IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 002480

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ANTHONY WILLIAM DUNNING

Delivered On:	27 March 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Victoria 3006
Hearing Dates:	30 September 2014
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr A Pillay of Counsel, instructed by Ms D Ioannou of Maurice Blackburn, appeared on behalf of the family Mr N Clelland QC and Mr G Livermore of Counsel, instructed by Ms G Carosi of K&L Gates, appeared on behalf of Crown Melbourne Limited
Police Coronial Support Unit	Leading Senior Constable G McFarlane, assisting the Coroner.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of ANTHONY WILLIAM DUNNING

AND having held an inquest in relation to this death on 30 September 2014

at Melbourne

find that the identity of the deceased was ANTHONY WILLIAM DUNNING

born on 19 June 1971

and the death occurred 7 July 2011

at The Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004

from:

I (a) GLOBAL ISCHAEMIC BRAIN INJURY FOLLOWING CARDIORESPIRATORY ARREST DURING PRONE RESTRAINT (INCLUDING PRESSURE ON THE NECK) OF AN OBESE MALE WITH CARDIOMEGALY

in the following circumstances:

Summary

1. Mr Anthony Dunning was a 40-year-old man who lived alone in Ferntree Gully. He was single, did not have any children and was employed as a labourer.

2. On 3 July 2011, Mr Dunning spent the evening at the Crown Casino in Melbourne with his friend, Mr Matthew Anderson and Mr Anderson's partner, Ms Olivia Fergusson. All three had spent the afternoon at the football before arriving at the Casino at around 6.00pm.

3. The three friends spent the majority of the evening gambling and drinking alcohol. At around 10.30pm, Mr Anderson and Ms Fergusson left Mr Dunning and attended at the food court. Upon their return to the gaming floor, Mr Dunning was in the company of Crown Security and Service Officers.

4. By 10.43pm, Mr Dunning had spent approximately four and a half hours gambling and drinking alcohol. He was standing on the gaming floor of the Crown Casino outside the 'Velvet Bar' with his mobile phone in his hand.

5. Shortly afterwards he was asked to leave by Security Officer (SO) Matthew Lawson. Mr Dunning walked towards the exit accompanied by SO Lawson and two other SOs. Before reaching the exit, Mr Dunning and the security staff encountered Mr Anderson and Ms Fergusson. After an apparently heated verbal exchange, Mr Dunning began walking towards the exit. He was followed by Mr Anderson and Ms Fergusson. There was a confrontation between Ms Fergusson and SO Quoc Tran. Ms Fergusson was brought to the floor, as was Mr Anderson shortly afterwards.

6. At this time, SO Cameron Sanderson and SO Christian Luta were accompanying Mr Dunning to the exit. When Mr Dunning saw what had happened behind him, he turned towards Mr Anderson and Ms Fergusson but was shuffled towards the door. He then attempted to push past SO Sanderson and was grabbed by SO Sanderson and SO Luta. SO Lawson then took Mr Dunning to the floor by grabbing him around the legs. SO Lawson straddled Mr Dunning and sat on his torso. He placed his arms around the head and neck of Mr Dunning.

7. SO Sanderson was restraining Mr Dunning's left arm while his right arm was pinned under his body. SO Luta attempted to remove the right arm but was told by SO Lawson not to intervene. SO Benjamin Vigo then moved towards Mr Dunning's right hand side. SO Lawson lifted Mr Dunning's weight off his right arm allowing SO Vigo to remove it and restrain him. Crown Casino patrons were gathered in the area. One observed Mr Dunning's face turning blue and advised security staff that they were 'choking him'. Another believed that Mr Dunning's head was buried in the carpet and should be turned to the side and said so.

8. The security officers restrained Mr Dunning by the arms, SO Lawson let go of his neck and got off his torso. When he did this, Mr Dunning had been restrained on the floor and held around the neck for approximately seventy seconds. By this point in time, there was no apparent voluntary movement from Mr Dunning. He was held down while handcuffs where requested by security staff. They were brought to the scene and his hands were placed behind his back and secured. As this occurred, SO Daniel Moussi alerted other officers that Mr Dunning was unconscious. This occurred approximately four minutes and ten seconds after Mr Dunning was first taken to the ground. He was then rolled onto his side with his hands still behind his back and his face appeared to be blue. He continued to be restrained by the arms and legs during this time.

