CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Justin James Cordy**
Citation:	**[2026] ACTCD 19**
Hearing Dates:	8 – 19 July 2024; 19 September 2024
Decision Date:	23 October 2026
Before:	Coroner Wilson
Findings:	[13]–[15]
Catchwords:	**CORONIAL LAW** – Manner and cause of death - death in custody – mental health – death by suicide in AMC – matters of public safety in AFP custody – AFP conduct did not contribute to death –– matters of public safety at the Alexander Maconochie Centre - observations and cell checks - access to means to complete suicide contributed to cause of death
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BA, 13, 34A, 40, 52, 55, 57, 70, 74-76 *Corrections Management Act 2007* (ACT) s14 *Coroners Act 2003* (Qld) s 46 *Crimes Act 1900* (ACT) s 309 *Criminal Code 2002* (ACT) s 27 *Mental Health Act 2015* (ACT) ss 9, 80
Cases Cited:	*Briginshaw v Briginshaw* (1938) 60 CLR 336 *Commissioner Chief of Police v Hallenstein* [1996] 2 VR 1 *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qd R 352 *Goldsborough v Bentley* [2015] 1 Qd R 138 *Harmsworth v The State Coroner* [1989] VR 989 *Inquest into the death of Anthony Romanas Caristo* [2020] ACTCD 9 *Keown v Khan* [1999] 1 VR 69 at 76. *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 *Mortimer v Coroners Court of Victoria* [2022] VSC 437 *R v Doogan; Ex Parte Lucas Smith & Anor* (2005) 158 ACTR 1 *R v Rogerson* (1992) 174 CLR 268 *Re State Coroner; Ex Parte Minister for Health* (2009) 38 WAR 553
Texts Cited:	Hugh Dillon and Marie Hadley, The Australian Coroner's Manual (2015)

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Annexures:	
	Annexure A – Witness List
	Annexure B – Second Statement of Detective Superintendent John Hawkins dated 9 October 2026

CORONER WILSON:

Introduction

1. Justin James Cordy was a young man of 34 years when he took his own life. He was a much loved father, husband, son, brother and friend. All those who loved Justin lost him too soon.

2. Justin died on Sunday 26 February 2023 whilst a detainee at the Alexander Maconochie Centre (AMC). His death was reported to the Coroners Court the same day.

3. The family requested we refer to Justin by his first name and I have done so, including in this report.

Summary

4. This report comments on matters of public safety connected with the inquest.

5. As this report will be provided to the Attorney-General, it sets out, as it must, my findings about any serious risks to public safety which were revealed in the inquest and findings about the quality of Justin's care and supervision which contributed to his death.

6. A matter of public safety revealed in this inquest was the poor treatment Justin received in police custody. This poor treatment did not contribute to his death. Comments are made to improve public safety of persons in police custody.

7. This report includes findings about the quality of care, treatment and supervision of Justin that contributed to his death.

8. In the AMC, he was given access to the implements he needed to complete suicide in his cell and was not adequately observed. Had he been adequately observed, his preparations for suicide may have been identified which should have led to intervention. Justin brought the object he used to tie the ligature into his cell at 5pm the night before his death. It was in his cell from 5pm Saturday until he was discovered at about 1pm on Sunday. He was also given a shaving razor which contained razor blades in his welcome pack. These assisted him to create the ligature from his bedding.

9. Access to mop handles which could be used to tie a ligature, bedding which could be cut to create a ligature, and inadequate supervision within the AMC contributed to Justin's death.

10. Finally, this report comments on the administration of justice connected with the inquest. Those comments concern the lack of resourcing for the Saturday bail court, which reduces the capacity of that court to adequately consider whether defendants before it should receive immediate mental health care and treatment.

Jurisdiction

11. A coroner must hold an inquest into the manner and cause of death of a person who dies in custody.[1]

12. As I held an inquest, I am required to make the findings required by s 52 of the *Coroners Act 1997* (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
>
> (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
>
> (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; and
>
> (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

13. There is no question as to the identity of the deceased or where he died. The deceased is Justin James Cordy, who died at the AMC at 10400 Monaro Highway, Hume, ACT. Resuscitation attempts were ceased at 13:39 hours and Justin was declared life extinct at 13:40 hours on 26 February 2023.[2]

14. Justin's autopsy was conducted on 28 February 2023 at ACT Forensic Medicine Centre by Professor Johan Duflou.[3] Professor Duflou noted that the direct cause of Justin's death was hanging, with no antecedent causes or other significant contributing conditions indicated.[4] This was supported by the presence of injuries typical of a self-

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[1] *Coroners Act 1997* (ACT) ('*the Act*') s 13(1)(i).
[2] Exhibit 1, Brief AAA, p.4709; p5123.
[3] Exhibit 1, Brief AAA, p 448.
[4] Exhibit 1, Brief AAA, p 448.

inflicted hanging, including a ligature mark on the neck's surface and fracturing of the thyroid cartilage.[5]

15. Post-mortem CT scans found evidence of a hypoxic brain injury with features of diffuse cerebral swelling, which was likely linked to the hanging and noted to be the probable cause of death.[6] Professor Duflou confirmed that Justin suffered a cardiopulmonary arrest as a result of hanging. He considered that it would have occurred rapidly, within minutes after the commencement of the neck compression caused by the ligature. Based on the assumption that Justin was seen alive at 11:40 hours, Professor Duflou concluded that Justin suffered a cardiopulmonary arrest sometime between 11:40 hours and 13:00 hours, when he was found hanging in his cell.

16. More detailed findings as to the manner of Justin's suicide are set out below.

Scope of the inquest and the making of findings

Scope of the inquest

17. One of the main objects of the *Coroners Act 1997* (the Act) is to give functions to coroners to hold inquests into deaths, including deaths in custody,[7] and to make findings about the deaths.[8]

18. The Coroner must hold an inquest into the manner and cause of certain deaths, as set out in s 13 of the Act. It includes that a coroner must hold an inquest into the manner and cause of death of a person who dies in custody.[9]

19. The inquest incorporates all of the investigation into the death, including but not limited to the public hearing.

20. A coroner may decide not to conduct a hearing into a death which is listed in s 13 of the Act, if satisfied of the matters set out in s 34A of the Act. In those cases, an inquest still occurs, just without a public hearing.[10] Each inquest will still produce a written report with findings, comments and recommendations.[11]

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[5] Exhibit 1, Brief AAA, p 448.
[6] Exhibit 1, Brief AAA, p. 11.
[7] Defined in s 3C of the Act.
[8] *The Act* s 3BA(1)(c).
[9] *The Act* s 13(1)(i).
[10] The hearing is public except in certain cases: *The Act* s 40.
[11] *The Act* s 52(3).

21. A coroner cannot dispense with a hearing into a death in custody.[12] It is useful to bear in mind that the inquest extends beyond the evidence adduced during the hearing. This is relevant, for example, to the Coroner's findings about whether "a matter of public safety is found to arise in connection with the inquest"[13] or "any matter about the administration of justice connected with the inquest".[14]

22. The short point is, the hearing is not the inquest, it is merely part of it. The inquest started when the Coroner was notified of the death which was on the day Justin died.[15] Constable Bishop was the investigating officer for the coronial process.[16] He prepared the police coronial report which forms part of the evidence in this inquest, which he provided to the Coroners Court on 28 February 2023.[17] The inquest has been ongoing since 26 February 2023.

23. The authorities recognise that, notwithstanding the broad jurisdiction of a Coroner, an inquest should not be open ended. In *R v Doogan; Ex Parte Lucas Smith & Ors* (2005) 158 ACTR 1, the Full Court of the ACT Supreme Court stated at 6:

> The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the Coroners Act 1997 and make, if possible, the required findings and any comments that may be appropriate.
>
> ….
>
> The Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of this death?" or "what caused this fire?". It does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.[18]

24. The Full Court also warned Coroners against the conduct of "a wide-ranging inquiry akin to that of a Royal Commission" (at [28]) and provided an example of the limits of enquiry at [31]:

> … a coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred ... would not authorise the

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[12] *The Act* s 34A(2).
[13] *The Act* s 52(4)(a).
[14] *The Act* s 52(4)(b).
[15] Death notification for Justin was received by the Coroners Court at 6:55pm on Sunday 26 February 2023 from Constable Philip Cantwell.
[16] T32.
[17] Exhibit 1, Brief AAA, p.37; T42.
[18] *R v Doogan; Ex Parte Lucas Smith & Ors* (2005) 158 ACTR 1, 6.

> coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.

Findings about quality of care, treatment and supervision

25. Section 74 of the Act is, relevantly:

> The coroner holding an inquest into a … 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.

26. Section 74 requires that the "quality" of Justin's care, treatment and supervision be considered. Having regard to the ordinary meaning of the word "quality", the section is directed to the identification of a departure from an applicable standard or norm. It plainly involves consideration of whether the individuals who in fact provided care and treatment to, or who supervised, the deceased, met the standard expected of them by the relevant agency. It also extends to consideration of whether the agency's systems of care, treatment and supervision met a reasonable or appropriate standard, having regard to the risks faced by persons in custody.

27. A finding under s 74 cannot be made unless the Coroner forms an opinion that the individual failing, or the deficiency in the system, contributed to the deceased's cause of death.

