CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Matter Title:	**Inquest into the death of Luke Anthony Rich**
Citation:	**[2024] ACTCD 3**
Decision Date:	22 August 2024
Before:	Coroner Archer
Findings:	See [248], [249]–[254], [255]–[300], [301]–[308]
Catchwords:	**CORONIAL LAW** – death in custody – manner and cause of death – suicide by hanging – matters of public safety – mental health assessment processes – COVID-19 arrangements – inadequate observation processes – ligature points in cells – absence of Hoffman knives – collaborative suicide prevention framework – issues of parliamentary privilege – shortfalls in the care, treatment, and supervision of detainees
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3C, 13, 34A, 52, 55, 74 *Corrections Management (Correctional Centres) Declaration (No 2) 2009* (ACT) *Corrections Management Act 2007* (ACT) ss 14, 24, 30 *Crimes (Sentence Administration) Act 2005* (ACT) ss 17, 18 *Inspector of Correctional Services Act 2017* (ACT) ss 17, 35 *Parliamentary Privileges Act 1987 (*Cth) s 16
Representation:	**Counsel Assisting the Coroner** D Crowe **Counsel for the Family** J Ronald (instructed by Ken Cush & Associates) **Counsel for the Australian Capital Territory** K Musgrove (instructed by ACT Government Solicitor) **Counsel the Australian Federal Police** J Nottle (instructed by MinterEllison) **Counsel for Mr Daniel Knight** D Shillington (instructed by Snedden Hall & Gallop Lawyers)
File Number:	CD 29 of 2022

CORONER ARCHER:

INTRODUCTION

1. Luke Anthony Rich died at the Alexander Maconochie Centre ("AMC") on 1 February 2022. I will, with respect, refer to him as Luke. He took his own life by hanging himself from a ligature in the form of bed sheet secured to a rear door in his cell. He had been remanded in custody only the day before. Before he took that step, there were no overt signs that were observed that would have given rise to a suspicion that he was contemplating committing an act of self-harm.

2. Luke was a person of considerable capacity. His sudden death was tragic and has been felt keenly by his friends and family.

3. I repeat the expression of condolence I made to Luke's family during the proceedings.

4. What follows is an analysis of the evidence that was placed before me in the course of my investigation into Luke's death.

5. I make formal findings that are required by the *Coroners Act 1997* (ACT) ("the Act") and recommendations as to issues of public safety. I also include in these reasons, findings about aspects of Luke's care and supervision during his short period of incarceration at the AMC that, in my opinion, contributed to the cause of his death.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Findings

6. On 31 January 2022, Luke was arrested and remanded in custody following allegations of domestic violence made by his (possibly) ex-partner. In November 2020, he had been arrested and remanded in relation to allegations of violence against the same person.

7. Luke was assessed at the ACT Watch House, and, at the time of his admission to the AMC, he was found to be a low suicide risk (that is, no acute risks regarding self-harm or suicide, but with a history of self-harm or suicide).

8. He was remanded in custody at a time when COVID-19 arrangements were in place at the AMC. He was accommodated in a form of quarantine in the "Management Unit".

9. The induction assessment conducted at the AMC was thorough. However, expert evidence received during the inquest suggested that suicide risk assessment tools are of low predictive value.

10. Statistically, acts of self-harm are more likely to occur soon after admission into a custodial environment. Mitigation measures to address those known risks were not effectively implemented.

11. The rear doors of the Management Unit were known to be used as a ligature point for those detainees minded committing acts of self-harm. In 2020, they had been identified as needing urgent replacement. They were not replaced.

12. Luke died by suicide on 1 February 2022, the day after his admission. During that day, the observation regime was inadequate. In-person observations that were required were almost always not done. He was sighted in the hour before his death through a hatch in the cell door.

13. CCTV was relied upon as a form of observation because of a lack of staff resources. Luke rendered that form of observation ineffective by placing a sticker over the lenses of cameras located in his cell and in the yard. That practice was common amongst experienced detainees.

14. Observations were poorly recorded in a form that was tolerated, if not officially condoned by ACT Corrective Services ("ACTCS") Management.

15. Staff numbers at the Management Unit on 1 February 2022 were insufficient to address the duties (including observations) that Correctional Officers were required to perform.

16. At about 1900 hours on that day, Luke was discovered hanging from a sheet attached to the rear doors. The opinion of the nurse, who was the first responder, was that Luke had been in that position for some time.

17. Staff members were hindered in their attempts to remove Luke from the ligature by the absence of a Hoffman knife (a cutting instrument designed for that purpose).

18. I do not find the absence of the knife to have contributed to Luke's cause of death. However, its absence was not explained during the inquest, or, despite requests, after the hearing had concluded.

19. Attempts at CPR were competently attempted. Luke could not be revived.

Recommendations

20. I make the following recommendations in respect of public safety issues that arise from the inquest:

(a) Observations

21. I recommend that ACTCS publish guidance to staff, pursuant to s 14 of the *Corrections Management Act 2007* (ACT), that addresses, in light of the findings of this inquest:
    (a) the purposes of detainee observations;
    (b) how observations are to be recorded;
    (c) the role that CCTV is to play in the observation process; and
    (d) what is to be done when cameras are intentionally covered by detainees.

(b) Dangers represented by Rear Cell doors of the Management Unit

22. I recommend that:
    (a) external consultants be engaged to assess the safety of the rear doors in the Management Unit in light of the evidence in this inquest; and
    (b) the outcome of that review be published.

(c) The Absence of a Suicide Prevention Strategy

23. I recommend that:
    (a) a Suicide Prevention Framework for ACTCS be developed as a priority;
    (b) it gives expression to the need for suicide prevention to be accepted as shared responsibility at the AMC;
    (c) the terms of the Victorian Framework be considered in that process; and
    (d) an attempt be made as to assess the efficacy of the introduction of the Framework in the Victorian Prison system and reflect those learnings in the process of developing the framework document to apply at the AMC.

Section 74 Findings

24. For the purpose of this section, I reflect the findings made above. At the time of Luke's death, the Territory chose to accommodate newly arrived detainees in a physical environment they knew to be, in one important aspect, unsafe. The rear doors of the Management Unit cells were known to offer ligature points. The class of detainees that were to be accommodated in those cells were at greater risk of self-harm than general detainees. The length and nature of the period of COVID-19 isolation meant that new detainees were held in what amounted to a form of solitary confinement. That form of isolation may have been justified on grounds of public health. However, that did not obviate the need to take reasonable steps to ensure the isolation was as safe as it reasonably could be.

25. Luke's suicide, as with suicide generally, could not be reliably predicted. In light of that difficulty of prediction, Luke's assessment as being of generally low suicide risk did not

mean that such risk could be ignored. The reasonableness of the arrangements that were put in place is to be assessed against known risks associated with the physical environment of the cells in the Management Unit, with detainees of particular profiles, and the risks arising from remandees being placed in a form of health segregation for an extended period. Measures that were said to have been designed to mitigate some of those risks were not, in Luke's case, implemented.

26. The observation regime in place was inadequate. Staff resources were insufficient to address the safety needs of detainees. Staff members with responsibility for caring for Luke were not briefed as to Luke's mental health history, and known risks associated with the physical environment in the Management Unit cells. This is so both in relation to Custodial Mental Health Services ("CMHS") staff and Correctional Officers, who were on the ground discharging responsibilities in this respect of Luke's care and supervision.

27. CCTV cameras were used as form of observation, rather than detainees being observed, and engaged through personal contact. The reliance on CCTV cameras was an inevitable consequence of inadequate staffing resources to perform observations in person. Luke's decision to cover the cameras in his cell gave rise to greater safety concerns as a result. Those concerns were not identified nor acted upon.

28. These failures in the care and supervision of Luke – that is, the failure to address or to mitigate risks associated with the rear doors of the Management Unit cell in which he was accommodated – contributed to his death.

PART 1 - JURISDICTION

29. Luke's death was referred to the ACT Coroner's Court pursuant to s 13(1)(i) of the Act, as it occurred at the AMC when he was "in custody". Section 3C of the Act defines "death in custody" to mean a death that occurs at a "corrections centre". Section 24 of the *Corrections Management Act 2007* (ACT) empowers the Minister to declare a place to be a corrections centre. Through the *Corrections Management (Correctional Centres) Declaration (No 2) 2009* (ACT), the Minister for Corrections made such a declaration in respect of the AMC.

PART 2 - REQUIRED FINDINGS

2.1 – Section 52 of the Act

30. Having assumed jurisdiction in relation to Luke's death, I was required to hold an inquest[1] into the manner and cause of Luke's death and make findings that are required by s 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
>
> (1) A coroner holding an inquest must find, if possible—
> (a) the identity of the deceased; and
> (b) when and where the death happened; and
> (c) the manner and cause of death; and
> (d) in the case of the suspected death of a person—that the person has died.
>
> --
>
> (4) The coroner, in the coroner's findings—
> (a) must—
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
> (ii) if a matter of public safety is found to arise—comment on the matter.

31. In arriving at the findings a coroner is required to make, I was obliged to hold a hearing.[2]

2.2 – Section 74 of the Act

32. Section 74 of the Act requires me to include, in the record of the proceedings, findings about the quality of care, treatment and supervision of the deceased that, in my opinion, contributed to the cause of death.

PART 3 - THE COURSE OF THE INQUEST

3.1 – The Investigation

33. At my direction, the Australian Federal Police ("AFP") investigated Luke's death. The office of the ACT Government Solicitor ("ACTGS") facilitated the provision of statements from Territory employees. Relevant records were subpoenaed by the Court.

34. By the time the hearing for the inquest had begun, the ACT Inspector of Correctional Services ("the Inspector") had conducted a review of Luke's death as a "critical incident" for the purposes of s 17 of the *Inspector of Correctional Services Act 2017* ("the ICS Act"). Material in the form of statements and documents, and a report of his findings were obtained from the Inspector. That material was supplied to the coroner pursuant to

[1] In s 52 of the Act, "inquest" is effectively synonymous with a process of investigation.
[2] Section 34A of the Act does not permit a coroner to dispense with a hearing if the coroner has reasonable grounds for believing that the death, relevantly, is a death in custody.

s 35 of the ICS Act. In circumstances that are elucidated below, I decided not to rely on this material for the purposes of arriving at my findings.

3.2 – The Pre-Hearing Process

3.2.1 – Chronology

35. As my investigation concerned a death in custody, the terms of s 72 of the Act required me to appoint a lawyer as counsel assisting. By instrument dated 25 May 2022, Mr Dan Crowe of Counsel, was appointed as Counsel Assisting.

36. The hearing of the inquest was subject to a preliminary case management process. Directions hearings were conducted on 1 August 2022 and 1 December 2022.

37. Leave was granted to the Australian Capital Territory, the AFP, and Luke's family to appear at the inquest. A hearing date was set for 12 to 16 December 2022. A timetable was set for the provision of the coronial brief and the serving of an issues list by the coroner.

3.2.2 – The Parliamentary Privilege Issue

38. On 28 September 2022, the Territory indicated that an issue would be raised in relation to the material received from the Inspector. It was foreshadowed that, as that material amounted to "proceedings in parliament" within the meaning of s 16(2) of the *Parliamentary Privileges Act 1987 (*Cth), it was subject to parliamentary privilege and could not be tendered, received, or otherwise considered in the inquest. Submissions were invited and received on that issue.

39. I indicated that it was not my intention to resolve that issue, and the Territory, through ACTGS, was requested to take statements from witnesses who had already been interviewed by the Inspector.

40. In light of:
    - the parliamentary privilege issue raised by the Territory;
    - the delay in getting fresh statements from the Territory to replicate the interviews taken by the Inspector; and
    - the late provision of witness statements and the expert report of Professor Large,

    the family made an application for the hearing to be adjourned.

41. During the directions hearing of 1 December 2022, orders were made to grant leave for a Correctional Officer, Mr Daniel Knight, to be separately represented. Orders were also made to vacate the hearing date.

42. Orders subsequently made in chambers allocated 22 May 2023 as the commencement date for a five-day hearing.

3.2.3 – The Issues List

43. An issues list was distributed to the parties on 27 and 28 October 2022. The purpose of that list was not to bind the Court as to matters relevant to the findings I was required to make pursuant to ss 52 and 74 of the Act. Rather, the purpose of the list of issues was to signal to the parties the scope of the material in the brief that was likely to be considered in making those findings.

44. Those issues were the :
    (a) mental health assessment processes at the ACT Watch House;
    (b) mental health assessment processes at the AMC;
    (c) adequacy of the way the processes were followed in relation to Luke, including the communication of any information obtained at the ACT Watch House to relevant personnel at the AMC;
    (d) adequacy of the observations made of Luke while he was at the AMC on 31 January and 1 February 2022;
    (e) presence and identification of ligature points in the cells in the Management Unit at the AMC; and
    (f) availability of Hoffman knives to Correctional Officers at the AMC.

45. The approach taken in my findings is to adopt these issues as a structure to analyse whether, for the purposes of s 52(4) of the Act, public safety issues arise from the inquest. This accords with the approach taken in submission by Counsel Assisting and those granted leave to appear.

3.2.4 - The Hearing

46. The hearing was conducted from 22 to 26 May 2023.

47. At the conclusion of the hearing, the Court wrote to the Territory to seek further evidence in respect of a number of specified issues. Witness statements and other documents were produced and received as exhibits, without the need for the deponents to that material to be called and cross-examined.

3.2.5 – Views of the Family and Submissions

(a) Views of the Family

48. At the beginning of the hearing for the inquest, Mrs Karen Reid and Mr Gary Reid, Luke's mother and stepfather, were invited to make a statement about the inquest process. Karen spoke, and she said this:

> My goal and my prayers are that the whole truth is revealed. That God's plans will come to pass. That those responsible for looking after and keeping my son safe acknowledge their faults, and, above all, fix the doors so that no other mother and family has to go through this pain, heartbreak, anguish, and most importantly, separation from her child.

49. The family was represented at the hearing, and engaged actively in the questioning of the witnesses that were called.

50. The family made submissions. The alleged failure of ACTCS to mitigate the risks presented by the cell doors in the Management Unit remained a central concern.

51. The other issues addressed by the family as warranting adverse findings were:
    - (a) the use of CCTV as a form of observation;
    - (b) the lack of action to remove items placed on the camera lens;
    - (c) the lack of briefing to custodial staff about the risks associated with the isolation of new arrivals and the doors;
    - (d) the failure to implement proposed mitigation measures;
    - (e) the inadequacy of the observations that were conducted; and
    - (f) the unexplained absence of the Hoffman knife.

52. In relation to the observation regime, the family invited a finding that, if the observation conducted at 1800 hours on 1 February 2022 had been done in-person, and not through a portal, it may have been that preparatory steps taken by Luke to commit an act of self-harm may have been discovered.

53. The family expressed support for a recommendation proposed by Counsel Assisting about an overarching suicide prevention framework that would apply at the AMC. They also suggested that a specific recommendation be made about training in observation practices and procedures, with emphasis being placed on the importance of in-person observations. Finally, the family submitted that there should be compulsory drug and urine testing of remandees to ensure proper medical assistance, psychiatric support, and drug withdrawal treatment are available.[3]

---

[3] That issue was not canvassed during the hearing, and it falls outside the scope of the inquest. That submission was answered in detailed in submissions in reply from the Territory. It is sufficient to note

(b) Submissions of other Parties

54. Submissions and submissions in reply were received from the Territory. The AFP and Mr Knight declined to make submissions. The process of submission concluded on 26 April 2024.

3.2.6 – Section 55 Notice

55. My findings contain a comment adverse to a person, namely the Territory and Mr Knight. Consistent with my obligations under s 55 of the Act, I provided both the Territory and Mr Knight with a copy of the proposed comment, with advice consistent with that section as to how they may respond. Notice was served on the Territory and Mr Knight on 11 July 2024. A response was received from the Territory on 8 August 2024 in the form of a statement from Mr Jordan Russell, Assistant Commissioner, Custodial Operations at the AMC. That statement is attached to these findings. Mr Knight indicated through his legal representatives that he did not want to respond to the provisional findings.