9. After a further two minutes, first aid was administered to him and an ambulance was called. Mr Dunning was taken to The Alfred Hospital where he was placed on life support. Mr Dunning's condition was not survivable and life support was discontinued on 7 July 2011. Mr Dunning was confirmed deceased at 4.20pm the same day.

10. The above events at Crown Casino were fully captured by CCTV cameras.

11. As the submission by Crown Melbourne Limited (Crown) has pointed out, a feature of the inquest was that it was preceded by an extensive Victoria Police investigation resulting in

three Crown security officers being charged in connection Mr Dunning's death. All three were acquitted by a Supreme Court jury.

Purpose of a Coronial Investigation

12. This finding is based on the totality of the material the product of the coronial investigation of Mr Dunning's death. That is, the brief of evidence compiled by the Coroner's Investigator Sergeant Paul Rowe, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions. All of this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Findings as to uncontentious matters

13. In relation to Mr Dunning's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that Anthony William Dunning, born on 19 June 1971, aged 40, died at The Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004, on 7 July 2011.

14. There is no dispute about the cause of death, but I will deal with the medical evidence in greater detail later.

Inquest Scope

15. I set the scope of the inquest by letter to the interested parties dated 28 April 2014 as follows:

    (a) the training of security guards employed by Crown

    (b) the role Crown played in their training

    (c) the control of security guards at Crown

    (d) reviewing guidelines for Crown's policy for restraint of patrons.

16. The evidence at inquest was limited to these issues. The events at Crown Casino had been comprehensively canvassed by a large number of witnesses who gave evidence at the Supreme Court trial between 8 October and 16 November 2012. At that trial, SOs Lawson, Sanderson and Vigo were all acquitted of criminal offences.

17. The witnesses at inquest were:

- Mr William Dunning, father of the deceased
- Sergeant Paul Rowe, Coroner's Investigator (CI)
- Mr Xavier Walsh, Chief Operating Officer at Crown.

18. The issues within scope were dealt with primarily by Crown calling Mr Walsh to respond to the matters raised by Mr William Dunning in his statement and his oral evidence.

19. One further issue arose: whether policies, protocols or practices existed governing Victoria Police attendances at Crown Casino. The CI was requested to make further enquires on this point in response to evidence of an agreement that police would not attend Crown Casino unless called. Victoria Police advised that '*Victoria Police does not have any agreement or Memorandum of Understanding or the like in place with Crown Casino*'.[1] In addition, neither the Chief Commissioner nor his delegate has issued any instruction or policy in relation to police attendance at Crown Casino.[2]

The evidence at inquest

20. Mr William Dunning read his statement.[3] The first issue he raised was the use of the CCTV footage at the inquest. He believed that the CCTV '*puts the complete circumstances surrounding Anthony's apprehension and death into proper context*'.[4] He also stated that he believed the footage illuminated a number of the issues within the scope of the inquest, relating to training and behaviour of the security staff employed by Crown on the evening of 3 July 2011. The CCTV footage was played in full at the inquest.

21. The Dunning family submitted that the key issue within the scope of the inquest was deficiencies in the training and practical application of that training by security personnel employed at Crown, given that the restraint of Anthony Dunning on the ground was against specific training provided to Crown security personnel.

22. The family submitted[5] that

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[1] Letter from Supt Derek Lamb, Victoria Police Civil Law Division dated 26 March 2015.

[2] Ibid.

[3] Exhibit 1, statement of Mr William Dunning dated 25 September 2014.

[4] Ibid page 1.

[5] Submissions of the Dunning family, pages 2-3.

- The placing of an arm around the neck of Mr Dunning and pulling back was conceded to be a technique that Crown personnel were not trained in.[6]
- The placing of the weight of SO Lawson upon the back of Mr Dunning when he was lying prone was something that was to be avoided according to Crown training.[7]
- There was a failure to consistently monitor Mr Dunning to ensure that his vital signs were stable such that it could be immediately noticed if he slipped into unconsciousness and remedial medical attention given. He was held about the neck and restrained for some 70 seconds and only after four minutes of restraint whilst prone on the ground, was he rolled over.