28. The phrase "contributed to the cause of death" encompasses the similar concepts of contribution and cause. In a different statutory context, a finding that a person "contributed to the cause of death" has been said to require a finding that a person's acts or omissions were *a* cause of death.[19] The same meaning should be given to the phrase as it is used in s 74, with the result that the issue to be determined is whether the quality of Justin's care, treatment and supervision was *a* cause of his death. Again, the relevant test is the 'common sense' test laid down in *March v E & MH Stramare Pty Ltd*: *Commissioner Chief of Police v Hallenstein*.[20]

29. Section 74 does not specify whose care, treatment or supervision can be the subject of findings. Justin died while in the custody of ACT Corrective Services (ACTCS) at the AMC. Justin had been in the custody of ACTCS since approximately 8:30 hours on 25 February 2023, when he was collected from the Watch House by Corrections staff and

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[19] *Keown v Khan* [1999] 1 VR 69, 76.
[20] *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; *Commissioner Chief of Police v Hallenstein* [1996] 2 VR 1, 17.

conveyed to the ACT Magistrates Court. He had been in AFP custody from the time of his arrest on 24 February 2023 at about 12:45 hours to the time he was collected by Corrections from the Watch House the following morning.

30. There is no question that I have the authority and the obligation to make findings, pursuant to s 74, in relation to the quality of care, treatment and supervision of Justin while in the custody of ACTCS, provided I hold the opinion that the quality of that care contributed to his cause of death, based on the evidence.

31. What is less clear is whether s 74 extends to the making of findings in respect of the quality of the care, treatment and supervision of Justin while he was in AFP custody. Although Justin had been continuously in custody from the time of his arrest to the time of his death, the AFP was not the agency that had custody of Justin at the time of his death. It is arguable that s 74 extends to findings about the quality of Justin's care in the days immediately preceding his death, if the quality of his care, treatment or supervision by the AFP contributed to his death. As I have concluded that Justin's care and treatment by the AFP, despite being sub-optimal, did not contribute to his death, the findings pursuant to s 74 will not extend to the quality of his care whilst in AFP custody.

Findings, comments and recommendations about public safety

32. The Act recognises that the broader purpose of an inquest is to contribute to a reduction in the number of preventable deaths. This is recognised in subsection 3BA(1)(d)(i) of the Act, which provides that one of the main objects of the Act is to allow a Coroner, based on the findings in an inquest, to make recommendations and comments about the prevention of deaths.

33. Section 3BA relevantly provides:

> (1) The main objects of this Act are to—
>
> (a) establish the Coroner's Court and position of Chief Coroner; and
>
> …
>
> (d) allow a coroner, based on the coroner's findings in an inquest …, to make recommendations and comments about the following:
>
> (i) the prevention of deaths;
> (ii) the promotion of general public health and safety …;
> (iii) the administration of justice…

34. Subsections 52(1) and (4) 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;

…

(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; and

(b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

35. Counsel Assisting submitted, that the only limiting consideration is that the matter of public safety must be found to arise *in connection with* the inquest.[21]

36. The AFP submitted, "that when s 54(4)(a) [sic] of the Act is read in conjunction with the objects in s 3BA(1)(d) and in light of its contextual placement within s 52 entitled "Coroner's findings", there is a further limiting consideration in that the comments must also be based on the Coroner's findings… the comments must arise out of the findings and the power to make them does not thereby enlarge or provide any separate jurisdictional basis for a Coroner to enquire into issues." [22]

37. In reply, Counsel Assisting submitted:

> 5. It is not clear whether the "findings" referred to in [AFP submissions] paragraphs [25-26] are limited to the mandatory findings referred to in s.52(1) of the Act. If so, that would be a surprising constraint on a Coroner's powers.
>
> 6. In any event, the submission [that the coroner's power to comment is limited by s.3BA(1)(d) and that comments must "arise out of" findings] should not be accepted. Section 3BA(1)(d) does not place a further limitation on a coroner's powers to comment on matters of public safety. The submission assumes, incorrectly, that s.52(4)(a) does nothing more than confer on a coroner a power (and obligation) to make comments about matters of public safety. Properly understood, s.52(4)(a) confers a power to make comments about matters of public safety (s.52(4)(a)(ii)) and a power to make findings about such matters (s 52(4)(a)(i)). Under s.52(4)(a)(i), a coroner must "state whether a matter of public safety is found to arise in connection with the inquest". Put differently, if a matter of public safety arises in connection with the inquest, the coroner must make a finding to that effect. If such a finding is made, then, under s 52(4)(a)(ii), the coroner must include in the findings, a comment on that matter.

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[21] Counsel Assisting's Submissions (**CA Submissions**), [24].
[22] Submissions by the Australian Federal Police (**AFP Submissions**), [25]-[26].

7. On this basis, the phrase "based on the coroner's findings" in s 3BA(d) does not impose an additional limitation on the comment making power in s 52(4)(a)(ii). The "findings" in s 3BA(d), encompass a finding under s 52(4)(a)(i). The only limitation to the power to make such a finding is that it must arise in connection with an inquest.

8. It is otherwise accepted that a distinction should be drawn in a coroner's findings between comments and findings.

38. Subsection 57(3)(c) explains that a report to the Attorney-General on an inquest may make recommendations about matters of public safety if the recommendations relate to the Coroner's findings about a cause of death and would, in the Coroner's opinion, improve public safety.

Comments about the administration of justice

39. One of the main objects of the Act is to allow a Coroner, based on the findings in an inquest, to make recommendations and comments on the administration of justice.[23] A Coroner may, in the Coroner's findings, comment on any matter about the administration of justice connected with the inquest.[24]

40. However, s 57(3) allows a Coroner to include in a report to the Attorney-General, recommendations about public safety. It would seem a recommendation could only be made about the administration of justice if it also was a matter of public safety.

41. The term "administration of justice" refers to the due exercise by a court or competent judicial authority of its jurisdiction to enforce, adjust or declare the rights and liabilities of persons subject to the law in accordance with the law and the actual circumstances of the case.[25] The same phrase, used in legislation granting jurisdiction to Coroners in other States and Territories, has been interpreted as extending to issues which, although connected in some way with the death being investigated, is unconnected with the cause of death or any matter on which a Coroner is obliged to make findings.[26]

42. In this report, I have found that the fact Justin was not the subject of a s 309 order by the Court, did not contribute to his death. Put another way, I have found that had a s 309 order been made, this would not have prevented his death. However, in conducting the inquest, I have received evidence about the operation of the Saturday bail Court in the ACT Magistrates Court, and its operation is connected with the inquest. Justin was told

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[23] *The Act* s 3BA(1)(d)(iii).
[24] *The Act* s 52(4)(b).
[25] *R v Rogerson* (1992) 174 CLR 268 at 280 per Brennan and Toohey JJ and at 300–4 per McHugh J.
[26] *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qd R 352*; Goldsborough v Bentley* [2015] 1 Qd R 138 at 144.

by the nurse he spoke to on the night of his arrest, to speak to "mental health" the next morning at Court. The Mental Health Court Assessment and Liaison Service (MHCALS) does not operate on Saturdays. Further, the junior lawyers who appeared on a duty basis in each of the bail matters, did so with limited training and no support. The obligations on them were too high such that those appearing in the Saturday bail court do not receive the same level of service, or representation, as those who appear in the weekday bail courts. This is not a reflection of the abilities of those individual lawyers, but of the system within which they were expected to work.

43. Those defendants who have the misfortune to appear in the Saturday bail court cannot have their mental health considered in the same way as those who appear before the bail court on a weekday. This impacts the administration of justice.

44. The justification for MHCALS not operating on Saturday, as it does on weekdays, is staffing issues, combined with a lack of request from the Court and a reduced number of defendants on Saturdays. The evidence in this inquest does not support a finding that there is any material difference in the number of defendants who appear before the weekday bail court and the Saturday bail court.

45. I suggest better resourcing for the Saturday bail court, including more support and training for the duty lawyers and the availability of the MHCALS.

Standard of proof

46. Findings to be made by a Coroner must be based on proof of relevant facts on the balance of probabilities. They must be based on a rational assessment of the relevant evidence to an appropriate level of confidence. The principle laid down in *Briginshaw v Briginshaw* (1938) 60 CLR 336 applies.[27] That principle is:

> …. when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.[28]

47. The "gravity of the consequences" extends, in the coronial context, to damage to the reputations of witnesses, which must be taken into account when a Coroner is exercising the power to make comments.[29]

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[27] *Minister for Health* 561 [21] (Buss JA); *Mortimer v Coroners Court of Victoria* [2022] VSC 437, [89].
[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361–2 (Dixon J).
[29] Hugh Dillon and Marie Hadley, *The Australian Coroner's Manual* (2015), 11–12.

Background

48. Justin was born in Canberra on 3 January 1989. His parents were Jane and James Cordy.

49. Justin's parents separated before he started school. He had two half-brothers: Tristan, who was Jane's son, was older than Justin, and Bryce, who was James' son, was six years younger than Justin.

50. After his parents separated, Justin lived with his mother and Tristan, and spent every second weekend with his father. He met Sheryl Gurr, now Sheryl Cordy (Sheryl), at high school. He later described his childhood in positive terms and said that he had a close supportive relationship with his mother.

51. Justin and Sheryl's first child was born in November 2009. At around that time, the family moved to Queanbeyan and Justin began a plumbing apprenticeship. Justin and Sheryl's second child was born in May 2011. Justin and Sheryl married in 2011.

52. By about October 2017, Justin and Sheryl had separated. Sheryl believes that, by around this time, Justin had become involved in using methamphetamine.

53. Justin's first contact with ACT Corrective Services was on 9 October 2017, when he was subject to a supervised bail order for damage to property.

54. On 15 November 2017, Justin was remanded in custody at the AMC. This was his first period of incarceration at the AMC. He was released on bail two days later.