PART 4 - THE EVIDENCE

4.1 – Luke Rich – Relevant Personal History

56. Luke was 27 years old at the time of his death. He was born on 15 October 1994, in Gosford NSW. He had three siblings – two brothers and a sister. In 1996, when Luke was about two years old, his parents separated due to his father's gambling and alcohol misuse. Luke's father was abusive, and violence had unfortunately permeated the life of the family.

57. Following the separation, Luke's mother relocated with her children to Newcastle NSW and later re-partnered with Mr Gary Reid, who became Luke's stepfather. In 2020, Luke described himself as having a "distant relationship" with Mr Reid, but had remained very close with his mother, by whom he felt loved and supported. He also reported to have maintained frequent contact with his siblings, in particular his eldest brother, Joshua.

58. When Luke was about sixteen years old, his parents asked him to move out of home, as his behaviour had started to become "destructive" and was straining their relationship. Having been on his own for a short period of time, Luke asked to move back in with his parents. To support Luke, Karen and Gary helped him move to Lithgow NSW instead, where Gary was working at the time and became a steadying influence in Luke's life.

---

that other than COVID-19 arrangements a urine test would have been performed on admission. If performed, it is likely that it would have confirmed what Luke had told staff during his induction – that he had been using illicit and prescribed drugs.

Whilst in Lithgow, Luke completed a carpentry apprenticeship and a Certificate IV in Building and Construction. He became a qualified carpenter and lived with his boss for some time, before moving with his family to Taree, NSW.

59. Family and friends would remember Luke as a hard worker. Prior to his passing, Luke was working as a site foreman at a construction company, and he had worked 'as hard as [his] body would let him'. Luke's position required him to relocate frequently, and he had worked in various locations across NSW, including Linfield, Oran Park and Wollongong.

60. In around 2017, Luke met WT in Lithgow NSW. The two started seeing each other and moved in together shortly thereafter. The couple eventually moved to Canberra in 2020.

61. Luke met NE a week or so before his death.

4.2 – Domestic Violence

62. Material was received during the inquest in relation to the nature of the relationship between WT and Luke. WT maintained that, at times, Luke was violent towards her. The truth of those allegations was not accepted by Luke's mother and stepfather. For present purposes, it is not necessary to resolve that conflict, other than to observe that allegations of domestic violence made by WT had led to Luke being arrested and incarcerated on remand twice (the last time being the occasion on which he took his own life). Those periods of remand, and the reasons for them, form part of the factual matrix in respect of which Luke's decision to take his own life falls be assessed.

4.3 – Luke's 2020 Arrest and Remand

63. In the morning of 7 November 2020, WT, concerned about the amount of drugs Luke had consumed the previous evening (according to her, cocaine, and Xanax) and after he made threats of self-harm, called for an ambulance. The AFP and ACT Mental Health Services ("ACTMHS") were involved in the response to her call. WT was allegedly assaulted by Luke shortly after making the call.

64. Luke was arrested and charged with offences of damaging property and assault. He was remanded in custody and remained at the AMC until he was granted bail on 10 December 2020.

65. There is no indication in the evidence before me that during his remand period, any issues concerning Luke's mental health[4] or his general behaviour were raised. CMHS

[4] Ex 1.63 contains his medical records from that admission. No continuing mental health issues were raised.

closed Luke's file on 16 November 2020, as no mental health issues or suicide risks were identified.[5]

66. Luke did not return to custody in respect of those offences after he was granted bail. He was sentenced on 15 December 2020. The Court Duty Report prepared in respect of that sentencing process noted that Luke had talked of escalating drug use before his arrest, which he said was a means of dealing with the stress associated with his relationship and work. A medical report cited by the author of that report recorded "depression" and "anxiety" diagnoses for the offender, who advised he was not medicated for those conditions.[6]

67. At sentence, he was convicted of common assault and two damage property charges, and he was placed on a Good Behaviour Order with conditions. Those conditions included that he be supervised on probation for 9 months, or any such lesser time directed by the Director-General.[7]

4.4 – Luke's 2022 Arrest

68. The evidence before me suggests that, but for the period in the three months or so before his incarceration in 2022, Luke achieved some stability in his life. He remained in a relationship with WT. The relationship with his family improved, although there was a level of estrangement following his first arrest. Whilst he had lost his employment after his arrest, he found a new and demanding job as a site foreman in the building industry and had made a concentrated effort to lose weight and improve his fitness. He spent some time in Wagga Wagga during the year for his employment.

69. His period of ACTCS supervision under the Good Behaviour Order expired on 14 September 2021. The notes made by his case officer at the time of his discharge from supervision in September 2022 painted a positive picture of his progress:
    - he had complied with the terms of his supervision;
    - a single drug screen was negative;
    - he engaged with counselling service, initially an online provider and then Relationships Australia; and
    - he remained in employment.

70. Asked of self-reflections at that time as to what he had learnt, Luke was recorded to have said the following (errors included):

---

[5] Ibid 17.
[6] Ex 1.128.
[7] Ex 1.151.

- He can't address life's problems with drugs or alcohol. He said he was previously self-medicating with alcohol and cocaine. He claimed he always knew it was wrong, but now he can really see that is it, because he has experienced the negative side effects (i.e. getting a criminal charge and being incarcerated in AMC).
- He claimed it's better to reach out for help through counselling or psychology sessions.
- Luke talked about how he has been focused on his self-development over the past couple of months. He talked about how he is not a person who commits crimes and that he is so much better than that. CCO (Community Corrections Officer) supported this chain of thoughts. Luke then talked about how jail and attending the Corrections office had been a massive eye opener for him, and he never wants to find himself in that position again. He said it was embarrassing to attend our office in his work uniform, and to be around other offenders.
- Luke said jail was 'rubbish' and 'embarrassing'. He also talked about how it negatively affected his family and his career. He said he felt bad the way that he had left his previous employer and noted it "burnt" potential references. Luke then talked about how lucky he is to have found the job he has, and that his criminal charges have not affected his position there.
- Luke talked about how sad he was that he had hurt his partner. He said if he does something like that again, he would admit himself into a behavioural change program (like the one with Everyman). He claimed that if he did it again, it would show he had a problem, and he would be inclined to reach out for more intense help.[8]

71. Despite these aspirations, in the period immediately before his arrest on 31 January 2022, aspects of Luke's life circumstances deteriorated significantly. In the early hours on 31 January 2022, the AFP responded to a 000 call and went to his Waramanga home. Luke, WT, and another woman, NE, were present. WT told the attending officers that she had been assaulted by Luke on 26 January 2022 at their home. She alleged that she had attempted to hide an amount of cocaine belonging to Luke. She alleged that he then assaulted her, and she left.[9]

[8] Ex 1.152.
[9] WT presented at the Canberra Hospital the same day complaining of head, neck and back pain. She said she fell over a dog: Ex 1.90.

72. WT said that she returned to the house in the early hours on 31 January 2022 to collect some of her possessions. She saw NE there. An argument developed with Luke. She alleged that she was forcefully thrown out of the house, causing minor injury[10] to her feet, ankle and elbow.[11] She called the police.

73. Luke was taken into custody and taken to the City Police Station.

74. The video from the body-worn cameras of the arresting officers does not suggest Luke was in an abnormal level of emotional distress.[12] Clearly, he was frustrated with being taken into custody. The footage did not obviously show that his physical movement was compromised by a level of intoxication.

75. After Luke's death, WT was interviewed again. Apart from giving an account of the events surrounding Luke's arrest, she also described his behaviour over the month before then. She indicated that his drug and alcohol use had been escalating because of what she said was related stress. She said, "it just got really out of control".[13]

76. As set out below, and as to the issue of drug use, there is evidence that tends to corroborate this account.

77. NE was also interviewed after Luke's death. She indicated that she had known Luke for a week or so prior to his arrest. As far as she (and Luke) was concerned, the relationship between Luke and WT was at an end and had been "for days". Relevantly, she indicated that on the night of his arrest, they took cocaine and "did some nangs".[14] She described what happened when WT arrived, and said the only contact involved him grabbing her by the shirt in the bedroom and later pushing her outside where she fell backwards. Once the door was closed, and before the police arrived, she said he (Luke) repeatedly said he was "going to jail".[15]

78. In her conversation with the police, NE indicated that, at some point in time, she and Luke had discussed acts of self-harm (arm cutting) and suicide.[16]

---

[10] Breaking of the skin was depicted in photographs taken by attending police: Ex 1.85.
[11] It was made clear at the hearing that the material in relation to Luke's arrest on 31 January 2022 was not being received to enable an assessment to be made of the truth of WT's allegations. It is noted that NE, who was present at the time, claimed that WT had assaulted her, and that Luke was acting in defence of her: Ex 1.83. Luke told attending police that the damage observed in the house was caused by WT: Ex 1.83. As noted, the material was received to enable a realistic assessment to be made of Luke's state of mind at the time he decided to take his own life.
[12] Ex 1.83, Ex 1.84.
[13] Ex 1.17.
[14] Ex 1.18 Q40.
[15] Ex 1.18 Q49.
[16] Ibid Q173, 178.

4.5 – Charge and Remand

79. Once Luke was at the City Police Station, he was lodged in the ACT Watch House at 0556 hours. A CCTV footage of his time in the Watch House was tendered.[17] Largely, Luke slept, and he appeared sleepy when conscious.[18] He was given food and drink, but he did not consume them.

80. During the intake process, when he was asked questions about thoughts of self-harm, he indicated "no". He denied the use of alcohol and illicit substances in the last 24 hours.[19] No cause for concern was identified either in respect of his physical or mental health, and no referral was made to clinicians to assess his condition.[20] The officer undertaking the review did not recall that anything out of the ordinary was indicated by Luke's responses or presentation.[21]

81. Whilst at the Watch House, he was provided with a copy of the audio recording of WT's Family Violence Evidence in Chief interview with the police. He was charged in his absence, and bail was refused by the duty sergeant.[22]

82. A brief of materials was emailed to the DPP and the Court registry. That included a statement of facts, and charge sheets. That material was also included in the Detainee (Custody) File ("the BART file"), which, in any particular case, might also include any court orders (e.g. family violence orders), a property sheet, and a prisoner history form, which provides an account of the person's history while in custody.

83. Luke was taken to the ACT Magistrates Court at 1043 hours. He spent approximately four hours at the Court, mostly in the cells. He appeared before a Magistrate briefly at about 1300 hours. He was charged with the offences of assault and assault occasioning actual bodily harm. Those charges addressed both the events of 26 and 31 January 2022.[23] He was represented, on a duty basis, by a solicitor from the ACT Legal Aid Office. As part of the process of giving instructions to his solicitor, Luke would have been made aware of the allegations that had been made against him. He appeared by audio-visual link from the court cells. He made no application for bail and was remanded in

---

[17] Ex 1.91.
[18] Ibid.
[19] Ibid.
[20] Ex 4.
[21] Milner Ex 3 at [32]-[33].
[22] Ex 1.95, Ex 3.
[23] The charge in respect of the events of 26 January 2022 was of common assault. It was possible that the number and seriousness of charge(s) ultimately preferred in respect of that event may have escalated during the prosecution process.

custody.[24] No mental health issues or matters going to his safety in custody were raised with the Court.

84. Whilst at the Court, he was in the custody of ACTCS' Court Transport Unit. An Initial Assessment form was completed, which did not identify any self-harm risks. A Return and Transport Risk Assessment Form was also completed. This form was directed at identifying risks that might arise in respect of Luke's custody at the Court and when he was being transported to the AMC. Again, no risks were identified.[25]

85. He was taken from the court building at about 1500 hours and arrived at the AMC at 1520 hours.

86. At about 1545 hours, Luke was allowed to make a phone call and chose to call WT. That conversation was recorded in accordance with the law and standard practice. Both parties were aware that the conversation was being recorded. Substantially, the content of the call revolved around NE being at the house and the distress that had caused. WT did say that she would help Luke.[26] Practicalities were discussed about money and Luke's employment. The only part of the conversation dealing with what confronted him at the AMC was in these terms:

> **LUKE:** No. I'm here until the twenty-first of next month. And then I'll probably get two years or so.

87. They expressed their love for each other in concluding the call.[27] What that meant, so far as Luke's state of mind and future focus was concerned, is difficult to say. As is noted elsewhere, on his telephone list NE was a named as a "friend" and WT as his "partner".

4.6 – Induction at the AMC

4.6.1 – General Issues

88. The quality of the process of Luke's induction at the AMC, particularly in relation to the assessment of his mental health, is analysed below.

---

[24] A warrant of remand was issued pursuant to s 17 of the *Crimes (Sentence Administration) Act 2005*. At least from the signing of that warrant, Luke was in the custody of the Director General, and he was required to keep Luke in custody under full time detention under those Acts: s 18 of the *Crimes (Sentence Administration) Act 2005.*

[25] Ex 1.173.

[26] Ex 1.213. This comment may have significance in terms of the criminal litigation. On the previous occasion he had been charged, WT indicated a preparedness "not to press charges" (see Ex 1.63 at page 17). Whilst the DPP continued the prosecution, WT gave a letter of support in the sentencing process.

[27] Ex 1.213.

89. What emerges from the evidence is that, in broad terms, the purpose of the induction process was to:

- Identify any health, mental health and social issues that might affect a prisoner's safety or the safety of others;
- ensure that, subject to operational considerations, appropriate accommodation and support arrangements were put in place; and
- any security and safety concerns for Luke, the AMC and its staff, and other detainees were addressed.

90. The responsibility for conducting the induction process was shared between ACTCS and Justice Health. Within Justice Health, there was a co-ordinated response between Primary Health (tasked with addressing general health issues), and CMHS, whose primary focus was on mental health issue or concerns.

91. Luke's induction adhered to the standard structure. The induction process began at about 1530 hours.

4.6.2 – *Corrections Assessment*

92. Luke was interviewed by ACTCS staff, who asked a series of standard questions. His answers were recorded in a tick box form. An objective assessment was also undertaken. Relevantly, the induction form indicated that Luke was not a known drug user. Based on that assessment and the health assessment detailed below, he was classified as medium security, which was the default classification.[28]

93. At the time, specific COVID-19 arrangements were in place at the AMC. Consequently, Luke, like all new arrivals, was accommodated in the Management Unit. Those arrangements are addressed at length below.

4.6.3 – *Justice Health Assessment*

94. Luke's health assessments were undertaken concurrently by Nurses Neelu Vinod (Primary Health) and Isabel Manzano (CMHS). Each clinician separately recorded their own observations and the information Luke provided.

(a) Primary Health

95. Nurse Vinod qualified as a registered nurse in 2008 and had been employed at the AMC since May 2019. He had been trained in undertaking primary health assessment at the AMC. Nurse Vinod provided a statement[29] and gave evidence. He found Luke to be co-

[28] Ex 1.178.
[29] 18 November 2022: Ex 1.21.

operative and gave information clearly and coherently. His conclusion was that Luke "had no primary health concerns and had "normal vitals".[30] He recorded Luke as indicating that he drank "6 beers" "weekly". He denied benzodiazepam and opioid use. In respect of "stimulants", he was recorded to have said he used cocaine by smoking it "7gm" "daily". He indicated his last use was "30/1/22" and the duration of use was "6-7 days".[31] Luke told Nurse Vinod that he was currently taking Seroquel for insomnia, and he had been using 100 mg each night for the last 6 months.[32] The last dose was 5 days ago.

96. In evidence, Nurse Vinod said that the use of cocaine Luke had indicated (7 grams a day) would indicate a very high level of use. However, he qualified that evidence by saying that Luke's indication was "like for the last few days he's been using this much amount".[33] He confirmed, as he had noted at that time, that Luke did not display signs of alcohol or drug withdrawal.[34] He told the Court that he had later contacted the prescriber Luke had identified in respect of the Seroquel, who denied in writing they had dispensed such a medication to him.[35]

97. A COVID-19 PCR test was completed.[36]

98. Although a pattern of (perhaps considerably recent) cocaine use was identified, no plans were made to address withdrawal issues that might arise.