23. The family submitted that the seven security guards were acting contrary to their training and that this indicated a major failing in the training of Crown security personnel and in the application of their training at the time of Mr Dunning's attendance at Crown.[8] The family stated that whilst the training manuals given to security personnel are now adequate,[9] the failure to abide by the training when staff are called upon to deal with patrons (as set out above), showed a failure to ensure that security personnel are properly trained, in the sense that it showed that they had not properly understood their roles and obligations even after that training. The family submitted that there was a culture of wilful disregard for the training that allowed security personnel to feel able to act in the manner in which they did.[10]

24. The Dunning family submission also addressed what was described as excessive use of force against Ms Fergusson and Mr Anderson on the same night, in the context of the same incident. Apart from noting that submission and noting that these incidents appear on the CCTV footage (which was the central evidence at inquest), this matter was raised to support the proposition that there was a permissive culture on the part of Crown in relation to the use of force by its security officers.[11]

25. In relation to the treatment of both Mr Anderson and Ms Fergusson, I note the submission by Crown on the point.[12] There was a concession by Mr Walsh that it is '*arguable*'[13] that SO

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[6] Inquest transcript, page 43.

[7] Ibid pages 43 and 54.

[8] Submissions of the Dunning family, page 3.

[9] See Exhibit 10, expert opinion of Dr David Wells dated 25 September 2014.

[10] Submissions of the Dunning family, page 4.

[11] Ibid pages 2-3.

[12] Submissions of Crown Melbourne Limited, page 10.

Tran used disproportionate force when responding to being assaulted by Ms Fergusson, and arguable that security officers used disproportionate force when taking Mr Anderson to the ground.

26. I agree with the Crown submission to the effect that these appear to be clear instances of non-compliance with training rather than evidence of a '*lack of training*'[14], but I do not agree that they do not point to a '*culture of wilful disregard for training and procedures*'.[15] In my opinion, having viewed the video footage, both of these events (Mr Anderson and Ms Fergusson) appear to be instances of disproportionate force being used by Crown staff. This would suggest a '*culture of wilful disregard for training and procedures*' as was submitted by the Dunning family. On the evidence the training and licensing regimes applicable to security officers at Crown were generally sound, and were tightened and improved after Mr Dunning's death. But as the Dunning family put it, it is a question of behaviour and compliance.

27. The Dunning family submission also deals with the actions of SO Lawson on 20 June 2011 involving another Crown patron, Mr Evan Koka.[16] This issue is strictly outside the scope of this inquest and I note Crown's submission on the point. The Dunning family asserts that the Lawson/Koka incident and Crown's assessment that Mr Lawson had not done anything wrong '*is demonstrative of a permissive culture of overly aggressive behaviour by security personnel.*'[17] Mr Walsh, on behalf of Crown, did not accept this assertion, and Crown contends strongly that there was no such permissive culture.

28. Having considered the CCTV footage, and having reviewed the submissions, in my view it is reasonable to conclude that the behaviour of the security officers on the night was demonstrative of an attitude that strict compliance with training and procedures was not necessary, and that a failure to comply would not necessarily be sanctioned. In other words, there appears to have been a permissive attitude towards the use of force 'outside training' as conceded (in a qualified way) by Mr Walsh, in relation to the restraining of Ms Fergusson and the holding of Mr Dunning around the neck. Crown argues that I should not conclude that there was such a permissive approach or culture. However, I infer from the actions on

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[13] Inquest transcript, pages 74 ff.

[14] Submissions of Crown Melbourne Limited, page 10.

[15] Ibid.

[16] Submissions of Crown Melbourne Limited, page 4.

[17] Submissions of the Dunning Family, page 4.

the night that in the absence of a degree of permissiveness, these officers would not have conducted themselves in the way they did unless it was likely that sanctions would not follow breaches, knowing that their actions were captured on CCTV. The conclusion I reach is that they did not believe that sanctions would necessarily follow from non-compliant behaviour on their part. To this extent the family submission is well founded – there does appear to have been a '*permissive*' culture, a tolerance, of '*overly aggressive behaviour*' by the security guards who were present.