55. At all times material to this inquest detainees, on their arrival at the AMC, underwent an induction assessment, undertaken by Justice Health Service (JHS) clinicians. This included assessments by a clinician within the Forensic Mental Health Service (FMHS) team and the Primary Health (PH) team. The JHS PH clinician may decide to place a detainee on a medical alert rating, which ranged from M1 to M3, with M1 being the highest rating. The M rating would determine observation frequency.

56. As part of the FMHS induction, the clinician would:

    (a) Undertake an assessment of the detainee's suicide and self harm risk and arrive at an S rating, with five levels, S Nil being the lowest risk of self harm/suicide and S1 indicating the highest risk. The S rating would determine the frequency of observations of the detainee.

    (b) Give the detainee a Psychiatric rating (P rating), also with five levels. A P Nil rating indicated no psychiatric concerns and a P1 rating was the highest and indicated that the detainee had a serious psychiatric condition.

(c) Give the detainee a triage rating from A to G. A triage rating of A indicated that the detainee was undergoing a crisis requiring immediate management and a G rating was given for advice or information, with no further involvement of FMHS required.

57. On his FMHS mental health induction screening at the AMC, which was undertaken by RN Walker on 15 November 2017, Justin was rated as P nil, S nil and given a triage rating of G.

58. On 15 February 2018, bail was revoked and Justin was remanded to the AMC. This was his second period of incarceration, which was to last for almost six months.

59. At his AMC forensic mental health induction on 15 February 2018, Justin reported suicidal ideation, which was assessed as related to his current situational crisis. A Suicide Vulnerability Assessment Tool (SVAT) was completed by the admitting nurse. Justin was given an S3 rating, with hourly observations and an F triage category.

60. On 19 February 2018, Justin was considered by a multidisciplinary team including psychiatrists and nursing staff. It was noted that he was presenting with current risk issues (thoughts of suicide). It was recommended that he remain on a S3 rating.

61. On 7 August 2018, Justin was convicted of nine offences, including family violence and assault offences. He was released from custody with a suspended sentence and a series of probation conditions, including to attend such assessments (including psychological) as directed.

62. ACTCS records indicate that Justin relocated to Western Sydney after his release and his supervision was carried out by Corrective Services NSW.

63. Despite their separation, Justin continued to maintain contact with Sheryl, who was the primary carer of their children.

2020 incarceration and suicide attempt

64. After returning to the ACT, Justin was remanded in custody on 10 April 2020 on charges relating to drug possession and possession of stolen property. This was his third period of incarceration at the AMC.

65. On the day he was remanded, Justin underwent a forensic mental health induction at the AMC. He was assessed by a psychologist. She noted a history of suicidal ideation without intent in custody in 2018. She recommended ratings of P nil and S nil and that no mental health follow up was required.

66. On 11 April 2020, Justin was placed in isolation due to a suspected contact with COVID 19. At around 14:25 hours, while in his cell, he attempted suicide by hanging ([redacted]).

67. Justin was taken to The Canberra Hospital (TCH) and reviewed in the Emergency Department. He returned to the AMC on 12 April 2020 and was placed in the Crisis Support Unit (CSU).

68. On 20 April 2020, Justin was considered and discussed at a multidisciplinary team review. It was assessed that the precipitating factors for the recent suicide attempt remained unclear. Justin had reported he was "fine" but was not willing to discuss events with clinicians. The plan included a psychiatric review that week for further risk assessment and asking Justin for consent to speak to family members and gather collateral information from ACTCS.

69. On 23 April 2020, Justin was reviewed by a psychiatrist. She noted two previous incarcerations at the AMC, a history of substance misuse and that he was the father of two children in custody of his ex-wife. He described his suicide attempt as impulsive. He noted that his hardest time in custody was following his arrival before he had come to terms with being in the AMC. He identified his children and girlfriend as strong protective factors. He said that he found being in the AMC difficult because he was worried he would lose them. He declined to consent to mental health staff speaking with his girlfriend, Sheryl or wider family.

70. Dr Fox recorded the following impression:

> Justin is a 31yo male who engaged in recent suicide attempt whilst in custody. This attempt appears to have been impulsive and as a result of a situational crisis, related to Justin's reincarceration into AMC and associated catastrophising regarding loss of relationships he had developed in the community. This was also in the context of placement in the Management Unit and associated depravation and social isolation, along with amphetamine withdrawal after consistent daily usage.
>
> There was no evidence on review today of major mood disorder or psychosis, or of overt problematic personality traits which may elevate his vulnerability to further suicidal behaviours.
>
> He does report ongoing difficulty with sleep, associated with anxious ruminations around being incarcerated, and this appears most consistent with difficulties around adjustment into custody. He is reportedly agreeable with seeking assistance from Primary Health or FMHS if this problem is ongoing, or he feels he needs further intervention around his anxiety including medications.

71. On 23 April 2020, a modified risk management plan was completed by the chair of a High Risk Assessment Team. The plan noted that Justin had denied thoughts of self-

harm and suicide and was feeling safe and settled. Justin's risk level status was modified to S4.

72. Justin was released from the AMC on 8 May 2020 on a supervised bail order.

May 2020 to September 2022

73. On 24 March 2021, Justin was convicted of driving while disqualified and failing to appear after a bail undertaking. He was released on a good behaviour order. On 29 June 2022 he was resentenced for breaching that good behaviour order.

74. In an ACTCS offender intake form dated 14 July 2021, it was recorded that Justin was employed as a labourer, he had a girlfriend, he had a good relationship with Sheryl and saw his children every second weekend. He also disclosed regular use of illicit drugs, including ice, which he had been using for 3 to 4 years.

75. Justin began a new relationship sometime prior to September 2022.

7 September 2022 to 21 February 2023

76. Justin was arrested on 7 September 2022 and charged with several offences, including destruction of property and minor theft. He sustained an injury to a finger on his right hand during his arrest. He was initially released on bail but bail was revoked on 12 September 2022.

77. On 12 September 2022, Justin underwent an induction at the AMC. The forensic mental health induction noted that Justin had a history of incarceration, suicide attempt by hanging, crisis contact with ACT Mental Health Service and substance use. The nurse noted no diagnosed major mental illness. Justin was assessed as settled at review and he denied any current thoughts, plans or intent of self-harm. He was given an S4 rating (nil observations) and nil P rating.

78. On 10 October 2022, while still in custody Justin underwent surgery at TCH on his right hand.

79. On 10 January 2023, Justin was brought to the clinic at the AMC after a suspected Buprenorphine overdose, which he denied. He was put on medical hourly observations and transferred to the CSU overnight. He disclosed that he was a daily user of GHB, buprenorphine and ice. He requested opioid maintenance therapy (OMT). He was notified the next day that he did not meet the criteria for OMT.

80. On 11 January 2023, he was placed on M1 medical observations, being 15 minute observations, which were changed on 13 January 2023 to M3 medical observations, being 60 minute observations.

81. On 17 January 2023, medical observations were removed.

82. On 12 December 2022, Justin was convicted of eight charges, including minor theft and damage to property. His sentences included terms of imprisonment. He remained in custody until he had a further sentence hearing on 18 January 2023 when he was convicted of five further offences. He was sentenced to a term of imprisonment that would conclude on 21 February 2023.

21 to 24 February 2023

83. Justin was released from the AMC on Tuesday 21 February 2023. He remained subject to an 18 month good behaviour order. Sheryl picked him up from the AMC, took him to get a haircut and then back to her house to get some clothes. She then dropped him at his girlfriends' father's home in Fadden. Sheryl believes that he purchased a Honda vehicle from his girlfriend's father.

84. On the evening of Wednesday 22 February 2023, Justin had dinner with Sheryl and their children at Sheryl's home.

85. Later that evening, Justin returned to his girlfriend's home in Calwell (the Calwell residence), which she owned and shared with the owner of the property. Justin and his girlfriend had an argument about a relationship she had while Justin was in custody. Justin left the premises in the Honda.

86. At about 00:45 hours on Thursday 23 February 2023, police noted a Honda driving erratically in the Canberra suburb of Richardson. It was reported by police as failing to stop, with the driver of the vehicle suspected to be Justin.

87. At about 09:00 hours on Thursday 23 February 2023, Justin returned to the Calwell residence. His girlfriend later told police that he woke her up by throwing coffee over her. She described him as being in a heightened state and in psychosis, crying and sweaty, and threw a box of juice at her. Justin used her phone to call Sheryl and while doing so, saw a text relating to her relationship while he was in custody. His girlfriend told police that Justin broke her phone, destroyed credit cards that were in her phone, abused her and threatened that an associate would injure her.

88. Justin left his girlfriend's residence and Sheryl later picked him up from shops in Calwell. She took him to see a couple of people and then he asked her to drop him off at Fadden Park, where he hid from police.

89. Just before 10:00 hours on 23 February 2023, Constable Blaine Jarvis (who on the day was Acting Sergeant Jarvis) was patrolling in a marked police vehicle in the suburb of Calwell. The owner of the Calwell residence saw the marked police vehicle and flagged it down.

90. Acting Sergeant Jarvis attended the Calwell residence and took a Family Violence Evidence In Chief (FV-EIC) statement from Justin's girlfriend. Police also interviewed the property owner.

91. During the FV-EIC, Acting Sergeant Jarvis was told that Justin was in crisis as he had found out about his girlfriend's infidelity and had told her that he did not want to be alive anymore. She said she believed this. She stated that Justin had been panicked about something that had happened the night before, but that it was "not her truth to tell". She explained that Justin was "terrified" of going back into custody at AMC.

92. At 10:11 hours, police issued a "Look out to be Kept For" minute in respect of Justin for aggravated common assault and other charges. Senior Constable Fergusson and Constable Russell arrived at the Calwell residence at about 10:15 hours to assist with the investigation.

