is practicable, take into account -*
>
> *(a) the means of the offender; and*
>
> *(b) the extent to which payment of the fine will burden the offender.*
>
> *(2) A court may fine an offender even though it has been unable to find out about the matters in subsection (1)."*

794. However, because s 57 of the Sentencing Act allows for a fine to be enforced under the FPINE Act, the end result is that at present a person may ultimately be imprisoned for failing to pay a court imposed fine, without the direct involvement of a judicial officer at the time of the imprisonment. This is what happened in connection with Ms Dhu's detention and it was in accordance with the applicable legislative provisions.

795. In April 2016, the Inspector of Custodial Services published his Report on Fine Defaulters in the Western Australian Prison System, noting that: "*imprisonment for fine default is currently impacting disproportionately on Aboriginal women, already a vulnerable and disadvantaged group.*"[514]

796. The Inspector's conclusion is supported by statistics that show females are over-represented in the fine defaulter's population, making up approximately 15% of the total prison population yet constituting 22% of the fine defaulter population. Of the female fine defaulters from July 2006 to March 2015, the Inspector found that the majority (64%) were Aboriginal females. However, the inverse was true for males, with 62% being non-Aboriginal, thereby supporting his concern that Aboriginal females appear to be

[513] RCIADIC, Regional Report, Volume 1 [4.2.5.2]
[514] Exhibit 23

particularly vulnerable to resorting to imprisonment to pay off their fines.[515]

797. The Inspector also found that an overwhelming 73% of female fine defaulters were considered unemployed, whilst of the male fine defaulters, only 10% were considered unemployed. By comparing the percentage of unemployed versus employed fine defaulters by gender and Aboriginal status between July 2006 and March 2015, the Inspector concluded that:

a. 52% of Aboriginal unemployed fine defaulters were women; and

b. 57% of non-Aboriginal fine defaulters with employment were male,

thereby supporting his proposition that Aboriginal women are historically the most vulnerable to fine default imprisonment.[516]

798. Following the concurrency provisions, which did not apply to work development orders, the experience has been that fine defaulters serve short stays in prison, with almost 80% serving less than a week, and 22% serving less than 48 hours.[517]

799. The Inspector for Custodial Services' analysis reveals a disturbingly high increase in the number persons being imprisoned for fine default after 2009:

> *"Between July 2010 and June 2015, on average, 1,102 people have entered prison for unpaid fines every year. This compares to only 396 people who entered prison for unpaid fines between July 2008 and June 2009, an increase of over 150%."*[518]

800. It is to be borne in mind that this data does not include the number of individuals taken into custody for fine default by police, as was the case for Ms Dhu.

801. The question must surely be asked: what benefit does the community derive from the incarceration of indigent fine defaulters?

State Government initiatives after Ms Dhu's death

802. The State Government has clearly responded to deaths in custody and the over-representation of Aboriginal people in the justice system in a number of ways. In June 2015, the Justice Ministers'

[515] Exhibit 23
[516] Exhibit 23
[517] Exhibit 23
[518] Page 5

Working Group was established, together with a Senior Officer Group with members drawn from the Justice portfolios and other key Government agencies.[519]

803. The key measures being considered by the Justice Ministers' Working Group have included the following:

> "*Increasing out of court options for low level offenders:*
>
> - *Pre-charge warnings for minor offences;*
> - *Police contracts that suspend a charge against an offender subject to them complying with the contract;*
> - *Expansion of the use of Criminal Penalty Infringement Notices;*
> - *Dealing with selected low level traffic offences as infringement rather than through the court system;*
>
> *Improving the fines enforcement and recovery process:*
>
> - *Changes to the issuance and execution of warrants of commitment and arrest warrants;*
> - *Enhancing the Fines Enforcement process to enable and encourage the uptake of immediate 'Time to Pay' options for Court fines and infringements;*
>
> *Avoiding detention and incarceration of suspects and court remanded prisoners:*
>
> - *Alternative arrangements to remand in custody;*
> - *Police to issue a notice to a suspect requiring them to attend a police station;*
>
> *Introducing and reforming Work Orders as an alternative to incarceration:*
>
> - *Introducing Community Work Orders as an alternative to fines;*
> - *Enhancing the use of Work and Development orders;*
>
> *Reforming sentencing options:*
>
> - *Expanding the use of pre-sentence options to enable greater use of court intervention programs;*
> - *Suspension of fines subject to good behaviour;*
> - *Increasing flexibility for the courts to conditionally suspend imprisonment;*
> - *Introducing a minimum term of imprisonment of three months."*[520]