29. The question is therefore whether such a culture has been corrected, what steps have been taken to reinforce expectations and obligations, and what changes have been made to training to security staff and in what ways.

30. On this issue, the evidence of Mr Walsh was helpful and comprehensive. He did not accept that there was a culture of noncompliance, but detailed the 'enhancements' made to training and documentation of procedures since Mr Dunning's death.

31. Dr Wells was asked to review Crown's Tactical Options Model Training Manual insofar as it concerned medical risks arising from methods of restraint. His report was thorough.[18] None of it was challenged in detail at the inquest as being in and of itself inadequate, insufficient, out of date or lacking credibility.

32. The evidence of Mr Walsh was that changes were made after Mr Dunning's death. He referred to the review by Dr Wells of the 36 volumes of procedures and manuals applicable to the tactical options model operations utilised by Crown and set out in their manuals. Dr Wells assessed the material relating to medical risks arising from methods of restraint, including the shut down technique and the risks of positional asphyxia. In his opinion that the material he reviewed is '*comprehensive, well drafted and satisfactorily identifies all of the key medical issues concerning the shutdown technique and positional asphyxia*'.[19] The manual was tendered at inquest. I accept Dr Wells' assessment and his evidence generally.

33. Mr Walsh stated that after Mr Dunning's death, Crown examined its training, policies and procedures to determine whether they could be 'enhanced' by way of *'articulating and re-emphasising and reinforcing the risks associated with positional asphyxia'*[20] that can arise

[18] Exhibit 10, statement of Dr David Wells, Victorian Institute of Forensic Medicine, dated 25 September 2014.

[19] Ibid page 1.

[20] Inquest transcript, page 114.

from using the shutdown position, and the need to employ best practice and exhaust all other options before using physical force.

34. According to Mr Walsh, Crown regarded it as crucial for the organisation to query whether it had done everything possible to ensure that its training was as good as it could be, in particular, training with respect to preventing positional asphyxia, and ensuring that if it is not safe or appropriate to have the patron come to their feet, officers could roll them onto their side. This direction/advice was not contained in previous training material.[21]

35. I accept Mr Walsh's evidence on each of these matters. It follows that I accept the proposition advanced by Crown that there is no need for a recommendation for further amendment or 'enhancement' of their security procedures or the training requirements underpinning them.

36. From the family's point of view, the most critical aspect of training is that officers dealing with patrons fully understand the risks of a shutdown procedure, the risks of positional asphyxia and the need to roll persons onto their side as quickly as possible.

37. Mr Dunning was restrained on the floor at 10.47pm. He was held in that position of restraint until 10.51.13pm. During those four minutes, he lost consciousness. A viewing of the video makes it clear that he was motionless on the floor. Mr Walsh conceded this from his viewing of it.[22]

38. On Mr Walsh's evidence, and on the viewing of video, it is clear that there was not an attempt to reposition Mr Dunning after he had been restrained in a prone position. He was not rolled over and remained motionless. Whether officers were endeavouring to communicate with him or not, this was inherently risky. Mr Walsh's evidence was that he thought that the addition to the manual reminding officers to reposition from the prone position as soon as practicable had come about as a result of Mr Dunning's death. This is a positive development. It cannot be over emphasised that guards, security officers and others need to fully understand that positional asphyxia can occur when a person is restrained or 'shut down' in a prone, face down position. Crown should routinely reinforce in training the risk of positional asphyxia and the appropriate means of mitigating that risk (rolling patrons onto their side if they are on the floor).

[21] Inquest transcript pages 113-5.

[22] Ibid pages 118-20.