(b) Custodial Mental Health Services

99. Nurse Manzano completed her undergraduate degree in 2017. She started working in "mental health" in 2018.[37] She had undergone formal training in administering the Suicide Vulnerability Assessment Tool ("SVAT"), which is a suicide vulnerability tool used by CMHS.

100. She started her role at the AMC in February 2021, and described herself as being, at the relevant time, a clinician with the Assertive Response Team ("ART").[38] According to her statement, ART was responsible for assessing the mental health of all new inductees into custody at the AMC. Her process was to first conduct a file review of the client's

---

[30] Ex 1.21 [5].
[31] Ex 1.21 Admission Assessment Form.
[32] Ibid.
[33] Vinod, T 25 May 22, 248. See also 250 at line 40.
[34] Ibid 249.
[35] Ex 1.21 [7].
[36] The COVID-19 test collected in the late afternoon of 31 January 2022 was reported as negative in a report time-stamped 0543 hours on 1 February 2022.
[37] Ex 1.20.
[38] Ibid.

mental health records held on the Mental Health, Alcohol and Drug, Justice Health Integrated Care eRecord ("MAJICeR"). Those records only include Canberra Health Services records and not those of private health practitioners. In conducting that assessment, she would consider the client's:

- psychiatric history;
- their level of engagement with community teams;
- any history of self-harm or suicide attempts;
- history of substance use;
- involuntary treatment; and
- current medications.[39]

101. During induction, her practice was to conduct an in-person assessment of their "current mental health presentation". Normally, this occurs at the same time as the assessment done by the Primary Health Team.[40]

102. The assessment process would also include a consideration of the need for ongoing ART involvement. ART would *not* be involved, unless there:
    - were acute risk factors; or
    - the client has a diagnosed or suspected mental illness that is assessed as moderate or severe.[41]

103. If neither of these considerations applied, a conversation would take place with the client about the "process for self-referral to CMHS".[42] Her practice was to "advise clients that if they were feeling unsafe, had thoughts, plans, or intent of self-harm or suicide, they could tell Custodial Officers who would contact the team".[43] She indicated that she would include a summary of relevant matters arising from the assessment in appropriate forms, including any required referrals.[44]

104. Nurse Manzano assessed Luke at his induction. Nurse Vinod was present. A Custodial Mental Health Notification Form ("the CMH form"), a Custodial Mental Health Induction Form ("the CMHI form"), as well as a SVAT were completed by her. The CMH form was used to inform ACTCS of the outcomes of the mental health assessment that had taken place at induction. The other two forms were used internally by Justice Health to inform any future care and treatment of Luke. Those forms and their content could not be

[39] Ibid [10].
[40] Ibid [11].
[41] Ibid [12].
[42] Ibid [13].
[43] Ibid [13].
[44] Ibid [14].

accessed by ACTCS. Some of the information from the CMHI form, for example, the "S" and "P" ratings and triage outcome, were used on the CMH form.

105. In her statement, Nurse Manzano described Luke to be "irritable" during the assessment.[45]

106. The significant entries made in the CMHI form were (in the terms used):
- Identified WT as his "partner" and next of kin;
- Denied having a regular GP (but referred to a GP at the Tuggeranong Hyperdome in relation to prescription medication);
- Denied a medical or allergy history;
- Said he had been taking Seroquel (100mg each night for six months) to assist with sleeping;
- Provided a history of substance use, including:
  - 6 beers per week (last used 30/01/22); and
  - 7 grams cocaine per day from 'five days ago' until 30/01/22;[46]
- Denied current withdrawal symptoms;
- Denied a current or previous mental illness diagnosis or family history of mental illness;
- Denied having ever felt he had excessive energy, special abilities, excessive spending or promiscuity or having experienced voices, hallucinations, paranoia, etc; and
- Described his mood over the preceding two weeks as "depressed", and his sleep over that time as "not the best", detailing only two hours per night for the past six weeks.[47]

107. On the CMH form, in the section entitled "Assessment – Case Formulation", Nurse Manzano noted:

> Superficial engagement on review. Nil evidence of a major mental illness on review. Luke denied all thoughts, plans, & intent of self-harm or suicide. Nil CMHS follow up indicated.

108. The "Recommendations" section of the CMH form contained ratings of psychiatric health and suicide risks according to different assessment criteria.

---

[45] Ex 1.20 [16].
[46] Nurse Manzano explained that the information she recorded in the form up until this point had been elicited by Nurse Vinod, as he worked through the corresponding sections in the paperwork he was completing. The information which follows was elicited by Nurse Manzano via her own questioning of Luke: T168:36-41.
[47] Ex 1.25 Annexure 'A' 2-4 and T168:15-169:43.

109. Psychiatric health was rated within a (P) range of P1 to P4:

> ***Psychiatric Ratings***
> P1 – Serious psychiatric condition requiring intensive and/or immediate care
> P2 – Significant ongoing condition requiring psychiatric treatment
> P3 – Stable psychiatric condition requiring psychiatric treatment
> PA – Suspected psychiatric condition requiring ongoing assessment
> Nil P rating required

110. These ratings and some of the practical aspects of them were explained by Nurse Manzano in these terms:

> All right. That is very helpful, thank you. And would you mind going through the same exercise with me for the P rating?---Sure. So 'P Nil' means that there is no history or diagnosis of major mental illness. …….
>
> P1 means that the detainee is presenting as acutely mentally unwell. P1s are very difficult to manage within the AMC environment, so if we're reading somebody a P1 we're leaning more towards hospitalisation of that client.
>
> Yes, yes?---P2 means that that person is currently mentally unwell, but we think that we can manage them at the AMC with some extra input from our team, as well as supports that can be provided by Corrective Services.
>
> P3 means that the client has a diagnosed major mental illness, however, is presenting quite stable, and we believe that they're suitable for the general areas of accommodation within the AMC. ……
>
> I should have mentioned before with the S1 – the S ratings and the P ratings – they also give our team an indication for how often we need to assess that client. So, for S1 and S2 ratings, someone from our team would have to see that person daily. For S3, it's sort of three times a week, and then S Nil means no follow up from our team. P1 means no follow up – sorry, P1 means daily contact, as is P2. P3 is fortnightly and PA is determined by how unwell we think that client is presenting. [Emphasis added]
>
> At any given time?---Yes.[48]

111. Luke was given a "Nil" P rating.

112. Suicide and Self Harm Risk recommendations were determined within the following (S) range:

> ***Suicide and Self Harm Risk Recommendations***
> S1 15/60 observations - Immediate risk
> S2 30/60 observations - Significant risk
> S3 60/60 observations - Potential risk
> S4 – Past history
> Nil Obs Rating

113. As to what the various "S" ratings meant in practice, Nurse Manzano explained that "S1 15" would indicate a client at a high risk of suicide, who would be on 15-minute

[48] Manzano, T 24 May 2023, 167-168.

observations, smocked and placed in the High Dependency Unit ("HDU").[49] S2 would be a high-risk client (again, in the HDU with 30-minute observations, and would wear their own clothing).[50] S3 was a rating of 60-minutes observations, where someone was accommodated in a mainstream unit who "might need a little bit of extra support or monitoring".[51] "S4 Nil Obs" means there is a history of self-harm or suicide, but there are currently no concerns.[52]

114. Luke was initially rated as "Nil" on this scale. Nurse Manzano indicted that this rating was given on Luke's self-report of no previous attempts of suicide. She went on to say:

> 16. I recall Mr Rich being a little reluctant to engage during my in-person assessment. I found Mr Rich to be irritable during the assessment. When I asked him about any history of suicide attempts, he reported that he had none. However, on reviewing his fie, I had noted that Mr Rich had a previous history of drug overdose. It was not clear from his medical records whether that was a suicide attempt or accidental. I recall amending my initial assessment of 'S nil' to 'S4 nil' because of the notes relating to a drug overdose.
>
> 17. An 'S nil' rating means that there is no history of self-harm or suicide attempts and no current concerns about acute risks. An 'S4 nil' rating means that while there are no acute risks regarding self-harm or suicide, there is a history of self-harm or suicide. The change in assessment rating would not have resulted in any change to Mr Rich's care or recommended observation requirements.[53]

115. In her evidence, Nurse Manzano explained this change further. In respect of the history of drug overdose, she said that because "our previous notes" were ambiguous as to whether the drug overdose had been intentional:[54]

> I erred on the side of caution and changed the rating. Also because he had a history with our team, and he had been put on observations the last time he was in custody, that S4 is also to reflect that".[55]

116. A mental health examination conducted in the context of Luke's assessment involved consideration of 24 different factors to be considered in characterising his presentation. The factors ranged from "anxiety" and "suicidality" to "excitement", "distractibility", and

---

[49] Ibid 166-167.
[50] Ibid 167.
[51] Ibid line 28.
[52] Ibid line 31.
[53] Ex 1.20 [16]-[17]. Although the form indicated "S4 Nil Obs", in fact all new detainees were on a regime of 60-minute observations. The frequency of the observations could be increased by the outcome of the assessment process.
[54] It was not made clear what the "drug overdose" being referred to was. It is likely that the reference derived from the contact between Luke and ACTMHS in the context of his 2020 arrest. ACTMHS notes from this event reference that "Girlfriend reported that Luke took an overdose with Xanax and Diazepam with alcohol". A "medication overdose" is also referenced. Ex 1.63 at page 1. At his 2020 induction at the AMC Luke denied any attempt at self-harm saying "it was news to me": Ex 1.63 at page 7. That denial was repeated in a subsequent review on 10 November 2020: Ex 1.63 page at 10.
[55] T 24 May 2022, 165, line 35.

"mannerisms/posturing". The tick box structure of that part of the CMHI form allowed for each factor to be assessed as "Present", "Possible", or "Absent". Three factors were ticked as "Possible" – "Depression", "Hostility", and "Uncooperativeness". The remaining factors were ticked as "absent".

117. The available triage categories were:

> ***Triage Rating***
> A – Crisis requires immediate management
> B – Crisis requires assessment within 2 hours
> C – Priority requires assessment within 24 hours
> D – Priority requires assessment within 72 hours
> E – Deferred non urgent assessment within 14 days
> F – Referred to other agencies, nil CMHS Involvement required
> G – Advice or information 1111 further Involvement from CMHS required

118. Luke was rated as "F".[56]

119. A SVAT was also completed for Luke.[57] The SVAT required the information that had been collected to be analysed in the context of potential suicidality. Significantly, the SVAT form was headed with this qualification:

> The goal of assessing suicide vulnerability is NOT to predict suicide, but rather to appreciate the basis of current or potential suicidality for that individual and allow for informed intervention and management of vulnerability factors.[58]

120. The summary of "current vulnerabilities" section of the SVAT distilled the factual findings of the assessment process, including:
   - poor mood and sleep patterns;
   - feeling "depressed";
   - being prescribed Seroquel by a doctor;
   - denied a history of suicide; and
   - history of OD in the context of situational stressors

121. This section concluded:

> On review today, nil evidence of major mental illness or mood disorder. Luke denied all thoughts (sic), plans, and intent of self-harm or suicide. Nil CMHS follow up indicated at this time, Luke may benefit from GP review to discuss depressive symptoms. Luke is aware of self-referral process.[59]

122. Static vulnerability factors, which were described in the SVAT as "fixed and historical in nature" were:

---

[56] Ex 1.20 CMS form.
[57] It was completed within a few hours of the assessment: T 24 May 2022, 170, line 35.
[58] Ex 1.20, Page 1 of SVAT. The capitalisation and underlining are as per the exhibit.
[59] Ibid.

- 27-year-old male;
- History of crisis contact with ACT MHS;
- History of OD in 2020;
- History of incarceration; and
- History of substance use.[60]

123. Dynamic vulnerability factors, being factors "which fluctuate in duration and intensity, and are present for an unknown length of time" were:
    - Substance use; and
    - Court outcome.[61]

124. Future vulnerability factors, "which can be anticipated to a certain degree", were:
    - Court 21/02/2022.[62]

125. Strengths and support were listed as:
    - Partner of 4 years;
    - Works as a builder;
    - Gyms;
    - Presented as future focused on induction to custody;
    - Denied all thoughts, plans, and intent of self-harm or suicide on review; and
    - Is aware of self-referral process.[63]

126. After noting the "S" and "P" ratings and triage category, the plan for his mental health care was:
    - "Nil CMHS follow up indicated at this time";[64]
    - "referral to Primary Health', "who will follow up with GP ROI re Seroquel prescription"; and
    - "Luke is aware of the process of self referral".

127. Nurse Manzano re-iterated that Luke was told that he could seek out mental health assistance if required.[65] He was also told that because of COVID-19 restrictions, he

---

[60] Ibid 2.
[61] Ibid.
[62] Ibid.
[63] Ex 1.20 Annexure 'B' 2
[64] Ex 1.20 SVAT 1
[65] Nurse Manzano described the self-referral process in these terms:

> Can you just explain what that is, please?---That would be a discussion with the detainee regarding that the nurses come round to the units about twice a day, show them the uniform that they're wearing underneath the - because we have to wear the full PPE, so show them the colour of the uniform, what they would look like, that they frequent the unit, that they can either talk to the Corrections staff or the nursing

would be remanded in an environment in which he would be isolated (on his own) for a period of time.[66]

128. The documentation was uploaded and available for interrogation by Justice Health staff.[67] However, as noted above, only the CMH Form was available to ACTCS.

129. Like all new inductees, Luke was subject to 60-minute observations.

130. Otherwise, the outcome of the induction process was that no special arrangements were put in place in respect of any health or mental health issues.

4.6.4 – Accommodation within the Management Unit

131. After the ACTCS and Justice Health assessments, Luke was taken to the Management Unit.

(a) COVID-19 Arrangements

132. At the time of Luke's admission, due to the introduction of COVID-19 pandemic procedures, new remandees were housed on their own in a single cell in the Management Unit. That process had been in place since September 2021, for reasons that are analysed more fully below.

133. On day one, remandees were subject to a COVID-19 test, as Luke was. If they were "COVID free", and remained "COVID free" at the end of day five, they were then transferred out of the Management Unit. If they tested positive on the "day one" test or at a later time, or if they refuse to undertake a test, that confinement period could be extended to up to 14 days.[68] [69]

134. Whilst in the Management Unit, remandees were subject to COVID-19 contact restrictions, which were designed to minimise close contact between detainees, and between detainees and staff. This meant that when staff members did interact with detainees in-person, they wore personal protection equipment, including masks.

> staff if they're having thoughts about harming themselves and they will let our team know. And then we also have ongoing training with Corrections about how to recognise if someone is mentally unwell and they can contact our team about that as well.

[66] T 24 May 2022, 178, line 5.
[67] Ibid 173, line 45.
[68] Natalie Adams, Senior Director of ACT Corrective Services at AMC, Ex 1.25 [21].
[69] Knight, T 25 May 2022, 290, line 8.

(b) Physical Environment

135. Before COVID-19, the Management Unit was a unit within the AMC that is used to accommodate and segregate detainees, who, for a variety of reasons, may present with greater behavioural challenges.[70] There were 14 cells (seven on each side), and each accommodates a single detainee. There is an enclosed officer's station between the two blocks of cells, where a Correctional Officer in the station can look out at the cells.

136. Each cell was divided into two parts. The front cell area was a room with a shower, a toilet, and a basin in one corner. A single bed was on the right as you entered the cell. The bed consisted of a single bed mattress, a fitted sheet, and a top sheet. Blankets were available. A closed-circuit television (CCTV) camera was fitted in one corner of the room, and footage produced by it can be viewed from the officer's station. On the front door of the cell, there was a small observation window/portal, orientated vertically, and a hatch below and to the left, orientated horizontally. Both the window and the hatch could be opened from the outside, but not from the inside.