[519] Exhibit 2, tab 54
[520] Exhibit 2, tab 54

804. In connection with the execution of Warrants of Commitment, the Justice Ministers' Working Group proposes that there be greater flexibility, such as allowing police discretion not to take persons in custody where the person is in ill health, in periods of high frontline response requirements or to make arrangements for a more operationally convenient time for imprisonment or transport. Such flexibility is also sought for when a person is already in custody and circumstances change:

> "*….it is also proposed to allow WA Police the ability to exercise discretion to release a person from custody in certain circumstances. If a person is in custody and a high frontline demand occurs, police require the legislative ability to release a person in order to re-direct resources from custodial care to the frontline. Similarly, if a person is in custody and complains of ill health, police require the ability to release the person to a medical facility for their proper care and treatment. The hours served in police custody could then be deducted from the Warrants of Commitment and any remaining hours/days served at a later time. The Department of the Attorney General is preparing a policy paper for the Attorney General's consideration.*"[521]

805. The obvious challenge for the Justice Ministers' Working Group, in positing this grant of discretion and flexibility in connection with Warrants of Commitment, is to ensure that detainees and prisoners are nonetheless treated in a consistent and equitable fashion when the discretion in exercised across the State.

806. The court was also informed of a range of other initiatives, amongst them being a trial of "*Turning Point*" contracts to divert low level offenders from the justice system. This is a voluntary program where eligible defendants may enter into a four month tailor-made agreement aimed at intervening early and identifying and addressing the drivers of criminal behaviour. A successful completion will result in the withdrawal of the prosecution.[522]

807. I take into account that many of the initiatives are in the planning or trialling stages. They all have merit, as part of a broad inquiry into the ways in which the over-representation of Aboriginal persons in custody may be reduced. However, there is a need to move from the planning to the implementation stage. The sentencing reform for low level offending that was foreshadowed through the Justice Ministers' Working Group is one initiative that is progressing, and is addressed below.

[521] Exhibit 2, tab 54
[522] Exhibit 18

Sentencing Legislation Amendment Act 2016

808. At the time of writing this finding, the *Sentencing Legislation Amendment Act* 2016 (SLA Act) received Royal Assent on 7 December 2016. The main provisions of the SLA Act, in particular within the context of this finding, Part 4, Division 3 of the SLA Act do not come into effect until proclamation.

809. Part 4, Division 3 of the SLA Act introduces a new sentence of "*suspended fine*" into the Sentencing Act, which the court can hand down where the statutory penalty is a fine only (or otherwise prescribed), whether or not the offender is present in court.[523]

810. Section 52 of the SLA Act inserts a new Part 8A into the Sentencing Act, incorporating new sections 60A to 60E that address the operation of the suspended fine provisions. Essentially, a court would be able to suspend a fine for a period of up to 24 months. The offender will not be required to pay any part of that fine unless during the suspension period the offender commits another offence, is brought back before the court, and the court makes a further order as to how the re-offender is to be dealt with.

811. The further options available to the court in sentencing a re-offender under these circumstances are to order the person to pay the suspended fine or any part of it, substitute another suspension period of up to 24 months (unless the suspension period has ended), or make no order in respect of the suspended fine. These powers may be exercised as often as is necessary.

812. The question of whether the re-offender has the means to pay the fine are ultimately addressed, because the court must order the re-offender to pay the fine that was suspended: "*unless it decides that it would be unjust to do so in view of all the circumstances that have arisen, or have become known, since the suspended fine was imposed.*" If the court decides that ordering payment would be unjust, it must provide written reasons.[524]

813. One of the obvious merits is that in the case of a suspended fine, the re-offender is brought back before the court for decision, rather than having the fine enforced through a subsequent executive act. This will mandate the consideration, by a judicial officer, of the re-offender's means to pay the fine at the relevant time, amongst other factors that must be taken into account.

[523] Sections 48 and 51 of SLA Act, amending sections 14 and 44 respectively, of the Sentencing Act
[524] New proposed s 60E(3)and (4) of the Sentencing Act

814. However, under the SLA Act, section 57 of the Sentencing Act remains unchanged. Ultimately therefore, if a fine is not suspended under the new proposed provisions, then it may still be enforced under the FPINE Act, which means that at a later time, Warrants of Commitment may still issue, as they did with Ms Dhu, without the oversight of a judicial officer.