93. At about 13:30 hours, AFP officers attended Sheryl's home. Constable McClure spoke with Sheryl, who told them that she had dropped Justin off in Greenway.

94. Senior Constable Fergusson was assigned as the case officer in respect of the offences involving Justin's girlfriend (family violence offences). He commenced preparation of a Statement of Facts for family violence offences, and Constable Russell prepared a minute requesting that the DPP consider making an application to the Court for an order under s 309 of the *Crimes Act 1900* (the s 309 Minute). A s 309 order causes the defendant to be taken by a police or corrections officer to an approved mental health facility for clinical examination for the purpose of deciding whether the defendant needs immediate treatment or care because of mental impairment.

95. The s 309 minute stated:

> During the argument, the defendant made threats of suicide to his partner, stating he "does not want to be alive anymore" and he wants to kill himself.
>
> Police hold concerns for the welfare of the defendant due to these insinuations of self-harm.

96. Constable Russell prepared an ACT Police bail consideration form (also referred to as a "Bail Opposition Form"), which recorded that a "s.309" was required.

97. Acting Sergeant Jarvis reviewed the s 309 Minute and the bail consideration form.

98. AFP Officers continued to search for Justin during the afternoon of 23 February 2023.

99. Justin called Sheryl during the evening of 23 February 2023. He asked her to book him a hotel because he needed to sleep. She did so, but he did not stay there. She picked him up from the suburb of Richardson at about 22:00 hours or 23:00 hours at his request, and dropped him in the city. She returned to see him at about 07:00 hours the following morning, bringing him some water. She described him as exhausted, having not slept. He told Sheryl that he had been trying to steal a car.

100. By about 11:00 hours on Friday 24 February 2023, Justin had stolen a silver Nissan Navara (the Navara). He met Sheryl in this car at the shops in the suburb of Theodore and she gave him some clothes. Justin was wearing a t-shirt and Sheryl did not observe any cuts on Justin's hands, wrists or arms.

101. At around midday, Acting Sergeant Boxx received information indicating that Justin was at the Theodore shops and using an older model Nissan Navara. He relayed this information to other officers via radio transmission.

102. By around 12:15 hours, a police vehicle had arrived in the parking area of the Theodore shops. The officer driving the vehicle positioned it to prevent the Navara reversing out of the area. Justin reversed the Navara into the police vehicle and then drove away at speed. The Navara caused considerable damage to the police vehicle, rendering it undrivable. Police officers attempted to pursue the vehicle on foot.

103. A short time later, a police radio transmission advised that the Navara had collided into a power pole (or light pole) in the nature reserve behind Crommelin Place, Chisholm and that the driver had left the vehicle on foot. There were later radio transmissions indicating that Justin had been sighted on rooftops and in yards of nearby residences and that there was a blood trail.

104. Detective Acting Sergeant Saunders and Constable Carl Graydon arrived in the vicinity of the Navara and were provided with information by members of the public as to where Justin had fled. Justin was noted to be bleeding.

105. During his foot pursuit, Justin entered several properties and approached members of the public. He encountered a man who was mowing a lawn. That man saw Justin holding a knife and described him having a splattering of blood "around [his] midsection". He

was reasonably certain there was no blood on the knife. Justin told the man that he needed to be driven to hospital, that it was an emergency, and that he would kill himself if he did not get help. During this encounter, Justin said that he was not going to hurt the man, and left towards the neighbouring property. The man did not see what happened next, but soon after heard the police yell loudly two or three times "drop the knife" and then heard shots that he thought were from a "stun gun".

106. Justin tried to enter another property through the backyard. He told the resident that "bad people" were after him. Justin left the property and was seen walking through the front gate, running up the side to the front of the house, turning right at the neighbour's house, and going down the side of their house.

107. Sometime after 12:33 hours, Constable Graydon arrived at a property in Heagney Crescent, Chisholm and saw Justin in a neighbouring property, brandishing a large kitchen knife.

108. Detective Acting Sergeant Saunders and Constable Graydon entered the yard. Constable Graydon saw Justin near the fence line. Justin jumped the fence into a carport and got into the driver's seat of an unlocked utility vehicle in the carport. The two officers jumped the fence.

109. Constable Graydon drew his Conducted Energy Weapon (CEW, or taser) and moved to the passenger side of the vehicle, while Senior Constable Saunders stood in front of the vehicle. Senior Constable Saunders saw that Justin had a large knife which he held to his wrist. He drew and aimed his firearm. Justin was yelling at police at this time. Constable Graydon opened the passenger side door, aimed his CEW and, having told Justin several times to put the knife down, deployed the CEW. Justin dropped the knife and got out of the vehicle, repeating that he was "sorry".

110. The arrest was captured on body worn camera footage.

111. Other AFP officers arrived at the scene. Justin was handcuffed behind his back while he lay on the ground. Several officers observed that he had blood on his clothes. One AFP officer attempted to provide Justin first aid, but he said he did not want to be touched.

112. At the time of his arrest, Justin was wearing a black long sleeve cardigan with no shirt and light blue fabric pants.

113. Justin told Constable Graydon that he felt dizzy and thirsty and that he had consumed 8 millilitres of "G". When asked what he proposed to do with the knife he said that he was "just scared" and that he was not going to hurt anyone.

114. A short time later, Detective Sergeant Billing took command of the incident. He gave evidence that, after his arrival, he began coordinating the investigation at the front of the residence and directed police resources as appropriate.

115. At 12:44 hours an ambulance was called. One paramedic arrived at the scene at 1:03pm and assessed Justin. The paramedic recorded that he was "clear" of the scene at 1:16pm.

116. At about 13:32 hours, Senior Constable MacDonald and Constable Cross arrived at the Heagney Crescent residence in a caged vehicle for the purposed of transporting Justin to the Watch House. Constable Cross was told that Justin had been assessed and cleared for custody by the ambulance and was to be transported to the ACT Watch House.

117. Justin was placed in the rear of the vehicle. The vehicle proceeded to the Watch House, with Constables Graydon and Saunders following. On the way, Detective Sergeant Billing was directed by the Duty Operations Manager (DOM) to take Justin to hospital because he had been involved in a collision. Detective Sergeant Billing did not believe Justin needed to attend hospital, but was told he must, so reluctantly directed Constable Cross to take Justin to hospital.

The Canberra Hospital (TCH) Assessment on 24 February 2023

118. At about 13:55 hours, Justin arrived at TCH in the custody of Constable Cross and Senior Constable MacDonald.

119. Justin was placed in a separate waiting room at the hospital while waiting to see the doctor.

120. At about 14:25 hours, nursing staff took a blood sample from Justin.

121. At 14:42 hours, Dr Bourke, an ED doctor, arrived and spoke to Constables Cross and MacDonald about Justin's reason for being at the hospital.

122. Dr Bourke conducted an assessment of Justin. She recommended that a second blood sample be taken but Justin refused. Justin underwent an ECG.

123. Dr Bourke prepared a discharge letter for Justin at 15:13 hours.

124. The entirety of Justin's time at TCH was recorded on police BWC.

The Watch House

125. Constables MacDonald and Cross transported Justin to the ACT Regional Watch House. They arrived at the Watch House at around 15:30 hours.

126. Leading Senior Constable Milner, who was the Acting Watch House Sergeant and had been briefed by Constable Graydon, conducted the Watch House intake for Justin. Justin denied any current thoughts of self-harm. He denied that he had attempted suicide in the past. He indicated that he did not wish to speak to ACT Mental Health. He indicated that he had consumed GHB and ice in the last 24 hours and had not slept since his release on 21 February 2023. After the intake, Justin was escorted to his cell.

127. Senior Constable Fergusson went to the Watch House and continued the preparation of the Statement of Facts in respect of the family violence and other offences alleged to have occurred on Thursday 23 February 2023. Constables Saunders and Graydon also attended the Watch House to prepare documents in relation to Justin's arrest and the brief of evidence for the Friday offending.

128. Constable Graydon completed a Statement of Facts in respect of the 16 offences alleged to have occurred that day and an ACT Police Bail Consideration Form. On the bail consideration form signed by Constable Graydon, the section of the form that stated "Is a Section 309 required" was completed "N/A". It was vetted by Detective Acting Sergeant Saunders.

129. Leading Senior Constable Milner vetted the two Statements of Facts, the s 309 Minute, and 'a Family Violence Bail consideration form'. He charged Justin with the charges listed on the two Statements of Facts.

130. Leading Senior Constable Milner prepared the DPP court file and BART file, being the file prepared for ACT Corrective Services to convey persons in custody from the ACT Watch House to the ACT Magistrates Court. It consisted of the Statements of Fact, the s 309 Minute, charge (or bench) sheets for the Court and Justin's criminal history.

131. The Watch House document entitled "Files to Court/DPP" records that a s 309 order was requested for Justin.

132. At about 16:30 hours, Sheryl called the Watch House to try to speak to Justin. An officer used the intercom to tell Justin that Sheryl was on the line. Justin indicated that he did not want to speak to her, because, he said, he was too tired to speak.