137. At the rear of the room was a wall with a door. The door was metal with a large polycarbonate (the product was called "Lexan") window. Metal bars were fixed horizontally across the width of the window. The bars were fitted closely to the Lexan, although, as it was tragically demonstrated, it was possible to create a small space between the bars and the Lexan. The door opened outwards into a small, encaged recreation area (about 2.5m wide x 3.5m long). That recreation area also had a CCTV camera, footage from it could also be viewed from the officer's station. The door to that area could be opened by the detainee when unlocked. Once unlocked, the door could not be secured in an open position against the adjoining wall.[71]

138. The safety history of the cells in the Management Unit is addressed below.

4.7 – Luke's Movements after Admission

139. Luke's movements and interactions with AMC staff, between the time he entered his cell and when he was found hanging at approximately 1855 hours the next day, have been reconstructed from the CCTV footage, recording of intercom conversations, observation records, and the observations of Custodial and Primary Health staff.

140. Luke entered Cell 3 of the Management Unit at 1718 hours on 31 January 2022. Correctional Officer, Mr Daniel Knight ("CO Knight") was on duty at the time. His

---

[70] *Corrections Management (Management of Segregation and Separate Confinement) Policy 2020* Ex 9.
[71] Ex 1.253-257.

recollection is that, on that day, he spent "quite a bit of time" talking to Luke.[72] He described that interaction as occurring either as Luke entered the cell and whilst the cell door was still open or at some later time.[73] He recalled Luke being polite and respectful and quite happy to engage with Corrections staff.[74]

141. When Luke was seen on CCTV entering the cell, he was carrying objects with him, including documentation that contained information about telephone access. During that evening, Luke read some of that material.

142. He was visited by CO Knight at about 1730 hours. During that visit, he was provided with a meal by CO Knight. CO Knight was in the room for about two minutes. Luke and CO Knight "fist bumped" when he left. After that, Luke smoked a cigarette at 2042 hours, and he laid on the bed and remained there until 0921 hours on 1 February 2022.

143. CO Knight and CO1 Mitchell McAppion were the Correctional Officers on duty in the Management Unit the next morning. Their shift started at 0730 hours.

144. Luke's activity within the cell until 1731 on 1 February 2022 is remarkable for how limited the contact between him and custodial or nursing staff was. He was provided with breakfast and lunch at 1005 hours.[75] Both meals were provided through the hatch in the door.

145. CO1 McAppion was also on shift at that time. He recalls being involved in providing Luke with the meals in the morning. In a statement signed on 22 November 2022, he said:

> I recall Mr Rich jokingly asking whether that food was all that he would receive for his meal.[76]

146. Nursing staff came to the cell at 1022 hours to do their rounds. They were captured on CCTV talking to Luke through the hatch. Given that no medical or mental health issues had been identified at induction, the contact was both COVID-19 -related (asking about symptoms, blood pressure check, and so on) and in the nature of a welfare check.[77] At 1042 hours, Luke spoke to CO1 McAppion over the intercom. That conversation was recorded. He asked about providing his phone number list, and was told that he (CO1

[72] Knight, T 25 May 2022, 303, line 45.
[73] Ibid 315, line 15-25.
[74] Ibid 303, line 19-45
[75] Lunch ws provided in the morning and could be consumed at a time convenient to the detainee. Knight. Ex 214 and summary in brief index.
[76] Ex 1.7: CO McAppion 22/11/22 [18].
[77] Vinod, T 25 May 2023, 255, line 9 (Vinod was not present but said this was part of the purpose of he visits). Both nurses who were present said they asked Luke whether he had any thoughts of self-harm or suicide or wished to speak to Justice Mental health clinicians and he said "No": Ex 17.4(b) and (c).

McAppion) would collect his “in a minute”.[78] It appears Luke’s phone number list was not collected. A similar call was made at 1333 hours,[79] and Luke was told to put the list under the door. In neither call (they were only seconds long) did Luke sound distressed or annoyed. Shortly after, at 1333 hours, Luke could be seen pushing a completed telephone contacts list under the door,[80] and it was collected by CO Knight.[81] The numbers of WT (identified as “partner”) and NE (identified as “friend”) were on the list.

147. At about 1616 hours, an evening meal was provided to Luke through the hatch door.[82] A conversation with Luke occurred at this time, and CO Knight could be seen refilling Luke’s thermos.

148. At some time in the afternoon (the time was not identified with precision and the moment was not captured on CCTV), Luke covered the viewing portal in his cell door. CO Knight said that whilst that was not unusual behaviour by detainees who were “regulars” and those who had been in the AMC “a few times before”, he thought that Luke doing that was “unusual”. The result of that action was that when the door was closed, Luke could only be visualised in-person by someone bending down and looking through the hatch.

149. At 1702 hours, CO Knight could be seen by camera as approaching the door of Cell 3. He did not interact with Luke.

150. Between 1635 and 1641hours, Luke could be seen going into the recreation yard and having a cigarette before returning inside. At 1716 hours, Luke was seen on the bed. He sat up and looked at the camera in his room. He peeled off a label on a water bottle, stepped onto the bed, and placed the label over the camera. Nothing further could be seen from that camera until after his death. At 1723 hours, Luke could be seen as going into the recreation yard again. He sat down and smoked another cigarette. He looked up into the corners of the yard, went into the cell and returned at 1731 hours to cover the camera there with a label. That is the last vision from that camera until after his death.

151. At 1803 hours, footage from a CCTV camera in the Management Unit (outside the cell) showed that staff went to the door of Cell 3. CO Knight could be seen speaking to Luke. By that time, the portal had been covered. CO Knight described that interaction in the following terms:

[78] Ex 1.224.
[79] Ex 1.225.
[80] Ex 1.209.
[81] T 25 May 2023, 320.
[82] Ex 1.216. T 25 May 2023 per CO Knight, 321.

> So, I remember I couldn't see him through his window so I said to him through his door, 'Hey, Luke, how you going in there, mate?' and his response was, 'Nah, I'm good, chief. I'm all good'. And I said, 'Anything you need? Anything I can do?', and he said, 'Nah, chief, all good'.[83]

152. At 1900 hours, CO Knight came to the door with nursing staff, including Nurse Vinod. When Luke did not respond, he opened the hatch and saw Luke hanging from a sheet attached to one of the horizontal bars in front of the Lexan backing. The sheet had been inserted between one of the bars and the Lexan backing and then tied into a knot. His feet were extended towards the cell door, and both heels were touching the floor, with his hips suspended "a few centimetres" from the floor.[84]

153. CO Knight called a "Code Pink" for the Management Unit. He motioned to CO1 McAppion to open the door to Cell 3. He did so within a few seconds,[85] and then went to the cell. CO Knight went to the officer's station to retrieve a Hoffman knife to enable him to cut Luke down.[86] He was unable to find one. He returned to the cell, and while CO1 McAppion lifted Luke, he removed the noose from around his neck. Possibly 30 to 60 seconds elapsed between discovery and the removal of the sheet.[87] Nurse Vinod observed that Luke's lips were already cyanotic when he first saw him.[88] He was not able to say how long Luke may have been in that position before he was discovered.[89]

154. CPR commenced immediately, and although competently performed by nursing and custodial staff, Luke could not be revived. An ambulance was called at 1900 hours, with a second call made at 1911 hours. An ambulance was dispatched at 1901 hours, and a second ambulance at 1912 hours. The first ambulance was on scene at 1915 hours, and the CPR effort was taken over by paramedics at 1917 hours.[90] CPR and

---

[83] T 24 May 2023, 306, line 41-45.
[84] Vinod, T 25 May 2023, 272.
[85] Ibid 271.
[86] A Hoffman knife was described by Ms Adams in these terms:

> So Hoffman knife – or they are sometimes referred to as an intervention knife, is a rather sharp implement that if someone is using strangulation, that this knife will easily cut through any cord, rope or material that is being used for self-strangulation, and part of the use of the knife will be to always cut – I think it's about 10 centimetres from any knot, to allow for any further investigation, and it's to provide staff with an option to have someone removed from the ligature around them. It's not actually designed to actually remove the ligature from the throat, it's to actually remove where it's attached to a hanging point.

[87] Vinod, T 25 May 2023, 272.
[88] Ibid 273.
[89] Ibid 274.
[90] Ex 1.97.

resuscitation efforts, including intubation and the administration of adrenaline, were unsuccessful. CPR and resuscitation were discontinued at 1943 hours.

155. Police arrived at the AMC at 2035 hours and began their investigation.[91] A Forensic Medical Officer examined Luke from 2140, and declared life extinct at 2230 hours.

156. Professor Johan Duflou, forensic pathologist, conducted a post-mortem examination of Luke's body on 3 February 2022. Professor Duflou identified injuries consistent with the apparent mechanism of hanging and the attempts at resuscitation.

157. Toxicological testing was undertaken. It revealed the presence of diazepam and nordiazepam (the breakdown product of diazepam) at levels consistent with therapeutic use. Cocaine was found at low levels (0.02 mg/L). Professor Duflou's opinion was that such a level could be the result of consumption of the drug prior to arrest or the result of consumption of the drug after being arrested.[92] He opined that "if it was the former, it would indicate that a high to very high level of cocaine would likely have been present in the blood of the deceased at the time of arrest, given the relatively short half-life of the drug (0.7 to 1.5 hours) and its expected persistence in blood following last consumption".[93]

PART 5 – EXPERT EVIDENCE

158. Professor Matthew Large, psychiatrist,[94] provided an expert opinion dated 8 November 2022.[95] He was briefed with a large collection of documents, including relevant medical, AFP and custodial records and Professor Duflou's autopsy report. He was briefed to give an opinion as to:

   (a) the adequacy of the mental health assessment and monitoring of Mr Rich, carried out at:

      (i) The ACT Watch House; and

      (ii) The AMC;

   (b) whether the assessment tools used were properly applied, and whether they are considered best practice in a custodial setting; and

---

[91] Ex 1.33 F/C Groves.

[92] There was no evidence before the inquest to suggest that consumption of cocaine could have occurred after arrest. Luke was searched at the Watch House. He was under supervision while he was there. He was isolated soon after his admission to the AMC and could not have sourced cocaine given the circumstances and the brief time he was there.

[93] Professor Duflou Ex 1.44.

[94] BSc, MBBS, fellow of the Royal Australian and New Zealand College of Psychiatrists, PhD in medical science.

[95] Ex 1.42.

(c) whether there was anything arising from the mental health assessments that indicated Mr Rich required a level of monitoring different than what he had received.

159. He was also invited to comment on the use and suitability of suicide risk assessment tools generally and in custodial settings, and to give an opinion as to whether there are alternatives available which might better or more accurately screen for potential suicidality.

160. Professor Large was called as a witness at the hearing.

161. The opinions given in his report were the subject of elaboration during his evidence. Those opinions were not subject to any real challenge during examination by Counsel Assisting, or during cross-examination by Counsels for those given leave to appear. Submissions received from parties given leave to appear, including the Territory, did not raise challenges to Professor Large's opinions.

5.1 – Predictability of Suicide & Risk Assessment Tools

162. Professor Large's central thesis was that "suicides of any sort, including suicides in custody, are not amenable to meaningful risk assessment. This is particularly so when the patient does not appear to have an obvious mental illness and when they deny experiencing suicidal ideas or plans".[96] In his opinion, a restriction on the efficacy of suicide risk tools is that:

> [i]nquiry about the presence or absence of suicidal ideas, which is the basis of most assessments of suicide risk, provides very little indication about future suicide behaviour. The largest review of this question to date found that only 40% of those who suicide had disclosed suicidal ideation and as few as 2% of those with suicidal ideation die by suicide in the following decade. This study suggested that the proportion of suicide descendants disclosing suicide ideas and the proportion of those with suicide ideas who die of suicide are even lower among people like Mr Rich who do not have a major mental illness.[97]

163. In respect of predicting suicide in a custodial setting, he opined that:

> It is the case that suicide risk assessment tools are used in a variety of settings in Australia. However, suicide risk models do not provide enough information to be clinically useful. There is no reason to believe that such tools perform differently in correctional settings and there are no meaningful alternatives that might better or more accurately screen for potential suicide and self-harm in correctional settings.[98]

[96] Ex 1.42, 34.
[97] Ibid 32-33.
[98] Ibid 33.

164. Professor Large was generally of the view that rather than concentrating on suicide prediction, the focus of care should be on ensuring there are positive steps taken to address a person's distress and suffering by sympathetic human interactions,[99] to reduce a sense of isolation, to increase feelings of hope, and to ensure that other therapeutic needs, such as other illness and drug withdrawal, are properly addressed. Medication and counselling can help, but they "only reduce suicide by probably only about 20%".[100] Increasing the level of observations had little discernible effect. He concluded that:

> Restriction of lethal methods, including the reduction of ligature points, is one of the few measures that can reduce suicide in institutional settings.[101]

5.2 – Luke's Decision to Take his Own Life

165. In respect of Luke's decision to take his own life, Professor Large offered this observation:

> In retrospect, a number of factors can be seen as contributing to the death of Mr Rich. These include the likely loss of his relationship and job, strained family relations, his likely coming down from cocaine use, the persistence of diazepam and metabolites, the fact of his incarceration, COVID isolation, and likely aspects of his personality and decision making. No hierarchy of importance should [be given] to these factors, and nor should it be concluded that these factors were predictive of suicide. The vast majority of people with similar or more significant suicide risk factors would not suicide.[102]

166. Professor Large also offered opinions in respect of the specific features of Luke's mental health assessments and his period of incarceration, which are addressed below.

PART 6 – ANALYSIS OF THE ISSUES

6.1 – Background

6.1.1 – Statistical Risks – Suicide in Prison

167. The witnesses who were called acknowledged that the risks of suicide were significantly elevated for prisoners, when compared to the general population.[103] When describing why suicide rates are elevated in a custodial setting, Professor Large noted the high rate of mental illness amongst detainees and the stresses of incarceration, namely separation from social supports, loss of a social role, loss of status, isolation, and loss

---

[99] T 26 May 2023, 343, line 35.
[100] T 26 May 2023, 342, line 45.
[101] Ex 1.42, 34.
[102] Ex 1.42, 34.
[103] Large, T 26 May 2023, 345-355: "to a factor of "10". Batten, T 22 May 2023, 80. Thomson, T 24 May 2023, 205.

of the use of drugs.[104] The risks are higher amongst younger inmates, particularly during the first 24 hours of incarceration, whilst on remand,[105] and whilst confined in isolation.[106] Hanging is a very common means by which people commit suicide in prison.[107]

6.2 – COVID-19 Arrangements at the AMC

168. In mid-August 2021, the ACT went into COVID-19 lockdown. Ms Natalie Adams was the Senior Director of Detainee Services at the AMC. She had been acting in that role since May 2021. In that role, she was responsible for developing arrangements for the isolation and testing of newly admitted detainees. On 6 September 2021, the isolation processes were enacted by the AMC shortly after the first COVID-19 case was identified in the ACT. In a statement tendered in proceedings, Ms Adams outlined why the Management Unit was chosen as the preferred isolation unit:[108]

> 16. The AMC does not have purpose-built units that could be used to isolate detainees from risks of COVID-19. Mr Batten and I considered whether a new admission could be placed within a unit in general population, however the units are constructed so that two cells at the bottom of the unit share air with two cells above. In effect, to safely isolate one detainee all four cells would need to be offline.
>
> 17. The option of the Management Unit for COVID isolation was proposed based on the below:
>
> (a) The Management Unit airflow meant that detainees in cells did not share air between them or the Officers Post;
> (b) The unit had two entry points to allow a specified entry and donning station and exit and doffing station;
> (c) The Cells had a rear yard allowing detainees to have outside air and ability to smoke (not available in any other cell within AMC);
> (d) The Management Unit had a room that was set up as a Health assessment room without the need to move detainees past other accommodation areas of AMC;
> (e) The Management Unit was next to the Health Centre and the closest accommodation unit to Admissions; and
> (f) The Management Unit cells had their own showers and toilets.