39. It is important to state as a matter of balance, perspective and fairness, that three Crown security officers were charged in connection with Mr Dunning's death and acquitted by a jury. It is also important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or may be guilty of an offence.[23]

40. I now turn to the medical evidence.

Medical cause of death

41. After the incident, Mr Dunning was taken to The Alfred Hospital, where he died on 7 July 2011. Ante mortem toxicological analysis revealed the presence of ethanol (alcohol) at 0.19g/100mL in blood and 0.20g/100mL in plasma.[24]

42. On 8 July 2011, an autopsy of Mr Dunning's body and post mortem CT scanning (PMCT) were performed by Forensic Pathologist Dr Noel Woodford at the Victorian Institute of Forensic Medicine, which revealed the cause of his death to be: *1(a) global ischaemic brain injury following cardiorespiratory arrest during prone restraint (including pressure on the neck) of an obese male with cardiomegaly.*[25] Dr Woodford stated that Mr Dunning *developed an unsurvivable global ischaemic brain injury as a consequence of diminished perfusion (blood supply) of the brain due to cardiac arrest (cessation of circulation due to an absence of heart beat).*[26]

43. Dr Woodford was not called at the inquest and both the family and Crown accepted the tender of his report without seeking to cross-examine him. I note that he gave evidence and was extensively cross-examined at the Supreme Court trial. Dr Woodford's report contains a detailed history of events at Crown as described to Dr Woodford and details from the Alfred Hospital medical deposition. He also referred to hospital and ambulance notes, and viewed the CCTV footage of the events at Crown. In his summary of the video footage, Dr Woodford describes the event as follows:

> *the deceased is taken to the floor, initially onto one side and then placed quickly onto his front (prone position). One of the security officers appears to place an arm around the front of the deceased's neck whilst the left arm is pinned by other*

[23] Section 69 *Coroners Act 2008* (Vic).

[24] Toxicology report of Ms Maria Pricone.

[25] Exhibit 11, report of Dr Noel Woodford dated 31 August 2011.

[26] Ibid.

personnel. The right arm is under his chest at this stage. There appears to be minimal movement of the deceased once he is on the ground. The security officer's arm remains around the front of the deceased's neck for over a minute and after release of this hold, the deceased remains in the prone position for approximately 5 minutes and is then turned onto his side whilst hand-cuffs are applied. The face at this stage appears plethoric and dusky. No attempts at resuscitation were made during this time.[27]

44. This is an accurate summary of the video footage. Dr Woodford's reference to 'approximately 5 minutes' is however, at best, an estimate, and the timeline of the CCTV footage shows this to be a four minute, not a five minute period.

45. Dr Woodford referred to the deceased's medical history as including '*morbid obesity, hypercholesterolaemia, pitting oedema, sleep apnoea and recurrent tonsillitis.*'[28] Mr Dunning was a non-smoker with no record of psychiatric illness.

46. A neuropathology report was prepared by Dr Linda Iles. Her formal finding was one of '*global cerebral ischaemic injury*'.[29]

47. In his comments, Dr Woodford stated that it appeared that Mr Dunning suffered a cardiorespiratory arrest in the setting of restraint characterised by prone positioning and pressure on the neck.[30] Dr Woodford further stated that the precise mechanism of cardiorespiratory arrest was not able to be determined with certainty, but that likely contributory factors include:

- Prone positioning in an obese man with a prominent/protuberant abdomen resulting in splinting of the diaphragm and diminished respiratory excursions.
- Pressure on the neck causing a degree of upper airway obstruction and vagal inhibition (reflex slowing of the heart rate as the result of stimulation of the vagus nerve in the neck).
- Cardiac enlargement (the heart weight was well above the predicted range for a male of the deceased's height and weight). Cardiac enlargement may predispose to relatively sudden onset of rhythm disturbance and arrest particularly in the setting of cardiovascular stress.[31]

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[27] Exhibit 11, report of Dr Noel Woodford dated 31 August 2011, pages 3-4.

[28] Ibid page 4.

[29] Neuropathology report of Dr Linda Iles, and Exhibit 11 page 14.

[30] Exhibit 11, report of Dr Noel Woodford dated 31 August 2011, pages 14-5.

[31] Ibid page 15.

48. In its submissions, Crown set out relevant evidence given by Dr Woodford at the criminal trial. This evidence was relied upon for the purposes of the inquest. The key conclusion of Dr Woodford is that, although he could not state with precision at what stage after Mr Dunning was taken to the floor his heart slowed or stopped, and could not state the precise mechanism of cardiorespiratory arrest, he was clear that the cessation of breathing occurred '*sometime after he was being restrained on the ground*'.[32]

49. I accept the formal cause of death description given by Dr Woodford in his autopsy report, taking into account the neuropathology report, and formally find that the cause of Mr Dunning's death was global ischaemic brain injury following cardiorespiratory arrest during prone restraint (including pressure on the neck) of an obese male with cardiomegaly.