133. At about 17:50 hours a phone call was facilitated, at Justin's request, between him and registered nurse Michael de Jesus, a mental health nurse working within the Access

Mental Health Team. The conversation lasted approximately eight minutes. RN de Jesus made the following note of the conversation, which is recorded as having occurred at 18:08 hours:

> Justin reported "I just like feeling confused, I got out from jail a couple of days ago. And I was getting engaged then I found out that she fell in love with someone else. I was so excited to get out but this happened".
>
> Then Justin reported that he woke up in an ambulance this morning and cannot remember what happened. He reported that he had 2-23 days episode of drinking/drug use(meth, GHB) but when he woke up in the ambulance, he was "so confused". He wanted to know what happened to his girlfriend as well.
>
> Justin could not remember if he attempted suicide during MVA. He however reported that he was suicidal since he got out of jail. He wowever [sic] denied current thought.
>
> He reported that he feel safe from himself at the moment and just wanted to talk to someone. Author recommended to Justin to relax and take a rest.
>
> Cat G: Advice

134. At about 20:00 hours on 24 February 2023, Constables Graydon and Saunders went to the Watch House and entered Justin's cell. There was a discussion with Justin about conducting a forensic procedure. Justin asked to speak to a lawyer and was given access to a phone and contact number for after-hours legal advice in relation to the procedure. Justin had a phone conversation with a legal advisor and said that he would not consent to a forensic procedure.

135. Constables Graydon and Saunders later left the Watch House, as the time frame in which the forensic procedure could be carried out had passed.

136. At 9:55pm, Special Constable Barton conducted a cell check on Justin. Further cell checks were conducted at 22:47, 23:51, 01:29, 01:58, 02:51, 03:56 and 04:55 hours.

Saturday 25 February 2023

137. At around 07:00 on Saturday 25 February 2023, the duty prosecutor from the Director of Public Prosecution's office (the prosecutor) for the ACT Magistrates Court Bail List collected files from the City Police Station relating to persons who had been taken into custody. These included the AFP files for Justin. The files included the s 309 Minute prepared by Constable Russell on 23 February 2023.

138. Once back at the DPP offices, the prosecutor scanned the documents for each of the nine people due to appear before the Court that morning, to create electronic files.

139. At 07:27 hours, the prosecutor emailed documents to the duty defence solicitor employed by Legal Aid ACT (the defence solicitor). The email to the defence solicitor attached

documents relating to nine persons in custody, including Justin. It attached the paperwork from Constable Graydon, relating to the offences committed on 24 February 2023 (non-family violence offending) as attachment "Cordy 1" and the paperwork from Senior Constable Fergusson and Constable Russell, relating to family violence offences committed on 23 February 2023 as attachment "Cordy 2". The documents emailed to the defence solicitor did not include the s 309 Minute but did include the two bail consideration forms prepared by Constables Russell and Graydon. The prosecutor advised the defence solicitor by her first email that the prosecution would oppose bail for Justin.

140. The prosecutor sent a further email to the defence solicitor attaching Justin's criminal history.

141. The prosecutor was subsequently informed there was a tenth person due to appear before the Court that morning. At 08:19 hours, the prosecutor emailed the Associate to the duty Magistrate with an indication of the DPP's position in relation to bail for the ten defendants due to appear.

142. At about 08:15 hours, a Protective Services Officer entered Justin's cell at the Watch House and told him it was time to go to Court. Justin was observed to be reserved, polite, and fully co-operative with the request to vacate and tidy the cell.

143. Two officers accompanied Justin to the charge counter. As they walked through the D-block yard and past the At-Risk cells, one of the officers asked Justin what had happened. Justin said that he could not remember and that he had been "fucked up". When the officer told Justin that he might have hit a tree, Justin said that all he knew was that his kids were going to be upset that he was going back to gaol.

144. At about 08:29 hours, Justin was conveyed to the ACT Magistrates Court by Corrections staff.

145. The defence solicitor conferenced Justin before his court appearance. After a discussion of the charges against him, he instructed the defence solicitor not to make an application for bail.

146. The defence solicitor also had a brief discussion with Justin about applying for a section 309 order and he instructed her not to do so.

147. At 09:00 hours on 25 February 2023, Justin appeared before the duty Magistrate, via AVL from within the Court building. There was no application for bail and Justin was remanded in custody. No documents were tendered or handed up to the Court. There was no reference to a section 309 order during the bail hearing.

148. Justin arrived at admissions at the AMC at about 13:00 hours on 25 February 2023.

149. The officer who processed Justin noted that he had a lot of dried blood on both hands, and his right hand had a big gash. Justin told her that he had not realised he had been in a car accident until a paramedic was standing over him, and there was blood everywhere. He declined an offer to contact Sheryl.

150. Justin's health induction at the AMC was undertaken by RN Silwal (mental health) and RN Jose (physical health).

151. At 13:40 hours on 25 February 2023, RN Jose completed an initial health screening form. It was noted that Justin needed to be in Covid isolation. RN Jose placed Justin on nil medical observations.

152. RN Silwal completed:

    (a) a Custodial Mental Health Notification form at 13:40 hours, recommending an S3 rating (potential risk of suicide or self harm) with 60mins observations, a nil P rating and triage category D (Priority: Moderate risk of harm and/or significant distress – Semi urgent mental health full assessment 12-48 hours);

    (b) an interim risk management plan recording that Justin "Denied any current thoughts, intent or plan of self-harm of suicide. Reported recent relationship breakdown. Identified kids as protective factors". In the plan, RN Silwal recommended a rating of S3 with hourly observations, due to "historical risk";

    (c) a Suicide Vulnerability Assessment Tool (SVAT);

    (d) a Custodial Mental Health Induction Screening Form (handwritten and online); and

    (e) a clinical note recording the background, assessment, impression and plan.

153. After being assessed by RN Silwal, Justin asked to contact Sheryl, and he did so just after 14:00 hours. As Justin was walking to the phone, he stated words to the effect of, "I'm gonna be in bigger shit now".

154. Justin's call with Sheryl was recorded. He told her that he thought he would receive a sentence of four or five years. Sheryl spoke to him about seeing a psychologist while he was in prison.

155. At 14:45 hours, Dr Jehne took a handover by telephone from RN Silwal and RN Jose. She was at home at the time of the call. She concurred with RN Silwal's recommendations and recommended a follow up on Monday with Mental Health.

156. A Shared Cell Risk Assessment Form recorded that Justin had been given an S3 rating and was on 60 minute observations. An ACT Induction Form recorded that Justin would be placed in the new reception area for males.

157. After processing, Justin was taken to the West Wing of the Special Care Centre (SCC). The SCC is a unit in where new detainees are housed.

158. Justin arrived at the SCC at about 16:00 hours on 25 February 2023. When he arrived at the gate, someone in the remand yard asked Justin why he was back. He replied with words to the effect "I don't know. I stuffed up. I only lasted four days." It was observed that Justin seemed quite "cranky" with himself, shaking his head and saying, "I can't believe I've done that." Justin was placed in cell 1 in SCC West. There were six detainees at the relevant time in SCC West. Justin's cell was next to a laundry room, containing cleaning products, brooms and mops.

159. All the detainees in SCC West at the time, including Justin, were placed on 60-minute observations.

160. There is a record referred to as a "Detainee Observation Form" which records that Justin was on hourly observations. On it, ACT Corrective Services officers have recorded that Justin was "into unit" at 15:00 hours, observed in his cell at 16:00 hours and in the common area at 17:00 hours.

161. At 17:02 hours, CCTV footage shows Justin walking from his cell and entering the laundry room next to his cell. He exited the laundry room and returned to his cell carrying what appears to be a wooden pole.

162. Justin completed a form requesting a health appointment, noting that he needed "to see a doctor about health in general".

163. After his arrival in SCC West, Justin spoke to an officer telling him that he had "really fucked up this time".

164. Justin was sent to the Hume Health Centre at the AMC to have the wounds on his hands assessed. The attending nurse recorded at 17:53 hours that he assessed and treated those wounds, and also assessed taser wounds on Justin's chest.

165. In the "Detainee Observation Form", ACT Corrective Services officers have recorded that Justin was observed in his cell every hour between 18:00 hours until 23:00 hours.

Sunday 26 February 2023

166. On Sunday 26 February 2023 at 07:52 hours, RN Dahal completed a Primary Health Notification Form stating that Justin was on nil medical observations.

167. In the "Detainee Observation Form", ACT Corrective Services officers have recorded that Justin was observed hourly in his cell between 00:00 and 09:00 hours.

168. CCTV from the AMC shows Justin leaving his cell at 09:45 hours. It shows that he was variously in his cell, in the corridor outside his cell, in the dayroom or in the courtyard off the dayroom, from that time until 10:48 hours, when Corrections Officer (CO) Leskinen returned him to his cell.

169. CO Leskinen had conversations with Justin at 09:50 to 09:51 hours and from about 10:09 to 10:11 hours. He recalled talking to Justin about where he might be held and if he could go back to the cottage where he had previously been housed. Justin also asked about jobs in the yard and the possibility of being employed.

170. In the "Detainee Observation Form", CO Leskinen recorded that Justin was observed in the common area at 10:00 hours.

171. Another officer later told police that he had a brief conversation with Justin during the morning when he was sitting on a chair near the computer. Justin asked if he could go back to the sentenced cottages because he had only been released four days prior. The officer told Justin that it would depend on what more senior corrections officers said.

172. At 10:19 hours, a nurse noted that Justin was called for a welfare check in relation to his right ring finger injury during the morning medication round in SCC West but refused to see nursing staff.

173. CCTV footage shows CO Leskinen opening the flap on the door of cell 1 and looking in at 1109hrs.

174. Detainees are locked in their cells during the lunch hour for corrections staff. On 26 February 2023, the lunch lock-in was called in SCC West at about 11:45 hours. As at this date, the lunch hour was typically between 12:00 and 13:00 hours.

175. CCTV footage shows CO Leskinen looking through the flap on the door of cell 1 at 11:40 hours. He does not open the door. The CCTV does not show any further checks on Justin by ACT Corrective Services staff before 13:03 hours.