815. The following recommendations are made in order to address the over-representation of Aboriginal persons in custody and, in particular, as the statistics show, the over-representation of Aboriginal females in custody for fine default.

Recommendation 6 – amendments to FPINE Act (specific)

I recommend that the *Fines, Penalties and Infringement Notices Enforcement Act* (WA) (section 53) be amended so that a warrant of commitment authorising imprisonment is not an option for enforcing payment of fines.

Alternatively, that the *Fines, Penalties and Infringement Notices Enforcement Act* (WA) (section 53) be amended to provide that where imprisonment is an option, the imprisonment must be subject to a hearing in the Magistrates Court and determined by a Magistrate who should be authorised to make orders other than imprisonment if he or she deems it appropriate.

Recommendation 7 – alternatives to imprisonment (general)

I recommend that the pending reforms outlined by the Justice Ministers' Working Group concerning the following measures be given a high priority for consideration by Parliament, with a view to providing alternatives to incarceration through legislative reform:

- **Increasing out of court options for low level offenders;**
- **Reviewing processes for incarceration under the fines enforcement and recovery process;**
- **Considering alternatives for avoiding detention and incarceration of suspects and court remanded prisoners;**
- **Introducing community work orders and expanding the use of work and development orders, as alternatives to incarceration.**

TRANSFER OF FINE DEFAULTERS FROM POLICE LOCK-UPS TO PRISONS

816. Ms Dhu was arrested on the afternoon of Saturday 2 August 2014, and she would have been due for release on Tuesday 5 August 2014. The question arose as to why she was detained at the SHPS Lock-Up for the four days, instead of being conveyed to Roebourne Regional Prison, where greater medical care and supervision could potentially have been offered within the custodial setting.[525]

817. At the material time, the Officer in Charge of the SHPS was of the understanding that prisoners who were to serve three days' imprisonment or less in default of payment of warrants were not to be transported to Roebourne Regional Prison, by reason of an instruction that had been issued by the prison's Superintendent in June 2011, being Local Order 68 "*escorts into the prison and warrants*". The exceptions to that instruction related to transportation from Karratha, Roebourne, Wickham or Port Samson. The reason given was that transportation back to the arrest location was not possible within appropriate time frames in most instances.[526]

818. Local Order 68 also stated that there was to be no transportation of prisoners to Roebourne Regional Prison overnight, between 7.00 pm to 6.30 am daily and that no prisoners would be received at any time where they have obvious or documented injuries or medical conditions that are not the subject of a certification document from a hospital or other medical person to state the injuries have been attended to.[527]

819. By the time the first Fitness to Hold Certificate had been issued for Ms Dhu, at approximately 9.30 pm on 2 August 2014, the earliest transportation to Roebourne Prison would have been at 6.30 am on 3 August 2014, and at that point Ms Dhu had less than three days to serve.

[525] Exhibit 4, tabs 56 and 62
[526] Exhibit 4, Tab 46
[527] Exhibit 4, tab 56

820. It transpired that there was confusion as to whether Local Order 68 had been rescinded as at 2 August 2014. Roebourne Regional Prison's Superintendent believed Local Order 68 had been rescinded by email instruction in October 2013. On the other hand, the Officer in Charge of the SHPS believed Local Order 68 was still operative as at 2 August 2014 and acted accordingly, thereby detaining Ms Dhu at SHPS Lock-Up.

821. Statistical information before the court for persons arrested on Warrants of Commitment from October 2013 until after Ms Dhu's death reflects that no prisoners had been detained at the Roebourne Regional Prison for a period of three days or less, until after Ms Dhu's death.[528]

822. I am satisfied that at the material time Mr Bond, the Officer in Charge of the SHPS lock-up was entitled to make the decision to detain Ms Dhu at the Lock-Up pursuant to the Warrants of Commitment and that it was also in accordance with the practice as it was understood at that time.[529] Section 16(7) of the *Prisons Act* 1981 (Prisons Act) allows for a person to serve a period of imprisonment in default of payment of a fine in a lock-up.

823. The detention facilities at Lock-Up were not fit for the purpose of accommodating a detainee who was unwell. Nor were they suitable for longer term detention. Having regard to the configuration of the SHPS, the location of the Lock-Up facilities, and the amenities in the cells, anything other than a very short term detention was undesirable.

824. By way of example, Ms Dhu had complained of sore ribs and sore bones, and she spent two nights on a mattress (90cm x 11cm x 185cm) on a concrete floor, with a pillow and blanket if required, and with the lights on throughout the night.[530] This is hardly suitable for a detainee who is unwell and needs to recover, let alone Ms Dhu who was gravely ill.