169. In her statement, Ms Adams acknowledged that "newly received detainees were at a higher risk of self-harm or suicide, and that extended quarantining may increase this risk".[109]

---

[104] Large, T 26 May 2023, 345.
[105] Ibid 346. Taylor, T 22 May 2023, 33. Adams, T 23 May 2023, 95-96. Thomson, T 24 May 2023, 205. See generally, Matthew Willis et al, 'Self-inflicted Deaths in Australian Prisons' (*Trends & Issues in Crime and Criminal Justice* No 513, Australian Institute of Criminology, 2016) 1 ('Self-inflicted Deaths in Australian Prisons').
[106] Taylor, 22 May 2023, 45. Manzano, T 24 May 2023, 185. Thomson, T 24 May 2023, 206. Chase, T 24 May 2023, 222.
[107] Large, T 26 May 2023, 347.
[108] Adams, Ex 1.25 [16] –[21].
[109] Ibid [22].

170. There was no material produced that suggested that this heightened risk was addressed as part of a co-ordinated policy-development process. Justice Health was consulted in relation to the decision to use the Management Unit for COVID-19 purposes, as far as it can be gleaned from the evidence before the inquest, in respect of public health related issues only.

171. Governance in relation to how that decision was to be implemented was not formulated or published by the time of Luke's death.

6.3 – The Identified Issues

172. The structure of the findings that follow addresses the matters identified in the issues list that was distributed to the interested parties. Each issue is assessed to determine what the answer to the question asked was, and whether the evidence suggested that:
   - (a) there was a co-ordinated approach to mental health care in respect of accused persons like those who were entering custody; and
   - (b) significant decisions involving health care, the circumstances of custody, and accommodation were taken in a way that demonstrated a co-ordinated concern for the potential for self-harm or suicide in custody.

6.3.1 – Mental Health Assessment Processes at the Watch House - Issues List (a) & (c)

173. The relatively close association in time between Luke's arrest and his suicide in custody raised the question as to whether the AFP conducted adequate mental health assessment of Luke.

174. The process of assessment that was undertaken at the ACT Watch House has been detailed above.

175. In Luke's case, there was a structured attempt made to elicit a history that may have informed any risk of self-harm. There were no demonstrated signs of mental illness or signs of recent self-harm. Whilst there was information available to the AFP to raise questions about Luke's self-reported history of drug use, an assessment was made that he was not presently intoxicated and not exhibiting signs of drug withdrawal. CCTV footage confirmed that he appeared to be sleepy at times. He did not show outward signs of distress, intoxication, or cognitive disturbance. It is possible that his tolerance levels for the drug disguised how much of the drug had likely remained in his system.

176. The information gleaned during the assessment process was appropriately disclosed to ACTCS.

177. Further, information arising from an ongoing criminal investigation was shared with ACTCS through the BART file process. The circumstances of his arrest threw some light on Luke's alcohol and drug use. The statement of facts referred, amongst other things, to WT's attempts to limit Luke's drug consumption and his consumption of drugs on the day of his arrest.

178. Professor Large examined the process of assessment carried out by the AFP. He opined that there was no discernible shortfall in the assessments made by the AFP.

179. I find that the mental health assessment processes adopted at the ACT Watch House were adequate.

6.3.2 – The Mental Health Assessment Processes at the AMC - Issues List (b)

180. The process of the assessment is detailed above. The process was undoubtedly thorough. The SVAT was not the only source of information. Generally, Mental Health records held by the Territory were available through the MAGICeR records system. This included records arising from Luke's first admission. It was also possible (as was the case here) for request to be made to the detainee's GP for further or additional information.

181. On the basis of the information obtained, it was accurately identified that Luke did not exhibit signs of mental illness. If he did, consideration could have been given to providing mental health support either in the Crisis Support Unit ("CSU") (if his needs were assessed as acute with an immediate threat of self-harm), or with a higher level of medical intervention and observations while he was accommodated in his cell.

182. The S & P ratings that were arrived at meant that Luke was to be treated as a remandee with no requirements that justified additional clinical attention, or a greater level of observations.

183. Professor Large concluded that ACTCS staff members "conducted reasonable assessments in line with the relevant policies", noting that the assessment process was designed to identify a range of medical needs, not just those relevant to mental health, and that the results were discussed with peers and a medical officer.[110] In his view, the SVAT form "adequately captured ascertainable information about suicide ideas and suicide risk" and Luke's mental health more generally.[111] I agree with his conclusions. I

[110] Ex 1.42, 32.
[111] Ibid.

find that it is likely Luke may have concealed the extent of his depression during the assessment process.

184. As observed above, suicide risk assessment tools do not work as a predictor of suicide and the SVAT, on its face, indicated that was so. That was also acknowledged by other witnesses. Nurse Manzano indicated that she was aware of the limitations of risk assessment tools. Ms Leigh Thomson, who was, at the time of Luke's death, the Team Manager at CMHS, agreed that Professor Large's opinions as to the lack of predictive value of suicide risk assessment tools accorded with her understanding of current research.[112]

185. Therefore, the risks that existed in Luke's case, namely his mental health history, age, status as a recent inductee, remandee, and the fact that he was isolated on his own for an extended period, had to be addressed by the provision of a custodial environment that appropriately addressed general and known risks of self-harm. The fact that Luke had been assessed as a low risk of self-harm did not obviate the need to ensure that known risks personal to Luke (notably, possible past threats of self-harm and recent heavy drug use) were addressed as part of a shared and collective response of all operational areas at the AMC. As much was acknowledged during the inquest process.[113]

6.3.3 – The Management Unit – Issues List (c) and (d)

6.3.3.1 - Introduction

186. The decision to accommodate remandees in the Management Unit was a decision taken to address public health issues arising from the COVID-19 pandemic. Specifically, there was an identified need to isolate new admissions at the AMC from the wider prison population.

187. Whether that decision was sound falls outside the scope of the inquest. Rather, the inquest considered whether:
   - the risks (if any) associated with accommodating remandees within the Management Unit (including the presence of ligature points therein) were considered; and
   - any identified suicide risk was appropriately mitigated (through observations and other measures).

[112] T 24 May 2023, 200.
[113] Taylor, T 22 May 2023, 43.

6.3.3.2 - Issues with Door Safety in the Management Unit

(a) General Maintenance Reviews

188. Issues concerning the safety of the rear Management Unit doors had been identified as part of ongoing maintenance of infrastructure reviews conducted before Luke's death.

189. Mr Craig Batten, Director of Facilities Management at the AMC,[114] provided a statement and gave evidence as to that history. Prior to April 2015, the window in the rear door was made either of Perspex or glass that was around 4mm thick.[115] It was susceptible to damage caused by detainees and could easily break or shatter (with the shards being available as weapons).[116] A contractor was engaged to provide recommendations for a replacement material and the Lexan panels were recommended. They were thicker and stronger, much more resistant to breakage, and could be retrofitted into the existing door frames. One door was re-fitted, and, in light of the demonstrated improvement in performance, all of the Management Unit rear doors were upgraded. That process was completed on 5 June 2015.[117]

190. During the upgrade process, it was brought to the attention of Mr Batten that there was "potential" for makeshift rope to be forced between the horizontal bars and the Lexan, allowing the door to be used as a ligature point.[118] On 5 June 2015, Mr Batten sent Mr Don Taylor, the General Manager at the AMC at the time,[119] an email to bring that to his attention,[120] and to suggest that there be "intermediate fixing" to stop the Lexan from bowing out in a way that would create this gap.[121] He met with Mr Taylor, and the doors were inspected. His recollection was that Mr Taylor "did not want to make additional modifications to the doors, which would depart from the original door design".[122] He reported Mr Taylor as saying that he did not think the problem represented an "obvious ligature point", in that tools would be required to create a gap between the Lexan and the bars. His recollection was that Mr Taylor said that the Management Unit was not for

---

[114] He had filled that role permanently since February 2014: Ex 1.27 [4].
[115] Ibid [16].
[116] Ibid.
[117] Ibid [17].
[118] Ibid [18]. Re-creations conducted by Mr Battens' team after Luke's death, which were videoed, suggest that insertion of the sheet may not have been possible without a tool such as a disposable cutlery knife. Luke had access to disposable cutlery. According to Mr Batten [21], there was normally filler tape between the bars and the Lexan. The filler tape had been removed creating a slight gap. The re-creations suggested that even then a tool was needed to feed the sheet through. Ex 1.17 [21].
[119] Mr Taylor was the General Manager of Custodial Operations until April 2016. In that position, he had direct responsibility for the daily operations and facility management at the AMC: ibid [3]-[4].
[120] Ibid [18] Annexure 'C'.
[121] Batten, Ex 13 [18].
[122] Ibid [20].

"at risk prisoners". Any risk could be addressed by placing at risk detainees in the CSU, rather than by adopting an engineering solution.[123]

191. Mr Taylor, in a statement tendered during the inquest,[124] indicated that he was not in favour of further modification of the doors, because:
   (a) bowing was unlikely, and if it did occur, the "only time the risk was exposed was when any detainee had access to the external area of the door";[125]
   (b) an additional staff member was put in place in the Management Unit "for the purposes of monitoring detainees that had the rear door open",[126]
   (c) access to the rear door (opened) was only possible when extra monitoring staff were rostered in the area;
   (d) detainees in the Management Unit were being visited by an on-site psychologist;
   (e) higher risk detainees could be placed in the AMC "T risk" unit;
   (f) detainees placed in the Management Unit would not be of new arrival status at the AMC; and
   (g) an at-risk process would identify risk factors relating to a detainee, and they would be managed through the High Risk Assessment team.

192. Mr Taylor went on to say that an additional concern "for any door" is that, in an open position, "it can be utilised as a ligature point regardless of any additional bars or structure/fittings. An anchor point for any ligature can easily be facilitated through inserting an item at the top of the door as it is being closed".[127]

193. Mr Batten indicated that he was satisfied with his discussion with Mr Taylor. They both agreed that the horizontal bars on the rear door were not "an obvious ligature point".[128] He added the use of the Lexan "removed all the gaps that had been there previously".[129] He went on to add that an industrial "felt tape" was used between the Lexan and the bars as a "dampener" to reduce the likelihood of cracking".[130]

[123] Ibid [20].
[124] Taylor, 16 November 2022, Ex 1.32.
[125] Ibid [6a]. Mr Taylor, in evidence said that in preparing the statement, he incorrectly stated that the bars were inside the cell: T 22 May 2023, 29-30.
[126] Ex 1.32 [6b].
[127] Ibid [7]. Once the door was "buzzed open" the detainee had control of its movements: Batten, T 22 May 2023, 55.
[128] Batten, T 22 May 2023, 74.
[129] Ibid.
[130] T 22 May 2023, 74.

(b) Prior Acts of Self-harm in the Management Unit

194. On 23 March 2020, a detainee committed an act of attempted hanging in a Management Unit cell by using a piece of clothing over the door and causing it to be secured by closing the door. He spun around, causing the ligature to tighten, and then dropped his weight, causing the ligature to tighten further. Staff intervened. Initially no pulse was detected. CPR was conducted, an ambulance was called, and he was transported to hospital.[131] The inmate survived.

195. On 13 May 2020, a similar event occurred. A detainee secured a ligature by slamming the door closed on the item of clothing and placing it around his neck.[132] CPR was performed, and an ambulance was called. Again, the inmate survived.

196. The second incident in time prompted correspondence on the following day from Mr Batten and the then-Director of Contracts and Procurement to Mr Jon Peach, the Commissioner for ACT Corrective Services. Mr Peach in turn sent a memorandum to the Director-General of the ACT Government's Justice and Community Safety Directorate. According to that brief, prior to that being sent to the Director-General, the Minister for Corrective Services announced that the doors within the Management Unit were to be replaced urgently.[133] The brief to the Director-General stated that:[134]

> Due to an incident that occurred in the AMC on 13/5/20, it has been identified that all of the high security doors in the AMC's Management and Crisis Support Units are no longer fit for purpose, and present a safety risk to detainees and custodial officers. As a result, up to 42 doors require urgent replacement.

197. The cost of the replacing the doors was given at $610,000. The exemption from normal capital works processes was justified on the basis that "the inherent safety risk identified with the current doors, and the replacement of these doors have been deemed as urgent".[135] The brief was approved by the Director-General.

198. The replacement of the rear doors did not go ahead. An approval had previously been given under an infrastructure funding program[136] to allocate $300,000 to replace the front doors of the Management Unit cells. The reason for that was that they were considered to be destructible, and, therefore, capable of being damaged by detainees. Despite the

---

[131] Ex 1.275.
[132] Ibid.
[133] Ex 13, Supplementary Statement of Craig Batten, Annexure 'D'.
[134] Ibid. The brief was a *Procurement Threshold Exemption (Single Select) Brief*. The purpose of the brief was to seek exemption from the usual procurement rules that required a public tender process for procurements valued at $200,00 or more.
[135] Ibid [8a].
[136] Better Infrastructure Funding, Batten, Ex 1.27 [9].

approval that had been given for funds to replace the front and rear doors, it transpired that funding for all the doors to be replaced had never been secured, and it was not available.[137] The replacement of some of the more problematic front doors to the cells in the Management Unit occurred after Luke's death,[138] apparently funded by the $300,000 infrastructure allocation.

(c) Continuing Concerns about Door Safety

199. In November 2019, an external architect was commissioned to undertake a review of the design features of the Management Unit. The scope of the review was determined during 2020.

200. In March 2021, information was being gathered internally as part of the review process. On 30 March 2021, Mr Batten sent an email to Ms Corrine Justason, the Deputy Commissioner of the AMC, and others, listing issues relevant to the design review. In respect of the rear door (referred to as the "mid door" in the email), it was noted relevantly that they could not be locked open, the glazing was not strong enough, and that "bars are ligature points". In evidence, Mr Batten claimed that the identification of the horizontal bars as ligature points may have been an erroneous reference to the self-harm incident of 13 May 2020, which he appears to have assumed involved use of the horizontal bars.[139]

201. In their draft report dated 13 April 2021, Pedavoli Architects noted that the rear doors were not consistent with contemporary design standards. In their view, the door should have been solid with a window to the side to provide light.[140] The bars were not identified as representing a ligature point. However, it was recommended that all cell doors within the Management Unit should be replaced with a contemporary "fit-for-purpose" design.[141]

202. The draft review was distributed for comment. Mr Batten noted that:[142]

> I do not recall that many people responded or were interested in the review at all.

203. The review was not progressed, and the architects "were not engaged to design remedial work for the AMC Management Unit".[143]

---

[137] Ex 1.27 [13].
[138] Ex 13 [15].
[139] T 22 May 2023, 54, line 20.
[140] Ex 1.252, 9.
[141] Ex 1.252, 14.
[142] Ex 13 [29].
[143] Ex 13 [30].

6.3.3.3 – Remediation Work to Doors after Luke's Death

204. After Luke's death, remedial work was done to the doors by placing a flat strip of metal at the rear of the door and securing that to the bar by using Orlock rivets.[144] That device removed the possibility of a gap being accessed between the bar and the Lexan.[145] The cost of that upgrade to all the doors was, according to Mr Batten, about $3,500-$4,500 and took about 3 months to complete.[146]

6.3.3.4 – The Decision to Accommodate New Detainees in the Management Unit

205. As noted, Ms Adams acknowledged that there were risks associated with the new COVID-19 procedures that involved extended quarantining of new detainees. Therefore, a range of measures were developed to mitigate that risk:
    - (i) medical reviews by Justice Health staff (at a minimum of twice daily);
    - (ii) an initial screening of the detainee by a member of the Forensic Mental Health Team;
    - (iii) the availability of portable telephones to allow detainees in isolation regular telephone access to remain in contact with family and friends;
    - (iv) the inclusion of detainees' family members' contact numbers on 'the approved telephone contact list' as a matter of priority for new arrivals into COVID-19 isolation;
    - (v) provision of $20/week telephone credit to all detainees to support family/community contact during COVID-19;
    - (vi) provision of 'reading materials such as magazines' to detainees in the MU; and
    - (vii) making books/magazines from the library available to detainees isolating in the MU.[147]

206. No risk assessment was done to take account of the suicide or self-harm factors that arose from the physical environment of the Management Unit.[148] Ms Adam's attention was not drawn to any issues concerning the doors representing a risk,[149] although she seemed to have been aware of a couple of episodes of attempts at self-harm in the Management Unit cells, including one where the rear door was used as a ligature

---

[144] A form of high strength structural rivet.
[145] Batten, T 22 May 2023, 62.
[146] Ex 1.27 [39], T 22 May2023, 71.
[147] Adams, Ex 1.25 [22] and T 23 May 2023, 96-98.
[148] Adams, T 23 May 2023, 134, line 31.
[149] Ibid 132.

point.[150] Ms Adams stated that Mr Batten did not raise issues regarding the concerns that had emerged about the safety of the units.[151]

(a) Risk Mitigation Measures

207. Whilst the safety of the physical environment was not considered in the decision to accommodate new arrivals in the Management Unit, there was advertence to the general issue of the elevated risk that flowed from the fact that the detainees were new arrivals in the AMC, and that they were going to be accommodated on their own for an extended period of time.