176. In the "Detainee Observation Form", an ACT Corrective Services officer recorded that Justin was observed in his cell at 12:00 hours.

Code Pink

177. Shortly after 13:00 hours, CO Viertel went into the West Yard to commence head checks. He started his check at cell 1 in SCC West. Other officers went into SCC North.

178. CCTV footage shows CO Viertel opening the door to cell 1 at 13:03 hours. CO Viertel later told police that when he first saw Justin in his cell, he appeared to be sitting on the floor facing the television. When he took a second look, he saw a makeshift rope around Justin's neck. He entered the cell and called for another officer to bring a Hoffman knife.

179. CO Leskinen and CO McGilvray later told police that they entered the cell in response to the call. Justin was lifted off the ground. CO Leskinen used the Hoffman knife to cut the ligature on the right side of Justin's neck.

180. CO Viertel called a Code Pink on the radio at 13:03 hours and began CPR.

181. Another officer entered the cell and then left to retrieve the defibrillator, which was located in the officer's station. A further officer entered the cell, saw the ligature being cut, and called a second Code Pink.

182. Despite extensive resuscitation efforts by officers and paramedics, by 13:40 hours no signs of life were observed and resuscitative efforts were ceased.

Observations of the ligature

183. Witnesses described the ligature found on Justin as [redacted].

Subsequent investigations

184. The AFP were notified of the death and Constable Bishop, who became the case officer for the inquest, arrived at the AMC at 14:26 hours.

185. A search was conducted of Justin's cell by the AFP at 18:35 hours on 26 February 2023.[30] Constable Bishop observed that the front window of the cell was covered by sheets of A4 paper taped together with band aids. These sheets of paper appeared to be made up of the induction paperwork given to inmates on arrival.

186. During the search, Constable Bishop observed a [redacted]. He also observed the [redacted] and a secondary noose on the ground, as well as a blue plastic three blade razor on the ground inside the cell, which appeared to be missing a couple of blades.

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[30] Exhibit 1, Brief AAA, p 73

Constable Bishop searched the laundry room adjacent to Justin's cell and observed a rack of broom holders containing six braces or holders, one of which was empty.

187. Constable Bishop later seized items from the cell, being a razor and a blade found on a bench within the cell. Another razor blade was found beside Justin's body on the floor outside the cell.

188. A separate property seizure record dated 28 February 2023 records the seizure of a white fabric ligature, a white blanket and a wooden broom handle in plastic wrapping from inside Justin's cell.

Post-mortem report

189. Justin's autopsy was conducted on 28 February 2023 at ACT Forensic Medicine Centre by Professor Duflou. The accompanying post-mortem report was finalised on 17 April 2023.

190. The direct cause of Justin's death was noted to be hanging, with no antecedent causes or other significant contributing conditions indicated. This was supported by the presence of injuries typical of a self-inflicted hanging, including a ligature mark on the neck's surface and fracturing of the thyroid cartilage.

191. It was noted within the report that Justin had a number of minor injuries across his body, many of which suggested recent self-harm attempts. In addition, toxicological testing found the presence of methylamphetamine and amphetamine in Justin's urine, although no alcohol or illicit substances were identified within his blood. It was determined that neither the minor injuries nor recent substance use had contributed to his death.

192. Additionally, the ACT Forensic Medicine Centre received a number of items from Cell 1. These were three lengths of a torn or cut blanket which had been tied together for the likely purpose of being used as a ligature, a white blanket with an irregular edge matching the lengths of the ligature and a broom handle

193. Post-mortem CT scans found evidence of a hypoxic brain injury with features of diffuse cerebral swelling, which was likely linked to the hanging and noted to be the probable cause of death.

Issues

194. The issues list for the inquest contained the following ten issues:

(a) Consideration of Justin's physical and mental condition by AFP officers involved in PROMIS 7360225 (FV charges) and PROMIS 7361157 (theft and driving charges) and at the Watch House.

(b) Relevance of a section 309 request by an AFP officer to assessments and recommendations by other officers.

(c) The reason for the assessment of Justin at the Canberra Hospital Emergency Department on 24 February 2023 and the adequacy of that assessment.

(d) The adequacy of the mental health assessment of Justin by Access Mental Health on 24 February 2023.

(e) The absence of an order under s 309 of the Crimes Act 1900 in respect of Justin on 25 February 2023 and the systems by which concerns of AFP officers as to the mental health of a person facing charges are communicated to the Watch House, the Mental Health Court Assessment and Liaison Service, the DPP, Counsel appearing for defendants, the Court and Forensic Mental Health Services at the Alexander Maconochie Centre (AMC).

(f) The role of the Mental Health Court Assessment and Liaison Service and the limitations in the services it provides.

(g) The adequacy of the mental health assessment of Justin at the AMC.

(h) The systems and procedures for performing and recording observations of detainees by Corrections staff at the AMC and the adequacy of the observations of Justin.

(i) The risk associated with the items included in the "pack" provided to Justin at the AMC.

(j) Justin's access to items in the communal laundry room and the risk associated with that access.

The hearing, evidence and written submissions

195. The hearing took place over 11 days. In addition to Counsel Assisting, there were five represented parties. The transcript comprises 945 pages and will be referred to using T followed by the page number.

196. The brief of evidence, which is exhibit 1, comprises Brief AAA and Brief AAB and are referred to by page numbers in this report.

197. In addition to the brief of evidence, videos from CCTV and body worn camera footage, audio files, further statements and photographs were tendered during the hearing. They were marked Exhibits 2 to 18 inclusive and will be referred to by their exhibit numbers.

198. After the parties were sent the provisional findings on 27 August 2026, pursuant to s 55 of the Act, Detective Superintendent John Hawkins provided a second statement, pursuant to s 55(1)(b). In paragraph 8 of this second statement, Detective Superintendent Hawkins requested, pursuant to s 55(3) of the Act, that I include in the report the statement, thus I have annexed it to this report.

199. Given I was holding an inquest into a death in custody and I was requested by a member of Justin's family, namely his brother Tristan, to inspect the scene of the death, I authorised that inspection pursuant to s 70 of the Act. I found that it would be in the interests of justice to conduct that view, which was facilitated by ACT Corrective Services on 9 July 2024. Tristan, Sheryl and most of the legal representatives attended, as did I.

200. A list of witnesses who gave evidence at the hearing is annexed to these findings.

201. There was expert evidence admitted at the inquest. Justin's autopsy was performed by Professor Johan Duflou on 28 February 2023. Professor Duflou prepared an autopsy report[31] as well as a supplementary report responding to further questions, dated 10 June 2024.[32] He also gave oral evidence on 16 July 2024.

202. Two emergency medicine specialists gave evidence. Dr Mark Lee is a Director of Emergency at Lake Macquarie Private Hospital and an Emergency Medicine Consultant with some 20 years' experience. Dr Robert Day is a Senior Staff Specialist at the Emergency Department of Royal North Shore Hospital and has held that position for some 20 years.

203. Expert evidence was also received from two senior psychiatrists: Professor Christopher Ryan and Professor Matthew Large.

204. Professor Ryan is a professor at the University of Notre Dame, an adjunct professor at the University of New South Wales and a clinical associate professor of psychiatry at the University of Sydney. He is also clinical lead of the consultation-liaison psychiatry service at St Vincent's Hospital in Sydney. Professor Ryan prepared a report for the Coroner dated 31 May 2024.

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[31] Exhibit 1, Brief AAA p.448-458
[32] Exhibit 1, Brief AAA p.6570

205. Professor Large is a senior staff specialist psychiatrist at Prince of Wales Hospital in Sydney and clinical director of the Eastern Suburbs Mental Health Service. He is also conjoint professor in the discipline of Psychiatry and Mental Health at the University of New South Wales. Professor Large prepared a report at the request of the Australian Capital Territory Government Solicitor dated 27 June 2024.

206. Sheryl and Jane Cordy and Tristan Francis each provided family statements to the Court. Sheryl read hers to the Court on the opening day, Tristan read his to the Court on the closing day, and Jane provided her statement in writing.[33]

207. Annexed to these reasons is a list of acronyms referred to herein.

208. After the hearings concluded, the parties were provided an opportunity to provide written submissions. The following written submissions were received:

    (a) Submissions

        i. 28 October 2024: Submissions filed by CA, and served on parties

        ii. 21 November 2024: Submissions filed on behalf of [redacted]

        iii. 24 November 2024: Submissions filed on behalf of Tristan Francis

        iv. 29 November 2024: Submissions filed on behalf of the AFP, Submissions filed on behalf of the ACT and Submissions filed on behalf of [redacted]

    (b) Submissions in reply

        i. 6 December 2024: Submissions filed on behalf of [redacted]

        ii. 9 December 2024: Submissions filed on behalf of the ACT

        iii. 13 December 2024: Submissions filed (in reply to the ACT's reply, which was not objected to) on behalf of the AFP

        iv. 20 December 2024: Submissions filed by CA

    (c) Submissions responding pursuant to s 55 of the Act

        i. 27 August 2026: Section 55 notices sent to ACT and AFP

        ii. 24 September 2026: ACT's s 55 response (submission) filed

[33] MFI 6.

(d) 11 October 2026: AFP's s 55 response (submission and statement) filed (extension had been granted to 12 October)

Issue 1 – consideration of Justin's physical and mental condition by AFP officers

Summary

209. Consideration by the AFP of Justin's physical condition and mental condition was poor. However, there is no evidence to suggest that had their consideration been better, Justin would not have died. That is, the poor consideration of Justin's health by the AFP did not contribute to his death.