825. At the inquest, Assistant Commissioner Bell informed the court that whilst the SHPS Lock-Up was deemed suitable for detaining persons for longer than 24 hours, ideally persons ought not to be detained in any police lock-up for longer than 24 hours (save for the Perth Watch House where different considerations apply). The primary purpose of a lock-up is to detain persons overnight, in order for them to appear in court the next day.[531]

826. Assistant Commissioner Bell addressed the high level discussions that were had with the Department of Corrective Services regarding

[528] Exhibit 4, tab 56
[529] ts 1848
[530] Exhibit 2, tab 54.1; Exhibit 3, tab 17
[531] ts 1848 - 1851

the cessation of their practice of not accepting regional prisoners who have less than three days to serve in custody. He informed the court that a resolution was reached with respect to detentions between Monday and Friday; these persons will be transferred to the regional prison, even if they have one day to serve in custody.[532]

827. However, if a person is arrested by police on a Warrant of Commitment on a weekend, say a Saturday, then the evidence at the inquest reflected that that person will still not be transferred to the prison until the Monday. Assistant Commissioner Bell explained that the Justice Ministers' Working Group has considered options, such as seeking a discretion not to enforce Warrants of Commitment on a weekend, and/or a discretion not to continue the detention of a person on a weekend where say, a staff member of a medical facility had advised that a detainee, although unwell, does not require hospitalisation.[533]

828. The IAU recommended that persons in custody that are to be held for periods longer than overnight should, where possible, be escorted to a correctional facility where greater medical care and supervision can be offered. A joint project was established to examine restricting police detention for warrants to a maximum of four to eight hours in circumstances where transport time does not exceed detention time. These considerations are ongoing.

829. It remains undesirable to hold a person in detention at a regional lock-up over a weekend, particularly where that person has sought or required some form of medical attention. It is to be borne in mind that the Warrants of Commitment are addressed to all members of the Police Service of Western Australia (in contemplation of the arrest) and to the Chief Executive Officer under the Prisons Act (in contemplation of the imprisonment). The matter of the conveyance of the prisoner requires a resolution.

830. The Commissioner of Police through his counsel agrees that detainees should not be kept in regional lock-ups for any more than 24 hours and informs the court that discussions are continuing with the Department of Corrective Services with a view to entering into arrangements to ensure that detainees are moved into their care are soon as possible.

831. The Commissioner, Department of Corrective Services informs the court that the Court Security and Custodial Services Contractor is required to clear police lock-ups in hub locations within 24 hours and transfer those persons in custody to the nearest receiving

[532] ts 1850
[533] ts 1851

prison. Under the existing processes, people in metro area, outer metro area and regional hubs are not detained in police lock-up for longer than 24 hours and in most instances are transported to the receiving prison on the day of apprehension. The Western Australia Police Service are responsible for transporting persons in custody to other lock-ups to the nearest agreed hub lock-up.[534]

832. The Commissioner, Department of Corrective Services also quite properly points out that if transporting the person is likely to result in the person being kept in custody for longer than their total detention period, transport may not be considered a reasonable course of action.[535]

833. On balance, I incline towards the recommendations outlined in the IAU's joint project proposal and supported by the Aboriginal Legal Service of WA (ALS). This proposal manages the timing considerations, and balances them with the use of the lock-up and transportation time and I make the following recommendation:[536]

Recommendation 8 – transport to nearest prison

I recommend that fine defaulters, if incarcerated pursuant to a Warrant of Commitment, should be transported to the nearest prison within four to eight hours of their arrest, where the transport time does not exceed the detention period.

ABORIGINAL VISITOR'S SCHEME

834. The Western Australia Police Service and Department of Custodial Services have developed the Aboriginal Referral Scheme, whereby detainees in police metropolitan and regional lock-ups, and the Perth Watch House, who self-identify as being Aboriginal (the Aboriginal detainees) can have access to staff from the Aboriginal Visitors Scheme (AVS). In February 2016, in line with the IAU recommendations, it was expanded to a 24 hours a day, seven days a week telephone support service for Aboriginal detainees and their families. It is managed by the Department of Corrective Services.[537]

[534] Exhibit 24
[535] Exhibit 24
[536] Exhibit 4, tab 62.1
[537] Exhibit 4, tab 62.1; Exhibit 18