208. The risk mitigation measures proposed by Ms Adams were examined during the inquest as to whether they were actually implemented.

(i) Regular Reviews by Justice Health (twice daily at a minimum)

209. Ms Amanda Chase was, at the relevant time, the Assistant Director of Nursing with the Primary Health team at the AMC. According to a statement signed by her on 21 November 2022:

> The Primary Health team would conduct an assessment of all detainees in the Management Unit three times a day in the course of doing medication rounds… [e]ven if a detainee did not require medication, an assessment would still be undertaken".[152]

210. The plan was, so far as the Management Unit was concerned, for medication rounds to occur at approximately 10:00-11:00 am, at the conclusion of the "lunchtime lock" (which ran from 11:30 am to 1:00 pm) and at 5:30-6:00 pm. It was not clear if the expectation was that contact would occur face-to-face, or if there was such an expectation that was communicated to staff.[153] There were no mechanisms in place to ensure that the contacts occurred.[154] Further, the pattern of nursing visits followed the same pattern that applied before COVID-19 arrangements were put in place.[155]

211. As Ms Chase agreed, the reality was that unless there was an "outreach" (that is, a request for a consultation with a nurse about a medical or mental health issue), there was no contact between nursing staff and detainees during the morning and afternoon rounds.[156] The round in the middle of the day was for quarantine purposes, and it was

---

[150] Ibid 132, line 35-55.
[151] Ibid 134, line 5-7.
[152] Chase, Ex 1.23 [10].
[153] Chase, T 24 May 2023, 219, line 35-45.
[154] Ibid.
[155] Ibid 230.
[156] Ibid.

directed at COVID-19 testing. It appears that this contact may have occurred through a closed door.[157]

212. In reality, therefore, there was no proactive outreach to detainees. Ms Chase conceded that the description given in her statement (extracted above) was incorrect.[158]

213. At the time, it appears that decision-making processes around COVID-19 arrangements were not such as to permit significant focus on mental health monitoring in the clinical setting. Ms Leigh Thompson was, at the time of Luke's death, Team Manager for CMHS. One of her responsibilities was to oversee clinical governance for Custodial Mental Health.[159] In her statement, Ms Thompson indicated that, close to the time of the changes in the accommodation arrangements for new detainees, she expressed concerns that her team "had not been specifically consulted about these changes to the housing of detainees".[160]

214. During the hearing, asked of what she would have raised in those discussions, Ms Thompson said she would have raised concerns about remandees not being accommodated with someone else and staff trying to do reviews through the hatch when clothed in full PPE.[161] If risks had been identified with the doors, then, in her view, CMHS should have been informed.[162]

215. Asked about whether CMHS and ACTCS[163] should have played a role in assessing the physical environment in which the detainees were to be placed, she answered:

> Should you have had a role to play?---Yes, I – in an ideal world probably. But we were always told we're a guest in a correctional environment. A guest service in a correctional environment so - - -
>
> But you're not told that explicitly but that's the feeling you got that you're a guest?---No. Told.
>
> You've been told?---I've been told that.

(ii) Initial Screening by Forensic Mental Health Team

216. The efficacy of the screening as a risk mitigation measure has been addressed.

---

[157] Ibid 237
[158] Ibid 239.
[159] Thomson, Ex 1.24 [4].
[160] Ibid [16].
[161] Thompson, T 24 May 2023, 209-210.
[162] Ibid 214, line 1-6.
[163] In cross-examination of Ms Chase, she suggested that she did not "represent" Corrections Mental Health during COVID-19 planning meetings concerning the use of the Management Unit. However, an "operational director" had responsibility above her for Corrections Mental Health and that person (unnamed) was at those meetings: T 24 May 2023, 234.

(iii) Portable Phones Being Available, (iv) Inclusion of Family Members Numbers to be Prioritised, and (v) Phone Credits

217. Professor Large considered those measures to be sensible. There were, however, significant practical issues that needed to be addressed. CO Knight explained the process by which a detainee would contact "the outside world" using a phone, noting that during the COVID-19 period, face-to-face contact with visitors (including legal visitors) was prohibited, and court appearances were also conducted remotely:[164]
    - detainees would fill out a list of persons they wanted to have on their phone list with their phone numbers;
    - Correctional Officers would then conduct a check to see if there were not court orders prohibiting contact with each person on the list;
    - checks then had to be made of whether the nominated person was prepared to receive calls from the detainee; and
    - once consent was obtained, "security" (who were responsible for ensuring that only nominated numbers were rung), would add that number to security's indices.[165]

218. During non-COVID-19 times, parts of this process were conducted by other areas within the AMC.

219. During the COVID-19 period, responsibilities fell to Correctional Officers to perform more of the phone access process.[166] When asked about how long it might take for a detainee to be put in a position to make a call to someone on their list, CO Knight could not say, other than to point out that they (Correctional Officers) were doing their best.[167] Even when phone access was arranged, it appears that the number of phones that were available in the Management Unit were limited. CO Knight's evidence was that there were two phones available, but only one outside line. Therefore, the custodial staff on duty had to carry the phone around to individual cells to allow it to be used. Legal and court calls were given precedence, and personal calls made by detainees had to be placed in gaps between those calls.[168] Handsets also had to be disinfected after each use. The evidence suggested that Luke was concerned to ensure that his phone list was processed. The evidence confirms this process had not been completed by the time he took his own life, and that he made no calls after he was placed in his cell.

---

[164] Knight, T 25 May 2023, 289.
[165] Ibid 290.
[166] Ibid.
[167] Ibid.
[168] Ibid 291.

(b) Auditing of Risk Mitigation Measures

220. Ms Adams said she was unaware of any auditing process to ensure the risk-mitigation steps were in fact occurring.[169] She confirmed that no direction was given in relation to observations being done in any way different to normal.[170]

6.3.4 – The Adequacy of Observations made of Luke at the AMC – Issues List (d)

Background – Purpose of Observations

221. All new detainees were placed on a minimum of one hourly observations. The result of Luke's assessment process was that he was subject to that same regime of hourly observations.

222. No policy documents that were produced at the inquest described what, for custodial purposes, observations were intended to achieve, and how they were to be conducted and documented. It was suggested by Counsel for the Territory, in cross-examination of CO Knight, that the commentary on the Observation Forms themselves was the official guidance as to how observations were to be conducted. Those requirements, as it was suggested to CO Knight, were re-enforced during recruitment courses,[171] and form part of a "learner guide" provided during a training program for Correctional Officers.[172] CO Knight's replies acknowledged the content of the form, but otherwise he did not recall the content of the training he was referred to.

223. The purpose of observations was variously described by witnesses. CO Knight described them as being to ensure the detainee "was alive and well".[173] CO3 Turner was, at the time of Luke's death, employed as an Area Manager at the AMC.[174] He was in charge of the Management Unit at the relevant time, and described the purpose of observations as "*mainly looking for signs of life, or anything that's going to indicate something else*".[175]

224. It is not suggested that if observations had been conducted as they were supposed to be, Luke might have been discovered as committing acts preparatory to an act of self-harm. The timing of his suicide and his decision to cover the cameras suggest that he was trying to avoid detection. However, the absence of contact meant that, if he was

---

[169] Adams, T 23 May 2023, 135.
[170] Ibid 136.
[171] T 25 May 2023, 326, line 5-20.
[172] Ibid line 30-45.
[173] Ibid 285, line 35.
[174] Turner, T 23 May 2023, 142.
[175] Ibid 149-150.

exhibiting signs of distress, they were not likely to be detected. The absence of human contact may have also compounded his sense of despair.

225. Professor Large saw observations as having limited immediate protective effects, in the sense of permitting the detection of acts of self-harm whilst they were being committed.[176] In his opinion, their efficacy lies in building a level of human contact between detainee and Correctional Officers, so as to mitigate feelings of isolation.[177]

How Observations were to be Conducted

226. As to how the observations were to be conducted, the Observations Form (in which observations were to be recorded) provided that:[178]
    (a) observations must be conducted in-person, not through camera.
    (b) the recording of observations must be made contemporaneously – at the time; and
    (c) observations must describe the detainee's behaviour as observed by the Correctional Officer (including any dialogue, request, and concerns, such as refusal to eat, and the appearance of the detainee).

227. The practice of observations at the time of Luke's incarceration might have varied from this directive. CO Knight indicated that he did his best to perform observations at the allocated interval. However, workloads did not always permit observations to occur exactly on the hour, and it was recognised that they could be done "a little bit late or a little bit early".[179] He strived to conduct the observations through the cell door, but occasionally he did it via CCTV.[180] The CCTV image was sufficiently clear on the screen in the officer's station, without the need to "zoom in" on a given cell's display.[181]

228. Whilst the use of CCTV in conducting accountable observations was not permissible, the camera in the Management Unit cells allowed a detainee to be observed in that way. As noted, Luke covered the camera in his cell with labels taken from drink containers. It appears to have been a commonplace that detainees would do this. CO3 Turner suggested that cameras that were covered in this way could be detected from the master

---

[176] Large, T 26 May 2023, 354. Professor Large based this opinion on what he understood to be the rates of suicide in psychiatric hospitals.
[177] Ibid 357-358.
[178] Ex 1.18.
[179] Knight, T 25 May 2023. This lack of predictability obviously may have some benefits provided that in the end the observations were done.
[180] Ibid 305, line 18. CO1 McAppion said the observations should be done at the window, and it was his practice to conduct observations at the window: McAppion, T 26 May 2023, 365.
[181] Ibid 286**.**

control room, and notification would be sent to the relevant area to remove the material that covered the lens.[182]

229. During COVID-19 arrangements, complications arose, as COVID-19 protocols would have required the use of PPE to enter the cell to remove any item covering the camera. CO3 Turner indicated that it was his "expectation" that Correctional Officers would request detainees to remove the covering. This did not happen in Luke's case, which does raise questions about how ingrained that practice was.

230. There was no evidence before the inquest that the use of CCTV footage was the subject of formal procedural guidance,[183] nor was there any suggestion that the greater use of CCTV was considered as a risk mitigation device in the context of COVID-19 arrangements.

(a) The Recording of Observations

231. As to how the observation sheets were filled out, the detail on them was scant. CO Knight's practice, and clearly the practice of others, was simply to write "in cell." CO Knight indicated that he had been filling out Observation Forms in this way for "some years." He, and he believed others, had not received adverse feedback in respect of that practice.[184]

232. In respect of Luke's observation sheets, on 1 February 2022, entries were made on the hour, at every hour until 1803. Until that time, the entries were uniformly "in cell." The entry for 1803 reads "in cell, talking through window".[185] The entry for 1900 (written in retrospect) says nurses treating detainee with CPR". CO Knight conceded that the entries were not necessarily recorded contemporaneously and said that "you just wrote them in when you had the chance".[186] When it was put that the appearance of the entries on the Observations Sheet gave the impression "of being written at the same time", he indicated "that's how I write".[187]

(b) The Observations of Luke Conducted on 1 February 2022

233. The officers on duty on 1 February 2022 in the Management Unit were CO Knight and CO1 McAppion. They commenced their shift at 7:30 am. CO Knight confirmed that CO1

---

[182] Turner, T 23 May 2023, 144, 156.
[183] Ibid 144: CO3 Turner positively asserted there was no such formal guidance.
[184] Ibid 327.
[185] CO Knight indicated that the words "talking through window" were written by someone else after Luke's act of self-harm, and after he had signed the observation sheet. Knight, T 25 May 2023, 299, line 40.
[186] Ibid 298, lines 3, 20-25.
[187] Ibid line 17.

McAppion was absent for a significant proportion of the afternoon and returned at about 4:00-4.30pm.[188] CO1 McAppion's recollection was that he only had one contact with Luke on 1 February 2022, when he handed over his lunch.[189]

234. Neither officer was given instruction or advice as to any heightened risks that might arise from the circumstances of Luke's confinement under COVID-19 arrangements, and neither was given any instruction as to how they might modify or address any risks posed by the cell doors.[190]

235. It is clear from the evidence that those responsible for conducting observations in the Management Unit on 1 February 2022 were busy. After 1500 hours, the Unit was full.[191]

236. CO Knight explained that during the COVID-19 period, Correctional Officers were asked to assume additional duties that would normally be performed by others, such as the setting up of phones and the conducting of checks of issues arising from their life outside (such as the care of pets). Those duties were over and above making sure they were – "the meals were done," "conducting observations during the day," and "generally staying in contact with the detainees in there to help them through the 14-day isolation".[192]

237. The burden of arranging telephone access has already been addressed.

238. On the day of Luke's death, staff responsibilities were increased due to the arrival of, at about 1500 hours, a detainee in the Management Unit because of his heightened and aggressive behaviour elsewhere in the AMC. CO Knight assisted with that transfer and that detainee's management. That detainee's behaviour disrupted others, including a detainee in Cell 14, who began kicking at the door and screaming.[193]

239. An analysis of the video footage of 1 February 2022 suggests there were in-person contacts at:

- 1005 (through the hatch) [144] ;
- 1022 (though the hatch) [146];
- 1616 (through the hatch) [147]; and
- 1803 (through the hatch) [151].

---

[188] Ibid 301. CO1 McAppion said that he was called away to "help the security team relocate a non-compliant detainee": McAppion, T 26 May 2023, 368, line 44.
[189] Ibid 370.
[190] Ibid 371, line 20-25, and 372, line 20. CO1 McAppion was aware that the rear door had been used as a ligature point "multiple times on multiple occasions". CO Knight said he did not know that the door had been used to commit acts of self-harm until after Luke's death: Knight, T 25 May 2023, 329.
[191] Ibid 303, line 35.
[192] T 25 May 2023, 284.
[193] Ibid 302-303.

240. Otherwise, if the observations recorded were conducted, they must have been done through the CCTV.

241. This suggests that if camera observations were done, CCTV was being relied upon to a significant degree to at least ensure the detainee was "alive and well". The covering of a camera, therefore, may have of been of greater significance than usual.

6.3.5 – The Absence of a Hoffman Knife – Issues List (f)

242. A Hoffman knife was described by Ms Adams in these terms:

> So Hoffman knife – or they are sometimes referred to as an intervention knife, is a rather sharp implement that if someone is using strangulation, that this knife will easily cut through any cord, rope or material that is being used for self-strangulation, and part of the use of the knife will be to always cut – I think it's about 10 centimetres from any knot, to allow for any further investigation, and it's to provide staff with an option to have someone removed from the ligature around them. It's not actually designed to actually remove the ligature from the throat, it's to actually remove where it's attached to a hanging point.

243. Those who first responded to Luke's act of self-harm were not able to access a Hoffman knife. This slowed down the process of removing Luke from the ligature and exposed responding staff to the trauma associated with having to lift Luke to prevent further compression of his neck.

(a) Established Procedure

244. When Ms Adams started in her role, she was requested by Ms Corrine Justason, Deputy Commissioner of the AMC, to consolidate two separate Hoffman knife policy documents. Her evidence was that in preparing those documents, she was told that "Hoffman knives being issued to all staff was not to occur", and she was to "create an operating procedure that allowed Hoffman knives back out into accommodation areas."