210. Matters of public safety do arise, therefore comments are made.

Events leading up to, and at, arrest

211. I find the following occurred at, or in the hours before, Justin's arrest:

(a) On Thursday 23 February 2023 Justin made threats to kill himself. These threats were recorded by police, who created the s 309 Minute.

(b) On 23 and 24 February 2023, Justin consumed a considerable amount of illicit substances.

(c) On Friday 24 February 2023, Justin drove the stolen Nissan Navara into a police vehicle.

(d) Shortly thereafter, Justin drove the Navara into a power or light pole with enough force to crack the engine block.

(e) Shortly thereafter, when police had cornered Justin in the driver's seat of a parked vehicle, Justin said to the arresting officers "I'm going to kill myself" and "I've already cut myself" whilst holding a large knife to his wrist. Whilst in the car, he used the knife to cut his left wrist. He inflicted four superficial incisions to his wrist area. He was then tasered and arrested.

(f) Upon arrest, AFP officers removed the bloodied knife from Justin's reach. Police applied handcuffs to Justin, which covered his left wrist. Police did not look at Justin's wrists to see if he had cut himself.

(g) The following police officers were involved in both the Thursday family violence matter and the Friday stolen vehicle and driving offences: SC Fergusson and A/g Sergeant Jarvis and Constable Russell.

(h) Justin repeatedly requested an ambulance. An ambulance was called.

(i) Police did not, at the time of arrest, share information amongst themselves, including that Justin had driven a car into a pole at speed, that he had threatened self-harm to his girlfriend the day prior and his girlfriend deemed the threats to be real, that he had been telling police that he would kill himself whilst holding a large knife to his wrist.

(j) None of the AFP officers involved in his arrest considered taking emergency action under the *Mental Health Act* in relation to Justin.

212. Not all of these findings of fact were agreed. The basis upon which controversial facts were found will now be explained.

Finding of facts opposed by the AFP

213. It is useful to set out in summary form the chain of events on Friday 24 February 2023:

(a) About 11:00 hours Justin stole the Navara then met with Sheryl.

(b) About 12:15 hours Justin drove the Navara into a police vehicle.

(c) Shortly after 12:15 hours Justin drove the Navara into a power pole at speed.

(d) Between about 12:15 hours and 12:40 hours police were pursing Justin on foot.

(e) Between about 12:41 hours and 12:45 hours police located Justin in a parked car and Justin was tasered.

(f) By 12:45 hours Justin was under arrest.

(g) Between about 14:00 hours and 15:15 hours Justin was at TCH. The cuts on his wrists are visible in TCH.

(h) At about 15:40 hours Justin was inducted into the Watch House. The cuts on his wrist are visible at his induction.

214. Sheryl met Justin, upon his request, at the Theodore Shops on Friday 24 February, between about 10:45 and 11:15.[34] At that time, he was wearing a t-shirt and Sheryl wrote in her statement "I did not see any lacerations or other injuries on his arms, wrists or hands".[35] On the basis of this evidence, I accept that, as at 11:15 hours on 24 February 2023, Justin's wrists were not cut.

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[34] Exhibit 1, Brief AAA p.5516, [46]-[49].
[35] Exhibit 1, Brief AAA p.5516, [48].

215. The AFP submitted that the Court could not act on Sheryl's evidence about not seeing any cuts to his wrists as it was "about 1.5 hours before his arrest" and others, including medical practitioners, did not observe the cuts even when they are plainly on his wrist as per the numerous pieces of footage capturing them.[36] It is unsatisfactory that medical professionals at TCH and the paramedic did not attend to Justin's cut wrist.[37] However, their attention was not drawn to his wrists, by either Justin or AFP members. Justin had handcuffs covering his wrists by that stage, and he was wearing a long black cardigan which sleeves, unless pulled up his arm, went down to his wrists. Sheryl, on the other hand, was with Justin for about 30 minutes whilst Justin wore a t-shirt. He was not wearing a watch. This exposed his forearms and wrists. I am comfortable in making the finding of fact that, between about 10:45 and 11:15 hours, Justin had no cuts to his forearms, wrists or hands.

216. Senior Constable McLean attended the site behind Crommelin Place, where the Navara collided with the power pole. The timing is not clear, but I infer that his attendance was after Justin had been taken arrested but before he had been taken from the scene of the arrest by Constable Cross and Senior Constable MacDonald.[38] That is because, at about 13:45 hours the Duty Operations Manager told Detective Sergeant Billing that Justin had to attend the hospital because he had been involved in a collision and "the information that [police] got is that the engine block has been cracked".[39] Since the Duty Operations Manager already knew about the collision into the pole, and the damage the Navara sustained, and could relay that information to the police officer with command of the crime scene at 13:45 hours, I find SC McLean must have attended the crash site by at least 13:30 hours.

217. Further, police knew about the crash as it happened, which was at about 12:15 hours. That is because a short time after the crash, a police radio transmission advised that the

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[36] AFP Submissions, paragraph [59].
[37] The ACT's s 55 submissions stated that this criticism ought not be made: [1]-[10] and [23]-[25]. As to Dr Bourke see below. As to Mr Tyrell, the ACT submitted the "criticism has no evidentiary basis and would be a denial of procedural fairness": [10]. In para 36 of Mr Tyrell's statement he stated he could not recall if those marks were on Justin's wrists when he saw him and that he may have seen them and taken no notice: see also T882. Mr Tyrell was asked about inspecting Justin's left wrist twice on T883 and about his usual practice as to wrist inspection during a "head to toe sweep" on T883. Mr Tyrell gave evidence that he would not have changed his physical examination or taken any further notice of Justin's left wrist area if he had been given information about using a knife to cut his wrist when he was tasered: T883 and 884. I have found that Justin cut his left wrist between about 12:41 and 12:45 and the paramedic attended to Justin about 13:03. I find it unsatisfactory that the paramedic did not attend to Justin's left wrist, and that he would not have even if told Justin had used a knife to cut his wrist (which he was not told).
[38] Exhibit 1, Brief AAA, p. 4036.
[39] Exhibit 1, Brief AAB, p.47(p6649); T762.

Navara had collided into a power pole (or light pole) in the nature reserve behind Crommelin Place, Chisholm and that the driver had left the vehicle on foot. One of the arresting officers, Constable Graydon, confirmed that he knew the vehicle driven by Justin "had been located collided with a power pole or light pole or something similar to that" before he "arrived at the scene".[40] He did not, as at the point of arrest, have any information about the severity of the collision with the light pole[41] or the speed with which Justin drove into the pole.[42]

218. Given the number of police involved in Justin's pursuit and ultimate arrest, it is not unreasonable that an officer would be tasked to attend the crash site an hour or so after the crash occurred.

219. Senior Constable McLean saw signs that the vehicle had been 'fishtailing' for approximately 100m before colliding with the pole. It had struck the pole with such force that the rear of the vehicle left the ground, causing it to "yaw" 90 degrees before being caught by a steel grounding wire attached to the pole, preventing it from flipping over. The engine had been cracked open and oil was spilling out onto the ground.[43]

220. Police photographs of the vehicle confirm Senior Constable McLean's account of the significant damage to the vehicle.[44]

221. This evidence enables me to infer that Justin drove the Navara into the power pole with significant force, or, put another way, whilst travelling at speed. It cannot be known whether he did this intentionally. RN De Jesus recorded in his file note about his conversation he had with Justin later that night "Justin could not remember if he attempted suicide during MVA. He however reported that he was suicidal since he got out of jail". MVA means motor vehicle accident.

222. After the collision, Justin ran from police, leaving a trail of blood. I find the trail of blood was not from his wrist, and that his wrist was not cut until the minutes before his arrest. I find this on the basis that his wrist was not observed to be bleeding before his arrest, nor was any blood on the knife until his arrest.

223. Between the collision with the power pole at about 12:15 hours and his arrest at about 12:45 hours Justin was on the run, being pursued by multiple police officers. Whilst

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[40] T106.
[41] T106.
[42] T108.
[43] Exhibit 1, Brief AAA, p.4036
[44] Exhibit 1, Brief AAA, p.5996

running from police, Justin spoke with a man who was mowing a lawn. According to this man, Justin was holding a knife. The lawn mower described a splattering of blood "around [Justin's] midsection".[45] Other members of the public who saw Justin just prior to his arrest described "blood over his stomach and around his hands and up on his shoulder"[46] and "blood was all over his hands and … over his body and everything".[47] I find that, prior to his arrest, Justin was bleeding from the cuts on his mid-section and fingers of his right hand, which can be seen in the footage of Justin's arrest, treatment in TCH and induction into the Watch House.

224. At some stage between running from the Navara and being arrested in the car port, Justin armed himself with the knife. The evidence is that Justin took the knife from a property on Deamer Crescent that he was running through.[48]

225. The man who was mowing the lawn was reasonably certain there was no blood on the knife.[49] Constable Graydon did not describe seeing blood on the knife in his statement when the knife was waved at him just prior to jumping the fence to arrest Justin.[50] I find that in the minutes before his arrest, there was no blood on the knife.