835. The processes for the usage of the AVS are now contained within the Lock-Up Manual, LP-02.01. The purpose of the AVS is to provide additional health and welfare support to Aboriginal detainees. The AVS does not provide legal advice. Nor is the AVS presently able to visit all places of detention across the State. It is primarily a telephone service. The telephone call is initiated by the Officer in Charge or Shift Supervisor, who will request a return telephone call at an agreed time so that the Aboriginal detainee can speak to a member of the AVS team.[538]

836. An Aboriginal detainee is to be given a reasonable amount of time to speak with the AVS member, and at the end of the conversation, the AVS member will outline any welfare concerns or other relevant issues that they may have in relation to that detainee. All relevant details of contact and response from AVS are to be recorded on the Custody system.[539]

837. Further, the Western Australia Police Service and the ALS Detainee Advice Accord requires, with the approval of the individual, that whenever an Aboriginal person is charged, police officers must advise their local office of the ALS.[540] It is to be borne in mind that this Accord would not have applied to Ms Dhu's situation, as she was detained under Warrants of Commitment and not charged with any offence.

838. The question arises as to what extent it is desirable to mandate that the AVS or the ALS be contacted, irrespective of the wishes of an Aboriginal detainee. At present, contact with the ALS is mandated when charges are laid, subject to the approval of the individual. Contact with the AVS is mandated whenever an Aboriginal detainee requests it. Other contact with the AVS is governed by the following:

a. where an Aboriginal detainee is expected to be in custody for six hours or longer, the detainee is to be asked if they wish to have the AVS notified of their detention, and if so, to be put in contact with the AVS;

b. irrespective of an Aboriginal detainee's request or consent, the AVS must be contacted in circumstances where the detainee is at risk of self-harm; and

[538] Exhibit 17.4; Exhibit 4, tab 62.1: currently AVS provide daily visitations to the Perth Watch House and have a call out facility should they be required in urgent situations, but there is great variance of availability throughout the State.
[539] Exhibit 17.4
[540] Exhibit 17.4

c. irrespective of an Aboriginal detainee's request or consent, the Officer in Charge or supervisor may notify the AVS if he or she believes it is in the best interests of an Aboriginal detainee.[541]

839. Despite these improvements, there may still be instances where an Aboriginal detainee may benefit from contact with the AVS, but may not feel comfortable making the request, and/or there remains a risk that police may not be proactive in making the requisite contact with AVS.

840. The IAU had recommended that the AVS and/or an APLO be contacted as soon as practicable after an Aboriginal person is detained in a lock-up.[542]

Recommendation 9 – mandated contact with AVS

I recommend that a policy be introduced by the Western Australian Police Service that requires the police to contact by telephone the Aboriginal Visitors Scheme once a decision has been made to detain an Aboriginal offender in a police lock-up. In addition, any APLO attached to the station should also be made aware by police that they may contact the Aboriginal Visitors Scheme at any time on behalf of a detainee.

Furthermore, once a decision has been made to take an Aboriginal detainee for medical treatment, contact by telephone must be made by the police to the Aboriginal Visitors Scheme advising it of that fact, the name of the detainee and which hospital or medical treatment facility the detainee is being taken to.

841. Ms Dhu's family, through their counsel, submit that a Custody Notification Service (CNS) based upon the current model in New South Wales, be established in Western Australia, and attach material concerning the CNS to their submission, though it is not before me as an Exhibit. The New South Wales CNS is operated by ALS (NSW/ACT) and provides a lawyer operated telephone service 24 hours per day, seven days per week. It is a combined legal and

[541] Exhibit 18
[542] Exhibit 4, tab 62.1

welfare telephone service, and the requirement for police to notify the ALS is mandated by legislation.[543]

842. I have taken account of the evidence concerning the difficulties that have been experienced in staffing the AVS with persons who are able to visit lock-ups in regional areas. As a result the initial concept was changed to make the AVS available in regional areas as a telephone service.[544]

843. I have also noted the information provided to me by way of submission from counsel for Ms Dhu's family, to the effect that since the introduction of the CNS, there have been no deaths of Aboriginal persons in police cell custody in that jurisdiction.

844. Sadly, Ms Dhu did not have anybody who was in a position of independence, to advocate for her welfare. There is insufficient evidence before me concerning the impact of a CNS based upon the New South Wales model, for Western Australia, in order to avoid deaths arising in similar circumstances.