50. This, on Dr Woodford's evidence, occurred during a prone restraint. It is not possible to be precise as to the contribution of the pressure to Mr Dunning's neck. As was stated at the trial, Dr Woodford agreed that he had no firm evidence as to whether vagal inhibition was an '*acute operative factor at the time, other than circumstantial evidence and the video*'.[33] He agreed also that apart from the circumstantial evidence and the video, he was not able to say with precision whether the pressure to the neck occluded the upper respiratory system partially or totally.

51. In light of the medical evidence and the CCTV footage, I find on the balance of probabilities that Mr Dunning's death followed a cardiorespiratory arrest whilst he was held and restrained by security officers in a prone position on the floor at Crown Casino.

52. It is clear that some of the actions of security officers were "outside their training" in the sense that maintaining Mr Dunning in a prone position for a four-minute period created a risk of him suffering positional asphyxia. He should not have been exposed to that risk by maintaining him in a prone position for that long. On Dr Woodford's evidence, the global ischaemic brain injury following cardio respiratory arrest occurred during the prone restraint on the floor. However, in light of the Supreme Court outcome, it would not be appropriate to formally find that any of the security guards dealing with Mr Dunning collectively or individually caused or contributed to his death. To so find would be inconsistent with the jury verdict.

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[32] Submissions of Crown Melbourne Limited, page 8.

[33] Ibid page 8.

Police Attendance at Crown

53. This became an important issue at the inquest.

54. Sgt Rowe gave evidence about arrangements between Victoria Police and Crown for attendance of police within the Crown complex. I asked for further information to be provided after the inquest on this point.

55. Sgt Rowe's evidence at inquest was, in essence, that there was '*probably an understanding that police don't go in uniform onto the gaming floor unless they're requested to attend*',[34] but that there was no such formal policy. Nor was there any policy or expectation that police attend Crown every time a person is restrained or detained.[35]

56. Sgt Rowe testified that there was no mandatory reporting to the police by Crown for every incident given the sheer number of incidents in the variety of circumstances. However, he did express the view that should a death or an assault occur, it should be '*drawn to the attention of police immediately*'.[36] He testified that, to his knowledge, there had been no changes to protocols or arrangements between Victoria Police and Crown. He agreed to obtain further information to confirm this.

57. Following the inquest, Victoria Police advised the Court that '*Victoria Police does not have any agreement or Memorandum of Understanding or the like in place with Crown Casino*'.[37] In addition, there was no formalised agreement by way of a memorandum of understanding or similar that stipulates the types of events or incidents Crown is expected to or required to report to Victoria Police.

58. Mr Clelland, on behalf of Crown, informed me that Crown now engages more regularly with Victoria Police following Mr Dunning's death and that Crown security holds regular monthly meetings with Victoria Police Operations. Police members attend Crown routinely throughout the week but, in particular, every Friday and Saturday night, assuming resources permit this and in particular, between 9.00pm and 4.00am the following morning. Attendance is usually limited to those areas external to the gaming floor.[38] This appears to be a reasonable arrangement.

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[34] Inquest transcript, page 19.

[35] Ibid page 21.

[36] Ibid page 23.

[37] Letter from Supt Derek Lamb, Victoria Police Civil Law Division dated 26 March 2015.

[38] Inquest transcript page 26.

59. Mr Walsh also gave evidence of other changes since Mr Dunning's death. A security directive was issued by the general manager of safety/security stating that where a patron is injured due to an eviction and ambulance attendance is required, that the matter be escalated to the general manager to determine whether police should be called. Mr Walsh explained that police had not asked Crown to change its procedures regarding when they are called, but that there is now a clear escalation process that had not been communicated before Mr Dunning's death.[39]

60. I accept that as a matter of practicality and sensible use of resources, it would not be reasonable to expect Victoria Police to enter into an agreement with Crown that it attend every single incident, either gaming floor or elsewhere in the complex. Properly trained security staff should be able to deal with most incidents safely. However, I agree with Sgt Rowe that where there is an injury, possibly arising out of an assault, police should attend.