245. The consolidated document "Hoffman Knife Operating Procedure" was submitted for approval on 21 September 2021. Consistent with the direction given, the document directed that a Hoffman knife would be kept in each accommodation area of the AMC in a locked box. The document also directed that at the start of each shift, the area supervisor was required to check that the Hoffman knife was available and provided to a Correctional Officer in the area, and that, at the start of each shift, the area supervisor would allocate the tool to a particular staff member for the duration of the shift.[194] A

[194] Adams, Ex 1.25 [28].

compliance form was developed, which required the area supervisor to sign off daily that the knife was present in the accommodation area.[195]

246. At the time of Luke's death, procedure in respect of the use of Hoffman knives had been promulgated to staff but not formally adopted. The further development of the document resumed the day after Luke's death.

(b) Reason for the Procedure Not Being Followed

247. For reasons that were not explained during the inquest, the procedure had not been followed on the day of Luke's death. Ms Adams indicated that "questions were asked" as to why the knife was not in the box. She was not aware of the outcome of that investigation. CO Knight was never informed where the knife was.[196] CO3 Turner's belief was that all the Hoffman knives had been taken to a professional sharpening business at the time, but he was unsure of the details.[197]

PART 7 – FORMAL FINDINGS

7.1 – Coroners Act 1997 – Section 52(1) Findings

7.1.1 – Cause of Death

248. The findings required by ss 52(1)(a) and (b) of the Act were not in contest. I find that:

> Luke Anthony Rich died on 1 February 2022 at the Alexander Maconochie Centre, 10400 Monaro Highway, Hume, in the Australian Capital Territory. He died as a result of suicide by hanging.

7.1.2 – Manner of Death

249. Luke took his own life by fixing a sheet from his bed to a bar that formed part of the rear door of Cell 3 of the Management Unit at the AMC. The relevant cell door was designed and constructed in a way that permitted that to be done. It is possible that Luke used bamboo cutlery that had been issued to him with his meals to push the sheet between the metal bar and the Lexan window.

250. I am unable to say with any degree of certainty why and when Luke decided to end his own life. There may have been a range of circumstances that weighed upon him:

- Allegations of domestic violence had been made against him, and he knew of their nature and scope. Those allegations were untested. However, they were

---

[195] Ibid [29].
[196] Knight, T 25 May 2023, 310.
[197] Turner, T 23 May 2023, 151.

serious. If proven to their full extent, a judicial officer would likely have considered incarcerating Luke on a full-time basis. He made comments at the time of his arrest that he feared such an outcome. He had previously experienced custody as a remandee, as a result proceedings arising out of a previous domestic violence incident involving the same person. By his own admission, he found his previous experience of custody to be difficult and humiliating.

- Luke's relationship with his long-term partner, the victim of his alleged violence, was possibly at an end.
- His inability to communicate with friends and family once isolated in his cell in the Management Unit may have created a sense of isolation from those protective factors and influences in his life.
- I find that at the time of his admission, he was, in general terms, depressed and anxious.
- His incarceration was likely to lead to a loss of his employment. Given the value he placed on discharging the responsibilities of his job in a proficient way, he was likely to have felt the impending loss of his job keenly.
- He was using illicit substances at the time of being taken into custody. Given there were traces of cocaine found in his blood at the time of his death, it is likely, and consistent with what he indicated during his induction assessment, that he was using that drug in considerable quantities. He may have been feeling physical symptoms associated with no longer having access to that drug.

251. However, in the absence of a record made by him of his suicidal intent, it is impossible to say exactly why it was that he had acted in the way he did.

252. It is also impossible to say when Luke decided to take his own life. The covering of the cameras in his cell may have been an indication that he had taken a decision to commit an act of self-harm. However, it may also have been an attempt to provide himself with a degree of privacy.

253. The observations at 1803 hours and 1900 hours occurred at about the time they should have. Luke seems to have timed his tying of the sheet to the door to a period when he would reasonably anticipate he would not be disturbed by Correctional Officers or nurses conducting observations or welfare checks. The covering of the cameras prevented his act of self-harm to be observed remotely.

254. In that regard, his actions spoke of determination to end his own life and to deliberately circumvent some of the protective measures that were in place.

7.2 – Coroners Act 1997 – Section 52(4) – Matters of Public Safety

255. I must consider whether matters of public safety arise in connection with the inquest I have conducted.

7.2.1 – Response to COVID-19 – the Decision to Use the Management Unit as an Isolation Facility

256. Mr Taylor, when employed at the AMC in non-COVID-19 times, regarded the Management Unit as unsuitable to accommodate new arrivals. However, clearly there was a need to establish processes to reduce the risk of new arrivals at the AMC transmitting the COVID-19 virus to other detainees.

257. It is also apparent that the implementation of the decision to use the Management Unit as an isolation facility was affected by the general challenges that were faced by public institutions in coping with COVID-19.

258. I make no finding that it is was inappropriate to use the Management Unit as an isolation facility.

7.2.2 – Assessment Processes – ACT Watch House

259. Consistent with the opinion of Professor Large, I find that Luke’s assessment process conducted at the ACT Watch House was adequate.

260. A realistic assessment of Luke was that he had been using cocaine and perhaps other drugs (illicit and prescription) in considerable quantities in the time leading up to his arrest on 31 January 2022. His use of cocaine in the time leading up to his arrest was disclosed in the police “Statement of Facts”. That information was conveyed to ACTCS and was revealed by Luke himself when he was assessed at the AMC.

261. His demeanour in the Watch House did not raise concerns. His mental health, criminogenic and drug use profiles were not out of the ordinary and did not of themselves suggest that he was at greater risk of self-harm.

7.2.3 – Assessment Processes – AMC

262. I find that the assessment processes conducted at the AMC at the time of Luke’s admission were adequate.

263. The process adopted systematically sought to identify medical issues and mental health concerns that were potentially relevant to Luke's circumstances. He was identified as not presenting with acute medical needs or mental health concerns. That translated to an hourly observation regime, and he was reminded of his ability to self-refer to clinicians if any need did arise. He had the opportunity to "self-refer" on the day he took his own life, but he did not do so.

264. An issue arises as to the extent to which mental health assessments are integrated into an overall strategy of addressing an elevated suicide risk in the cohort to which Luke belonged – young, a recent detainee, accommodated alone, and without access to family and friends through contact visit or use of the phone. The mental health assessments that were conducted were, for the reasons given, of limited value in predicting suicide.

265. The lack of a predictive value of suicide assessments was acknowledged by AMC staff during the inquest. General self-harm risks still had to be managed, particularly in respect of the exceptional arrangements that were in place because of COVID-19. However, it was not clear that induction processes formed part of a co-ordinated response in relation to detainee welfare generally, and the management of the risk of suicide specifically. The impression was that the response of the AMC to suicide risk was a siloed one, in which information relating to potential risks were not communicated effectively between areas having different functional responsibilities.

7.2.4 – Observation Processes – Management Unit

266. I find that the process of observation of Luke that took place on 1 February 2022 was unsatisfactory.

- There was no documented procedure associated with how prescribed observations were to be conducted, other than the observation form itself. Relevantly, according to the Observations Form:
  (a) the observations must be conducted in person;
  (b) notes of the observations must be made contemporaneously; and
  (c) observations must describe the behaviour.

- With the exceptions indicated above, the observations made of Luke on 1 February 2022 were not conducted in-person. If the observations were done at all, they were done by the use of CCTV. The records that were entered only confirmed that Luke was in his cell. They did not describe his behaviour.

- The purpose of conducting observations was not described in any policy or procedure. Observations conducted at hourly intervals are not likely to result in the detection of acts of self-harm. It is assumed that the purpose of observations in a custodial setting includes:
  - (a) detecting abnormal behaviours or issues which might inform protective measures being taken;
  - (b) establishing human contact with detainees; and
  - (c) confirming that the detainee is actually in the cell.
- There was no formal direction given that indicated that observations might :
  - (a) assist in addressing practical issues that a detainee was not able to action;
  - (b) lessen feelings of isolation;
  - (c) allow medical and mental health needs to be identified and acted upon;
  - (d) assist in developing a documented profile of a detainee's behaviour, so that
    - (i) proactive interventions can take place to address potential medical or mental health issues; and
    - (ii) demonstrated distress can be alleviated; and
  - (e) assisting in the development of appropriate case management strategies.

267. Those aims were most likely not being addressed by the observations regime that existed on 1 February 2022.

268. The shortcomings in the recording of observations were, I find, officially tolerated. No evidence was drawn to my attention to suggest that CO Knight misled the hearing in saying that he had been recording observations in that brief form for years without consequence.

269. I find that the use of CCTV for the purpose of conducting hourly observations was, likewise, tolerated. CO Knight was not challenged in respect of his evidence on this issue. No submission was made by the Territory to suggest that CCTV was not relied upon as a form of observation.

270. I also find that it was commonplace for cameras to be obscured by detainees. If the expectation was that the detainee would be requested to remove the material obstructing the lens, there was no evidence of that expectation being enforced in Luke's case. Given the reality was that staff were under pressure to perform observations at all, it was inevitable that CCTV was going to be relied upon to a greater extent than normal

to perform observations. Therefore, actions taken by detainees to cover cameras may have had a greater relevance to safety than normal.

271. I do not attribute blame to the individual Correctional Officers who were on duty. The staffing shortfalls were apparent and known at management levels. The absence of CO1 McAppion for a part of the day led to a situation where CO Knight's ability to conduct in-person observations was compromised.

272. I am unable to say what the consequences of those shortfalls were for Luke. During the observation that occurred at 1800 hours (in the hour before his death), nothing was noted by staff, and he made no request for assistance. It is possible that, at that time, he had already made up his mind to commit an act of self-harm. It is possible that he had not. It is also not possible to ascertain whether, if the door had been opened, acts preparatory to an act of self-harm would have been seen. It is not possible to determine when Luke began the process of attaching the sheet to the door.

273. This submission made by the Territory reflected upon this issue and decisions made by the Government as to how the COVID-19 risk was to be responded to:

> 53. In considering this evidence, the following should be given appropriate consideration and weight. Justice Health, along with all other aspects of the management of the AMC were being guided and directed by the overarching public health requirements set by the ACT government for managing the Covid risk in the high risk setting of the AMC, this could change frequently, sometimes on a daily basis. Further, Justice Health were required to adjust to the new circumstances in the absence of any increase in funding or personnel to meet the increased public health requirements. This was coupled with the circumstances that staff, including Justice Health staff were personally also required to isolate and not attend work if they were sick or otherwise exposed to the virus, creating rostering and staffing issues, and given the unique environment and skills required for health staff at the AMC, no additional staff could be pulled from other ACT health facilities.

274. I accept that the absence of suitable staffing arrangements may have impacted the ability of Correctional Officers to discharge their duties in this context, including conducting appropriate observations. However, the shortfalls in process that were highlighted in the inquest cannot simply be explained by COVID-19 related staffing issues. The shortfall in observation processes were clearly reflective of an ingrained culture and almost complete lack of procedural guidance.

275. I recommend that ACTCS publish guidance to staff, pursuant to s 14 of the *Corrections Management Act 2007* (ACT), that addresses, in light of the findings of this inquest:
    (a) the purposes of detainee observations;
    (b) how observations are to be recorded;
    (c) the role that CCTV is to play in the observation process; and

(d) what is to be done when cameras are intentionally covered by detainees.

7.2.5 – Ligature Points in the Cells in the Management Unit

276. I specifically address the submission made by the Territory on this issue.

277. It was put by the Territory that comments made by ACTCS staff members that the bars on the rear doors created ligature points were intended as referring to the possibility of the Lexan "bowing", and thereby creating space between the bars and the Lexan.

278. The submission was made that:

> From the evidence it is possible to find that the ligature point used by Mr Rich was not an obvious ligature point.

279. The submission made seems to be that the fact that filler tape was used, that tools were needed to remove the tape to create a gap, and that the Lexan did not "bow" meant that the ligature point was, therefore, not "obvious".

280. The Territory's submissions referred to the self-harm events of 2020 as "an unrelated incident" (sic).[198] The submissions went on to say that "unfortunately" funding could not be secured to replace all the doors.[199]

281. I do not accept these submissions. The email of 5 June 2015 sent by Mr Batten to Mr Taylor speaks of a possibility of a gap being created either by the Lexan bowing, or by the use of tools to remove the tape and create a gap between the bar and the Lexan backing. Tools in the form of cutlery were always available to detainees, and the re-enactment conducted by Mr Batten and his team after Luke's death confirmed, as was always suspected, that it was possible to create a ligature point without the Lexan "bowing".

282. Further, to identify the mechanism used by Luke to commit the act of self-harm as the measure of the risk is, in my view, unreasonable. Those in senior management positions, who, in 2020, advocated for the doors to be replaced did not make a distinction between the bars being a ligature point and the movable door being manipulated to create a ligature point. The rear doors of the Management Unit, taken as a whole, had been assessed as "unfit for purpose".

283. A suggestion was also made that the exclusion of ligature points in a custodial environment is practically impossible, and that attempts to achieve such a result can create an environment that is sterile and cold.

---

[198] Territory submissions [65].
[199] Ibid.

284. However, whatever the merits of this proposition, that was not the issue in this case. I find that the rear doors of the Management Unit were not fit for purpose and represented a risk to the safety of detainees. The rear doors, including the bars on those doors, had been identified as being unsafe. The bars had been identified as possible ligature points. The closing of the door to secure items adapted as ligatures had occurred twice before Luke's death. It was open to ACTCS to secure the Lexan to the bars in the way that was suggested in 2015, and that was actually undertaken after Luke's death. It took Luke only a short period of time to identify the door as a ligature point.

285. I recommend that:
   (a) external consultants be engaged to assess the safety of the rear doors in the Management Unit in light of the evidence in this inquest; and
   (b) the outcome of that review be published.

7.2.6 – Hoffman Knives

286. I find that, contrary to policy that had been distributed to staff, a Hoffman knife should have been available in the Management Unit at the time Luke was found hanging in his cell.

287. I find that, whilst the absence of the knife is likely to have added to the trauma of the staff who needed to remove Luke from the ligature he had created, it is not possible to say that the delay in accessing the Hoffman knife in this instance made a difference to their attempts to save Luke's life.

288. The absence of an explanation of where that Hoffman knife, and perhaps other Hoffman knives, was unsatisfactory.

289. I note that immediately after Luke's death, the process by which Hoffman knives were located has changed. The changed process is that each Correctional Officer is issued with a Hoffman knife when they come onto shift. The Territory has indicated that additional knives have been procured.

290. I find that response to be a reasonable one, and I make no further recommendations.

7.2.7 – A Suicide Prevention Framework for the AMC

291. Mr Taylor's suggestion that the management of suicide risk in a custodial environment is a shared responsibility is, with respect, correct. However, I find that Luke's death highlights the lack of a coherent policy framework to give effect to that conclusion:
   (a) The decision to use the Management Unit as a means of COVID-19 isolation for new arrivals at the AMC was a matter for ACTCS. However, it is clear that

decisions around this issue were not materially informed by assessing the impact of those arrangements on the mental health of new detainees. Although a CMHS staff member was, in a formal sense, "at the table" in respect of deciding to use the Management Unit as an isolation facility, there was no evidence that the concerns identified by Ms Thompson were being pressed or advocated for in planning processes.

(b) Ms Adams knew of the risks associated with the rear doors. If the mitigation measures were intended to mitigate suicide risks generally, as Ms Adams suggested, the evidence suggests they were not implemented in an effective way.

(c) In respect of the induction process, there was no evidence of how this process fitted into an overall scheme to address mental health concerns and manage suicide risks, particularly in cases where a detainee was accommodated in a mainstream unit.

(d) The absence of a Hoffman knife highlights not only a lack of accountability within senior management as to this issue, but also demonstrates a lack of insight as to how the ready availability of a knife should form part of an overall strategy to prevent harm.