845. However, the matter has been the subject of some consideration, which remains ongoing. The applicability of the CNS model to Western Australia was foreshadowed in the IAU recommendations.[545] The court was also informed that the expansion of the AVS scheme through the recommendations of the Justice Ministers Working Group was modelled on key aspects of the CNS, but that it goes further to provide access to concerned family and community members.[546]

846. A primary difference between the AVS and the CNS is that the latter is staffed by lawyers and operated by the ALS in that jurisdiction, an agency that is independent of the police and/or corrective services. On the information before me I am not presently persuaded that the AVS is modelled on key aspects of the CNS.

847. The introduction of a CNS, not to replace, but to operate alongside the AVS is a matter that warrants further consideration, particularly having regard to the differences between the two services.

[543] *Law Enforcement Powers and Responsibilities Act* 2002 (NSW)
[544] ts 1898
[545] Exhibit 4, tab 62.1
[546] Exhibit 18

Recommendation 10 – consideration of a CNS

I recommend that the State Government gives consideration as to whether a state-wide 24 hours per day, seven days per week Custody Notification Service based upon the New South Wales model ought to be established in Western Australia, to operate alongside and complement the Aboriginal Visitors Scheme.

THE SOCIAL DETERMINANTS OF ILL HEALTH

848. At the inquest I received evidence from Professor Sandra Thompson, Director of the Western Australian Centre for Rural Health at the University of Western Australia, concerning the general factors related to the health of Aboriginal persons, and specific factors as they applied to Ms Dhu's health.

849. Ms Dhu was a very young woman. In order to look at Ms Dhu's life and death within its proper and true context, regard must be had to the historical factors that ultimately coalesced to place her at greater risk of ill health and interaction with the justice system.

850. Professor Thompson described the historical factors as follows:

> "*Aboriginal people have historically experienced violence, exclusion, discrimination and separation from family as a result of historical policies and circumstances. The repercussions of past practices are profound, crossing generations. The legacy of these live on, remain in the minds of Aboriginal people and is part of their ongoing everyday experience.*"[547]

851. Professor Thompson addressed the much higher likelihood of social disadvantage generally experienced by Aboriginal persons, that inevitably impacts profoundly upon their health. She described a constellation of multiple difficulties that distinguish Aboriginal disadvantage and that underpins their diminished wellbeing and lower life expectancy.[548]

852. In Professor Thompson's experience, matters such as lower year 10 and year 12 completion rates, lower post-secondary education participation and attainment, lower labour force participation, lower household and individual income, lower home ownership and higher rates of homelessness result in a level of social disadvantage

[547] Exhibit 4, tab 60
[548] Exhibit 4, tab 60

of which susceptibility to illness is but one of the manifestations. Another is a greater rate of imprisonment.[549]

853. Professor Thompson assessed Ms Dhu's susceptibility to her acute infection from the perspective of the social determinants of ill health (as well as in relation to the proximate causes). The social determinants can result in life stressors that are overwhelming. People can seek to cope with stress in different ways. Taking illicit drugs is a particularly destructive and inevitably futile coping strategy. I am satisfied that Ms Dhu's infection was most likely triggered by bacteria that entered her bloodstream when she injected herself with amphetamines. Lower socioeconomic status is a known risk factor for staphylococcal infection.[550]

854. In Professor Thompson's experience, Aboriginal persons experience a substantially higher frequency of soft tissue and invasive infections and that while invasive staphylococcal infection is generally higher in males than females, mortality from this condition has been reported to be substantially higher in females than males.[551]

855. Professor Thompson noted that although Ms Dhu had no history of multiple infections such as would suggest she was immune compromised, amphetamine usage can seriously compromise the immune system and thereby reduce the body's natural ability to defend itself against infections.[552]

856. In her report Professor Thompson proffered reasons as to why someone in Ms Dhu's position was at risk and she identified them as follows:

> *"In summary and with the benefit of hindsight, it is clear that there are many ways in which Ms Dhu was at risk; her Aboriginality and lack of resources, her age and inexperience at negotiating for help, her injecting drug use that is a risk factor for septicaemia, her living conditions, which increase her risk for staph infections, her Aboriginality and injecting drug use that mean she may be treated less well within mainstream institutional settings...."*[553]

857. Professor Thompson described the societal patterns that lead to particular negative impacts, such as being treated less well, as "*institutional racism*":

[549] Exhibit 4, tab 60
[550] Exhibit 4, tab 60
[551] Exhibit 4, tab 60; ts 163
[552] Exhibit 4, tab 60; ts 161
[553] Exhibit 4, tab 60

> *"Institutional racism refers to societal patterns that have the net effect of imposing oppressive or otherwise negative conditions against identifiable groups on the basis of race or ethnicity. Institutional racism is manifested in our political and social institutions and can result in the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin."*[554]

858. Ms Dhu's family, through their counsel submit to me that the approach taken to Ms Dhu by some of the medical professionals at HHC and in turn the quality of treatment received by her was illustrative of the institutional racism discussed by Professor Thompson. They submit that it has nothing to do with the subjective or conscious deliberation of the particular staff, but societal patterns that lead to assumptions being made in relation to Ms Dhu's presentation and her own motivations.