61. The Dunning family submitted that '*[a] guideline be implemented at Crown which requires that Victoria Police be called as soon as possible and notified of circumstances where (i) a person has been restrained and (ii) emergency services, other than police, have attended.*'[40]

62. As set out above, Mr Walsh's evidence was that after a review of the incident, Crown did not consider that it was necessary to change its procedure. He noted that police had not requested a change of procedure. The matter has been left to the discretion of the security managers on site, and the standard operating procedures provide for this.

63. In response to the family's submission, Crown submitted that the current interaction between Crown and Victoria Police regarding the reporting of incidents and the calling of Victoria Police to incidents is dictated by protocols established and procedures in place to implement those protocols. It submitted that Victoria Police has not required Crown to change its procedures, noting that the CI testified that a 'hard and fast rule' regarding when Crown should notify Victoria Police was not appropriate.[41]

64. The Dunning family's submission argues that the requirement that the general manager, as a matter of discretion, decide on whether or not to call the police is insufficient.[42] In response to this, Crown submitted that it '*has, at all times, welcomed the presence of Victoria Police Offices at the venue, including the Casino gaming floor and could not, has not and does not*

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[39] Inquest transcript pages 115-6.

[40] Submissions of the Dunning family, page 5.

[41] Submissions of Crown Melbourne Limited, page 13.

[42] Ibid page 6.

seek to place any restrictions whatsoever on the presence of Victoria Police or its operations, anywhere on Crown property, including the Casino gaming floor'. Crown also submitted that it has '*a specific arrangement for the presence of additional Victoria Police during the busier periods on Friday and Saturday nights and the eves of public holidays*'.[43]

65. Although I understand the scepticism inherent in the family's argument that this leaves open the risk that Crown's primary concern will be its own legal position, on balance it is reasonable to allow the security manager to make a determination about when to involve police. Clearly, cases such as this will remind those discharging that function to do so conscientiously and not with the interests of their employer primarily in mind. To guard against this, the training of persons holding that position or discharging that duty should be clear, and should focus on the safety, welfare and risk of injury to those involved in incidents and the other patrons at Crown. This should always override any concern for the legal position of the employer.

66. Ultimately, I do not consider there is a need to make a recommendation in relation to police attendance at Crown.

Conclusion

67. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

68. At the conclusion of the inquest, I invited Crown to make any final concession or acknowledgement in light of all of the evidence and material before the Court.

69. Mr Clelland stated that Crown preferred to refrain from making such a statement, '*other than to observe that the training and procedures in place at the time required that a person should only be kept in the shut down position as long as necessary and that a person's vital signs should be continuously monitored throughout*'. Mr Clelland referred to Dr Wells' review of Crown's training and procedures, particularly regarding the risks related to positional asphyxia, and stated that Crown has reviewed and sought to improve its training, systems and procedures as far as possible.[44] I accept that.

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[43] Submissions of Crown Melbourne Limited, page 12.

[44] Inquest transcript, page 128.

70. I accept also that Crown ensured that the protocols, procedures and practices set out in its Training Manual and other documents that could be improved after this event, were in fact changed following Mr Dunning's death.[45]

71. Ultimately, I agree that, in the light of the evidence of Dr Wells, Sergeant Rowe and Mr Walsh, there is no need for a recommendation regarding further training or enhancement to training of security staff at Crown.

I extend my condolences to the family of Mr Anthony Dunning.

I direct that a copy of this finding be provided to the following:

Mr William Dunning, Senior Next of Kin c/o Ms Dimi Ioannou, Maurice Blackburn Lawyers

Crown Melbourne Limited c/o Ms Penny Stevens, K&L Gates

Ms Susan Van Dyk, Medico Legal Officer, Monash Health

Ms Margaret Angliss, Alfred Hospital

Sgt Paul Rowe, Victoria Police, Coroner's Investigator

Sgt Sharon Wade, Police Coronial Support Unit.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: **27 March 2015**

Coroners Court of Victoria

[45] Inquest transcript page 125.