292. After the hearing, the Territory was asked by me to address a number of issues, including the development of a more cohesive suicide prevention framework or approach strategy. A comprehensive reply was received, including a statement from Ms Narelle Pamplin, Assistant Commissioner, Offender Reintegration of ACTCS. Ms Pamplin spoke in detail of ACTCS's development of a "Detainee Health and Wellbeing Strategy" ("the Strategy"). As Ms Pamplin made clear, the Strategy is a foundational document aimed at improving the collaboration between key service providers. The development of a Suicide Prevention Framework will occur later. This will be led by ACTCS, in collaboration with CMHS, ACT Health, and the Winnunga Nimmityjah Aboriginal Health and Community Service as key health partners.[200]

293. Ms Pamplin also noted that an Induction and Screening Unit has been established within ACTCS, which "aims to strengthen induction and assessment processes in order to develop a more personalised and holistic perspective of a detainee's health needs, individualised circumstances, and immediate and long-term health needs".[201] Ms Pamplin conceded that reviews conducted had found that "the induction process was too siloed, and there was no centralised set of information from which to base an

[200] Pamplin, Ex 17 [8].
[201] Ibid [10].

individualised case plan".[202] The Induction and Screening Unit has been developed "to work collaboratively with Justice Health Services and Custodial Services to ensure that a broad range of supports can be provided to detainees at the earliest opportunity in order to minimise distress and ensure immediate needs are actioned".[203] The formation of the unit, Ms Pamplin stated, recognises "that the induction period is a time of increased risk".[204]

294. At the time of Luke's death, there were specific policies in place that provided specific situational guidance in respect of the management of suicide risk.[205] However, those policies were not intended to provide general guidance and only applied to detainees who were, or may be, eligible to be considered "prisoners at risk".

295. In 2015, Victoria developed a framework to address suicidality within prisons: *Correctional Suicide Prevention Framework Working to prevent prisoner and offender suicides in Victorian correctional settings (*'the Framework*').* In its foreword, the purpose of the Framework was described as complementing specific procedural documents by providing "a single overarching whole-of-system prevention framework to complement existing standards and procedures", and it serves as "a key reference guide for all relevant documentation and creates transparency in the key theoretical underpinnings and principles to guide the strategic nature of this work".[206] The Framework identifies a set of guiding principles to inform its prevention focus. These include:
    (a) The intention of suicide prevention must be to do no harm;
    (b) A prevention approach must be taken to the likelihood of suicide in correctional settings;
    (c) Suicide prevention in correctional settings is a shared responsibility; and
    (d) All staff must create a positive, responsive, and supportive environment for addressing suicide prevention in correctional settings.

296. The adoption of such a framework at the AMC would be to encourage advertence to suicide prevention in relevant decision-making, including that concerning infrastructure and prisoner accommodation, and case management processes.

---

202 Ibid.
203 Ibid [12].
204 Ibid.
205 See *Corrections Management (Court Transport Unit Person at Risk Management) Operating Procedure 2021* (Exhibit 8); and *Corrections Management (Management of At-risk Detainees) Policy 2019*, Ex 1.234.
206 *Correctional Suicide Prevention Framework Working to prevent prisoner and offender suicides in Victorian correctional settings 4.*

297. ACTCS has accepted the need for a suicide prevention framework, and Ms Pamplin indicated that the development of such a framework was expected to be completed by June 2024.[207]

298. I recommend that:
   (a) a Suicide Prevention Framework for ACTCS be developed as a priority;
   (b) it gives expression to the need for suicide prevention to be accepted as shared responsibility at the AMC;
   (c) the terms of the Victorian Framework be considered in that process; and
   (d) an attempt be made as to assess the efficacy of the introduction of the Framework in the Victorian Prison system and reflect those learnings in the process of developing the framework document to apply at the AMC.

7.2.8 – Co-operation with the Inspector

299. There is much for the community to gain from a legislative scheme that permits effective co-operation between the Inspector and the Coroner. That co-operation is envisaged by the ICS Act, and there is no absence of goodwill to make that process effective in assisting both the Inspector and the Coroner's Court to discharge their respective functions when a person dies in a custodial setting. If I am prevented from referencing the information and recommendations made by the Inspector in specific cases and in general, the Court's coronial function is thereby disadvantaged in investigating custodial deaths and in having available the expertise of the Inspector (and perhaps her findings in respect of a death in custody) when framing recommendations.

300. I am aware that the parliamentary privilege issue is under review. Therefore, I do not make any specific recommendations as to that public administration issue, pursuant to s 52(4)(b) of the Act.

PART 8 – SECTION 74 OF THE ACT

8.1 – The Statutory Framework

301. Section 74 of the Act provides:

> **74 Findings about quality of care, treatment and supervision**
>
> The coroner holding an inquest into a death in care or death in custody must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.

[207] Pamplin, Exhibit 17 [14].

302. I proceed on the basis that s 74 of the Act does not require a coroner in cases to which this section applies to always make findings about the quality of care, treatment, and supervision of the deceased. What the section calls for is for findings to be made when shortfalls in the quality of care, treatment, and supervision of the deceased "contributed to the cause of death". That shortfall does not need to be the only matter that caused the death.

303. Given the classes of vulnerable people that fall within the concepts of "custody" and "care", the legislative framework clearly envisages that a finding of contribution to the cause of death can occur when an act of deliberate self-harm is the operative cause of death. I do not regard that such an act breaks the chain of causation. However, in each case, the shortfall in the standard of care, treatment, and supervision must be such as to have made a contribution to the decision to take, or ability to give effect to a decision to take, one's own life.

304. For the purpose of this section, I reflect the findings I made above. At the time of Luke's death, the Territory chose to accommodate newly arrived detainees in a physical environment they knew to be, in one important aspect, unsafe. The rear doors of the Management Unit cells were known to offer ligature points. The class of detainees that were to be accommodated in those cells were at greater risks of self-harm than general detainees. The length and character of the period of COVID-19 isolation meant that new detainees were held in what amounted to a form of solitary confinement. The isolation may have been justified on public health grounds. However, this did not obviate the need to take reasonable steps to ensure that the isolation was as safe as it reasonably could be.

305. Luke's suicide, as with suicide generally, could not be reliably predicted. In light of that difficulty of prediction, Luke's assessment as being of generally low suicide risk did not mean that such risk could be ignored. The reasonableness of the arrangements that were put in place are to be assessed against known (statistical) risks associated with detainees of particular profiles and the risks arising from remandees being placed in a form of health segregation for an extended period. Measures that were said to have been designed to mitigate those risks were not, in Luke's case, implemented.

306. The observation regime in place was inadequate. Staffing resources were insufficient to address the safety needs of detainees. Staff with responsibility for caring for Luke were not briefed in respect of known risks associated with the physical environment in the Management Unit cells. This is so both in relation to the CMHS staff and Correctional

Officers who were on the ground discharging responsibilities in respect of Luke's care and supervision.

307. CCTV cameras were used as form of observation, rather than detainees being observed and engaged through personal contact. This reliance on CCTV cameras was an inevitable consequence of inadequate staffing resources to perform observations in-person. Luke's decision to cover the cameras in his cell and the portal gave rise to greater safety concerns as a result. Those concerns were not identified nor acted upon.

308. For these reasons, I find that a shortfall in the care and supervision of Luke contributed to his death.

POSTSCRIPT

309. I again offer my condolences to Luke's family and friends. Despite the challenges he faced, Luke was a person of great ability who was loved. He will be missed.

310. I acknowledge the contribution to the coronial process made by Luke's family. The investigation process and hearing were confronting and required the family to re-visit the trauma associated with his death. Their active engagement in the process of investigation and the hearing was of great assistance to the Court in the discharge of its statutory responsibilities.

I certify that the preceding three hundred and ten [310] numbered paragraphs are a true copy of the reasons for findings of his Honour Coroner Archer.

Associate: Markus Ching

Date: 22 August 2024

IN THE CORONERS COURT)
AT CANBERRA IN THE) CD 29/2022
AUSTRALIAN CAPITAL TERRITORY)

Inquest into the death of
LUKE RICH

Witness Statement – Jason Bernard Russell
Assistant Commissioner, Custodial Operations, ACT Corrective Services

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false or do not believe to be true.

2. My full name is Jason Bernard Russell.

3. I am currently employed as the Assistant Commissioner, Custodial Operations, ACT Corrective Services (**ACTCS**), at the Alexander Maconochie Centre, located 10400 Monaro Highway, Hume ACT (**AMC**). I commenced in this role in June 2019.

4. I have been employed by ACTCS since 22 July 2002. I started ACTCS as a Corrections Officer 1 (**CO1**), progressed through to a Corrections Officer 4 (**CO4**), reported to the training unit, and then worked in the Executive. In June 2019 I became the Deputy General Manager of Custodial Operations. In January of 2020 it was decided, due to organisational changes that my role would be changed to General Manager. In 2022, again due to organisational changes, my role was changed to the Assistant Commissioner of Custodial Operations.

5. The role of General Manager / Assistant Commissioner involves oversight of correctional operations across ACTCS operational sites including the AMC and the Court Transport Unit (**CTU**). I work with the ACTCS Custodial Management team to ensure the effective day to day operations of facilities and the ongoing service provision of detainee services. I represent Custodial Operations as a member of the ACTCS Executive and work closely with stakeholders and oversight agencies. I am the Executive sponsor for infrastructure projects specific to Custodial Operations, the Executive sponsor for Crucial Projects that pertain to Custodial Operations such as Blueprint for Change and the current Smoke Free project in the AMC, and I am the line Manager

for the Senior Management team at both the AMC and the CTU. I report directly to the ACTCS Commissioner.

6. On 15 March 2021 I was involved in an accident which required me to take leave from work until late July 2021. I underwent a graduated return to work 2-3 days per week until October 2021 when I underwent surgery. I was then on leave from work again until January 2022. I had returned to my role as the General Manager at the AMC by 31 January 2022.

7. I have previously provided a written statement, dated 9 August 2023, to the Coroner in this Inquest on behalf of ACTCS.

8. I now provide a second statement in response to a notice received under section 55 of the *Coroner's Act 1997.* The notice was issued to the Australian Capital Territory, which includes ACTCS. The notice includes proposed findings in relation to ACTCS. This response is in relation to paragraphs 14, 15, 24, 26, 227, 266, 268, 269, 274, 291, 304, 306 and 307.

9. ACTCS make the following points in response.

Changes to medical and mental health observations undertaken by Correctional Officers

10. While ACTCS acknowledges a practice had developed between Correctional Officers regarding medical and mental health observations of detainees, this was not condoned by ACTCS Management. The practice developed was inconsistent with ACTCS' expectations and approved practices. The identified inconsistency however, highlighted a need for change.

11. Since the Inquest, ACTCS has undertaken considerable work to develop procedural guidance and compliance activities to ensure Correctional Officers are acting in line with their obligations when conducting medical and mental health observations of detainees.

12. ACTCS has been developing an AMC and CTU Detainee Observations Operating Procedure (**Operating Procedure**) as well as updated Detainee Observation Forms (**Observation Forms**). The Operating Procedure provides clear instruction to ACTCS Correctional Officers on conducting effective observations of detainees. It aims to ensure the correct practice is consistently applied across the AMC and the CTU.

13. The Operating Procedure clarifies the correct process for conducting detainee observations. In summary, the correct, required process includes:

    - Conducting the observation at the required intervals (as directed by Justice Health Services);
    - Conducting the observations in person and not by CCTV;
    - The person who does the observation must be the person who signs the sheet;
    - If observations are conducted by two officers, they must both sign the sheet;
    - If an officer completes an observation and finds that another officer has also done the observation, they must both record the observation on the form independently; and
    - If an officer cannot complete an observation for any reason within the time period, they must escalate the issue immediately then conduct the observation as soon as possible.

14. In addition to the agreed process outlined above, the current draft Operating Procedure states that if a visual obstruction is present, the observing Correctional Officer must seek to resolve the visual obstruction as soon as practicable and as directed by their Area Supervisor, if possible, by negotiating with the detainee to remove the obstruction themselves, if they are able to remove it and/or created the obstruction.

15. Furthermore, the current draft Operating Procedure states Correctional Officers should ensure their entry on the Observation Form provides reasonable and useful information. The Operating Procedure also provides an example of entries considered to be useful and reasonable and those considered insufficient. However, it is noted the Operating Procedure is currently in the consultation stage and thus, the process outlined above may change before finalisation.

16. The updated Observation Forms have been designed to provide clearer, easily accessible instructions for conducting detainee observations. The format is more user friendly and provides prompts for specific information to be included.

---

17. The Operating Procedure is currently in the consultation stage. A draft has been developed and provided to relevant business units, including Justice Health Services, for feedback. The Operating Procedure is due to be finalised in October 2024.

18. The updated Observation Forms are also currently in the consultation stage. The forms have been drafted and are being trialled by Correctional Officers across the AMC and CTU. The updated Observation Forms are expected to be finalised simultaneously with the Operating Procedure.

19. On 20 May 2024, I sent an ACTCS wide message clarifying the correct procedure for conducting detainee observations and reminding Correctional Officers of their obligation to comply with this regime. Correctional Officers were also directed to commence trialling the updated Observation Forms from 10 July 2024.

20. Additionally, the ACTCS Compliance Team have commenced random 'spot checks' of observations to ensure the correct practice is being followed. These spot checks involve reviewing randomly selected observation sheets against CCTV footage. Any non-compliance is escalated to Senior Management so appropriate direction and education can be provided to the responsible Correctional Officer. Currently, the ACTCS Compliance Team are conducting random spot checks across all units within the AMC, except the Crisis Support Unit (SCU) where the inside of all cells are viewable from the officer's station.

Suicide Prevention Framework

21. Since the Inquest, ACTCS has commenced development of a Suicide Prevention Framework to guide how we work with clients both in the community and custodial correctional environments. The Framework covers four domains namely, risk screening and identification, environment, workforce capability and supports; governance and continuous improvement with two overarching considerations; collaboration and cultural awareness. A comprehensive consultation process has been completed and stakeholder feedback is now being incorporated. There is considerable work to be completed to address all stakeholder feedback. As part of responding to stakeholder feedback we are reviewing the *Correctional Suicide Prevention Framework Working to prevent offender suicides in Victorian correctional settings*. The Suicide Prevention Framework is due to be finalised by the end of 2024.

Accommodation within the Management Unit for COVID-19 Isolation

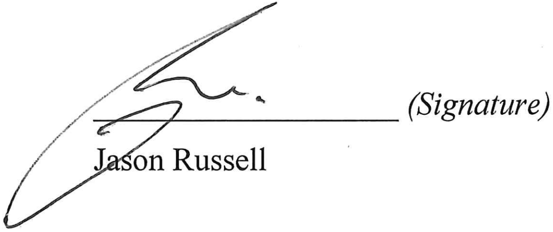
22. The Management Unit (**MU**) within the AMC is no longer being used as a COVID-19 isolation unit because there is no longer a need for it. Instead, the unit is used for its intended purpose, which is to accommodate detainees requiring more intensive supervision due to a multitude of reasons, including the safety/security of themselves and others.

23. The MU was used to accommodate detainees during the COVID-19 pandemic because it was the only viable accommodation option at the time. It was the only unit capable of sufficiently segregating detainees to manage and limit the transmission of COVID-19 across the centre noting the AMC was a high-risk setting. The MU was the only viable option for the following reasons:

    - The MU does not share any air flow or ducting with other parts of the centre thus, alleviating the possible transmission of COVID-19 to other accommodation units. The individual cells in MU are also ventilation isolated in that they do not share air flow or ducting with other cells or the officer's station in the same unit.

    - The MU was considered the least restrictive environment in that it still allowed for the operation (while adhering to COVID-19 protocols) of some services and provided the least impact on the daily routines of detainees accommodated within other units. MU also provided detainees access to a small courtyard at the rear of their cells, which is not available in any other cells within the AMC. The MU cells also had their own amenities.

24. COVID-19 advice from Canberra Health Services has changed over time and thus, so have the AMC's processes for managing and limiting the transmission of the virus across the centre. The length of segregation and the decision to remove a detainee from segregation is determined by Justice Health Services. This practice is consistent with the Commissioner's Instruction 03/2020 Health Segregation for COVID-19 (Restricted).



____________________ *(Signature)*

Jason Russell

Statement and signature witnessed by me about 3:30pm on 8 August 2024 at 2 Constitution Avenue, Canberra City in the Australian Capital Territory.

____________________ *(Signature)*

Claire Buxton (Print name)