859. I do not find that any of the HHC staff or police were motivated by conscious deliberations of racism in connection with their treatment of Ms Dhu, nor does Ms Dhu's family make that submission. It is important to be clear on this point.

860. However, it would be naïve to deny the existence of societal patterns that lead to assumptions being formed in relation to Aboriginal persons. This is not a matter only for HHC, or its staff or the police. It is a community wide issue and until there is a seismic shift in the understanding that is extended towards the plight of Aboriginal persons, the risk of unfounded assumptions being made without conscious deliberation continues, with the attendant risk of errors.

861. Very tragically, the social determinants of ill health of Aboriginal persons were borne out in Ms Dhu's life and in the sequence of events that led to her untimely death.

862. Professor Thompson opined that regular monitoring in a hospital setting would have identified Ms Dhu's deterioration earlier because health staff members are trained to identify the deteriorating patient.[555] Unfortunately Ms Dhu was not admitted into the HHC as a patient, so there was no close and ongoing monitoring over a period of time in the emergency department. Professor Thompson also quite rightly observed that it is not realistic to expect custodial staff to monitor regularly and interpret pulse, temperature, respirations and blood pressure.[556]

863. The police at the Lock-Up relied primarily on the two Fitness to Hold Forms issued by the HHC doctors in relation to Ms Dhu. The

[554] Exhibit 4, tab 60; ts 184
[555] Exhibit 4, tab 60
[556] Exhibit 4, tan 60

HHC medical advice was affected by premature diagnostic closure. The police were affected by preconceptions or assumptions concerning Ms Dhu. In order to assist in better recognising the risk factors for persons in custody, including Aboriginal persons who may be at greater risk of ill health, and breaking down preconceptions or unfounded assumptions, I make the following recommendations, having regard to Professor Thompson's review:

Recommendation 11 – greater monitoring

I recommend that the lock-up procedure manual be amended to make reference to the following in relation to the care of detainees:

- **A greater degree of regular monitoring should be provided to any detainee complaining of severe symptoms that necessitate repeated hospital attendances within a short space of time;**
- **New or changing symptoms in an unwell detainee may signify deterioration warranting medical review;**
- **Drug and alcohol use are risk factors for serious illness, and can both mimic and obscure the symptoms of serious illness; and**
- **A person found to be unconscious or not easily rousable whilst in police custody must be immediately conveyed to hospital by ambulance.**

RELEASE OF CCTV

864. On 28 September 2016 as part of this inquest I heard submissions from Ms Dhu's family in support of their applications for the release of the CCTV footage to the media. Counsel for various media organisations, Mr McCarthy, Mr Elliott and Mr Grant had leave to appear and I heard their submissions in support of their applications for release of the CCTV footage. Counsel for the interested persons made submissions.

865. I have taken account of the wishes of Ms Dhu's family, and the submissions made by all counsel on this matter.

866. Counsel for Mrs Carol Roe and Ms Della Roe submitted that the CCTV footage in Exhibits 5, 6, 9 and 11 be released to the media, in the public interest and consistent with their wishes. They did not seek any redactions to the footage.

867. Counsel for Mr Robert Dhu also submitted that the CCTV footage in Exhibits 5, 6, 9 and 11 be released to the media, in the public

interest and consistent with his wishes, but Mr Robert Dhu sought a redaction of the footage of Ms Dhu's final day outside and inside the HHC on 4 August 2014.

868. Counsel for Mr Robert Dhu also submitted that the release of the CCTV footage to the media (with the redaction) is the most powerful and effective way to honour Ms Dhu's memory.

869. Counsel for Mrs Carol Roe and Ms Della Roe and counsel for Mr Robert Dhu informed the court there is no disrespect to Ms Dhu in releasing the CCTV footage in the public domain (subject to the redaction sought in Mr Robert Dhu's case).

870. Counsel for Mr Ruffin supported the family's applications for the release of the CCTV footage to the media.

871. I have found that Ms Dhu most likely went into cardiac arrest while she was outside the HHC on 4 August 2014. I accept Mr Dhu's submission through his counsel that releasing this portion of the CCTV footage is a step across the line between the importance of Ms Dhu's legacy and disrespect.

872. I release the CCTV footage in Exhibits 5, 6, 9 and 11 to the media applicants in order to assist with the fair and accurate reporting of my findings on inquest, save for the footage of Ms Dhu outside and inside HHC on 4 August 2014. It is not in the public interest to release that portion and it is redacted from Exhibits 5 and 9. The transcript to assist with the fair and accurate reporting is also released.

873. I direct that media organisations pixelate in full all persons appearing on any of the CCTV footage, other than Ms Dhu and the police officers.

CONCLUSION

874. Ms Dhu was a dearly loved by her family and her death has left them heartbroken.

875. In April of 2014 she suffered a right 10th and 11th rib fracture after her partner threw her to the ground in the course of an altercation. Unfortunately the right 10th rib fracture did not ever heal properly and with the passage of time, and possible re-fracturing, it became infected.

876. The infection entered her bloodstream on one or more occasions when Ms Dhu injected herself with amphetamines. Her skin was likely breeched on multiple occasions with a needle, allowing the staphylococcus aureus (bacteria) that normally live on the skin to

enter the bloodstream. The infection subsequently lodged at the site of the 10th rib fracture, and Ms Dhu developed osteomyelitis.

877. Her immune system was unable to fight the infection. It progressed from a local bone infection to involve the adjacent tissues and then subsequently spread to cause septicaemia. By 3 August 2014 it was likely that Ms Dhu's sepsis was well established. On 4 August 2014 Ms Dhu developed septic shock, lost consciousness and tragically died.

878. On 2 August 2014 Ms Dhu had been arrested and detained at the Lock-Up pursuant to a number of Warrants of Commitment in respect of unpaid fines amounting to $3,662.34. She complained of rib pain and was escorted to HHC by police at approximately 9.15 pm for medical assessment. On this presentation Ms Dhu did not manifest signs of an infection, and she was discharged into the custody of police. On this presentation antibiotics would have been life-saving for Ms Dhu, but there was no basis for prescribing them to her. Unfortunately however, the treating doctor's discharge diagnosis was that Ms Dhu had "*behaviour issues*".

879. On 3 August 2014 Ms Dhu was again escorted to HHC by police at approximately 5.00 pm for medical assessment. On this presentation Ms Dhu did display some signs of infection. Unfortunately, whilst a number of investigations were undertaken, Ms Dhu's temperature was not taken, a chest X-ray was not performed, and her tachycardia was not properly taken into account. On this presentation, antibiotics would have been potentially life-saving for Ms Dhu. Errors were made and there was a missed opportunity to treat Ms Dhu for her infection at her presentation on 3 August 2014. Regrettably, Ms Dhu was discharged into the custody of police and the treating doctor's discharge diagnosis was to the effect that he queried whether she was withdrawing from drugs and that she had "*behavioral issues*". Her treatment and diagnosis at HHC was affected by premature diagnostic closure.

880. Ms Dhu's life-threatening infection continued to progress and the police responsible for her care at the Lock-Up, particularly on 4 August 2014 thought she was feigning her symptoms. As the morning progressed and she continued to suffer a catastrophic decline in her health, the behavior towards her by a number of police officers was unprofessional and inhumane. Their behaviour was affected by preconceptions they had formed about her.

881. Whilst Ms Dhu's established septicaemia was probably far advanced and potentially irreversible, giving her only a slim chance of survival on the morning of 4 August 2014, she ought to have been afforded every reasonable and proper opportunity for medical

assistance and an ambulance ought to have been called by the police that morning.

882. By the time Ms Dhu was escorted to HHC at approximately 12.40 pm on 4 August 2014, her prospects of survival were grim. Despite maximal attempts at resuscitation, Ms Dhu tragically died.

883. It is profoundly disturbing to witness the appalling treatment of this young woman at the Lock-Up on 4 August 2014. In her final hours she was unable to have the comfort of the presence of her loved ones, and was in the care of a number of police officers who disregarded her welfare and her right to humane and dignified treatment.

884. It is my hope that the recommendations I have made will avoid deaths occurring in similar circumstances. It is my expectation not to see such treatment of a person held in custody again.

R V C FOGLIANI
STATE CORONER
15 December 2016