226. I do not find that Justin cut his wrist whilst running through the residential premises and yards, especially as there was no blood on the knife before his arrest nor did any witness observe cuts on his wrists, as opposed to "a lot of blood" and "blood everywhere".[51]

227. I accept that after Justin's arrest, there was blood on the blade of the knife that Justin had been holding just before he was tasered. The evidence that establishes this includes:

    (a) Two AFP officers present at the scene of Justin's arrest - Detective Sergeant Billing and Constable Collins - saw that there was blood on the blade of the knife, after Justin's arrest.[52] This observation is recorded in Detective Sergeant Billing's police notebook.[53]

    (b) The property seizure record in respect of PROMIS 7361157 signed by Constable Graydon and Senior Constable Saunders records that a black-

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[45] Exhibit 1, Brief AAA, p.3789-90
[46] Exhibit 1, Brief AAA, p.3825
[47] Exhibit 1, Brief AAA, p.3802
[48] Exhibit 1, Brief AAA, p.3955 and 4003.
[49] MFI 2, [65]
[50] Constable Graydon described seeing the knife during the hearing at T96, T97 and T105. He was not asked if he saw blood on the knife. He did not mention seeing blood on the knife.
[51] Exhibit 1, Brief AAA, p.3805-3820.
[52] Exhibit 1, Brief AAA, p.3990, [8]; p.4002, [7].
[53] Exhibit 12.

handled Wiltshire kitchen knife with blood on the blade was seized from the garage at the scene of the arrest.[54]

228. Constable Graydon and Senior Constable Saunders were the arresting officers. Constable Graydon's body worn camera (BWC) captured the arrest. It was played many times during the hearing.

229. The BWC was activated shortly before Constable Graydon and Senior Constable Saunders jumped the fence of a property neighbouring the Heagney Crescent residence, in pursuit of Justin. It shows Senior Constable Saunders approaching the front of the vehicle in the carport. When Constable Graydon opened the passenger side door, Justin is holding a large knife to his wrist and shouting out words while Constable Graydon tells him to drop the knife.[55] Senior Constable Saunders has his firearm raised and pointed at Justin.[56] The footage shows Justin being tasered whilst sitting in the driver's seat, then getting out of the vehicle via the front passenger door and complying with Constable Graydon's instruction to lie on his front on the ground.

230. The words that Justin says immediately before he is tasered are sufficiently clear to hear Justin say, at least once, "I've already cut myself".

231. I accept the accuracy of the transcript of the BWC prepared by First Constable Bishop that, after Senior Constable Saunders shouted "drop the knife, drop the knife" that Justin and Constable Graydon are speaking at the same time.[57] While Constable Graydon is shouting "taser taser taser drop the knife", Justin can be heard saying "please sir I'm going to kill myself. I'm going to kill myself. I've already cut myself".[58] Justin is saying this whilst holding the knife to his left wrist.

232. The AFP submitted that, whatever words are discernible from listening to the BWC replayed, the fact is neither arresting officer heard the words at the time they were said by Justin.[59]

233. From watching the BWC footage, one can readily discern that the words spoken by Justin were loud enough to be heard by those around him. However, it is true that there were up to three people speaking and shouting at the same time, and that police had been running and jumping fences, and variously had their taser and firearm drawn. This would

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[54] Exhibit 1, Brief AAA, p.4135.
[55] Exhibit 1, Brief AAA, p. 4014; pp. 4039 – 4040; Exhibit 1, Tab 7.2.7, Graydon BWC.
[56] T.812:6 – 8.
[57] Exhibit 1, Brief AAB, p213 (p.6815)
[58] Exhibit 1, Brief AAB, p213 (p.6815)
[59] AFP submissions [53]; T97.37; T812.28-35.

have caused them to be breathing heavily and their adrenaline would have been activated. They were wearing radios which may also have emitted noise.[60] I accept Senior Constable Saunders' evidence that "there was probably a bit of audio exclusion there at the time".[61]

234. It must be noted Constable Graydon was one of, if not the most, junior officers at the scene, having only graduated from the police college less than two and a half years prior to this incident.[62] I acknowledge that he was in a high pressure situation, chasing an armed offender who had stolen a vehicle which he had used to ram into a police vehicle and who was wanted for family violence offences. I accept it is possible Constable Graydon did not hear the words Justin was shouting before he deployed his taser.

235. Later that afternoon or evening, Constable Graydon filled in a Use of Force Form.[63] It was checked by Senior Constable Saunders and completed by 21:04 hours that same evening. It contained the following (emphasis added):

> Use of Force Incident – Incident type
>
> Arrest (Street)
>
> …
>
> About 12:15pm on Friday 24 February 2023, a police vehicle was rammed by a stolen motor vehicle (SMV) in the Theordore shops car park…
>
> The subject fled the scene in the SMV by mounting gutter and driving over pedestrian paths and greenbelts. Several minutes later, a member of the public reported that the SMV had crashed into a power pole in Chisolm.
>
> Detective Acting Sergeant (D/A/Sgt) Tim Saunders and Constable (C/) Carl Graydon had responded to the incident and arrived in the vicinity of the crashed SMV along with other police to search for the subject, who had fled and been seen by members of the public jumping fences.
>
> Numerous members of the public assisted police by pointing out where the subject had run. He was seen to be bleeding.
>
> …
>
> The subject jumped the fence into a car port at … Heagney Crescent. The car port was partially enclosed with a roof and a closed roller door. At this time, the subject waved the large kitchen knife at C/ Graydon, before getting into the driver seat of an unlocked utility.

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[60] T813.17.
[61] T812.35.
[62] T140.04.
[63] Exhibit 1, Brief AAA, p.4137-4141.

C/ Graydon jumped the fence, followed almost immediately by D/A/Sgt Saunders. C/ Graydon moved to the passenger side of the vehicle while D/A/Sgt Saunders stood in front of the vehicle.

…

Concerned the vehicle would start and drive at him, D/A/Sgt Saunders drew and aimed his firearm at the subject, **who was now holding the knife to his own wrists, threatening to self harm.** C/ Graydon opened the passenger side door and continued giving loud and clear verbal directions to the subject to drop the knife.

The subject refused to comply with these directions. C/ Graydon successfully deployed his Conducted Energy Weapon (CEW), which immediately incapacitated the subject. He dropped the knife and obeyed further verbal directions to get out of the car before being informed by C/ Graydon he was under arrest. He lay on the ground on his front and D/A/Sgt Saunders applied handcuffs.

…

Behaviour of Subject –

Weapon used or presented by subject?

Yes

Weapon type

Edged weapon

236. Constable Graydon gave evidence that he obtained a "physical impression" that Justin was threatening to cut himself when he saw him hold a knife to his wrist.[64] He gave evidence that he did not hear what words Justin said at that precise moment, when he had the knife to his wrist.[65] However the contemporaneous use of force report he wrote included that Justin was threatening self-harm.

237. Senior Constable Saunders gave evidence that, at the time of arrest, he heard Justin speaking but could not recall what he heard him say. At the moment he had drawn his firearm, he formed the view Justin was threatening self-harm.[66]

238. After the relevant portion of his BWC footage was played, Constable Graydon was asked if Justin "says that he is going to do something to himself. Do you hear that?" and the Constable answered "Yes. Yes, I do". That is an answer to whether he heard the words in the footage, as opposed to hearing them on the day. He was then asked "Whether he

[64] T97.34.
[65] T97.37.
[66] T812.28 – 45.

said he was going to cut himself or kill himself, you certainly formed the view that he was threatening self-harm?" to which he answered "Yes, I did".[67]

239. It is the case that Justin did say "I'm going to kill myself" and "I've already cut myself" whilst holding the knife, which became bloodied, to his wrist. I accept Senior Constable Saunders and Constable Graydon could not recall what words Justin said, when they were giving evidence 17 months after the arrest. They both agreed they heard Justin saying words, but could not recall what words were said. Whatever words they heard, and it is possible they could not decipher any words on the day, they both formed the impression Justin was threatening self-harm. Constable Graydon could see through the open passenger door to Justin seated in the drivers seat, clearly holding the knife to his left wrist. This formed part of the reason Justin was tasered. When the knife was moved out of Justin's reach, it was bloodied.

240. The BWC footage shows streaks and smears of blood on Justin's chest and clothes. There is blood visible over Justin's right hand and before he is handcuffed, blood pools on the ground near his hands. At one point Justin lies on his right side. The fingers on his right hand are covered in blood and a thin line of what appears to be blood or a cut is visible just above the handcuff on Justin's left wrist. Blood pooled underneath his right hand.[68] Justin can be heard telling officers that he had lost a lot of blood.

241. Constable Cross also gave evidence that there was a cut at around that part of Justin's left wrist which appeared to be irritated by the handcuff on that wrist. He did not believe that it was bleeding at the time he saw it.[69] At several points during Justin's time in TCH, Constable Cross attempted to move the handcuff so it was not sitting in the cut or was protected by the sleeve of Justin's cardigan.[70] When Justin was first examined by Dr Bourke, he told her that his wrist was "a bit" sore.[71]

242. From the time of his arrest, until he was treated at TCH, Justin had his hands handcuffed behind his back. He could not have inflicted the cuts to his left wrist during this transportation. Furthermore, the cuts on his wrist were visible at arrest, and in TCH.

243. In Professor Duflou's first report, he noted that he had identified during the autopsy the presence of four superficial incisions showing likely early healing on the volar aspect of

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[67] T98.00-12.
[68] Exhibit 1, Tab 7.2.7, Graydon BWC, at 1:48:16Z.
[69] T227.41.
[70] T227-228; T240 citing Exh.1, Tab 7.2.4 at 14:48.34.
[71] Exhibit 1, Tab 7.2.4, at 14:44:56; Exhibit 1, Tab 7.2.4(a), p. 5932; T395.45.

Justin's left wrist and adjoining palm of the hand.[72] These incisions included a 70 mm transversely aligned superficial incision on the volar aspect of the left wrist and a 75 mm superficial incision/scratch mark extending from the ulnar of the left wrist onto the thenar eminence of the palm of the right hand. Professor Duflou considered that these injuries suggested recent self-harm attempts.[73]

244. These injuries are shown on four photographs taken during the autopsy.[74] They are also visible on photographs taken by the police after Justin had been declared life extinct.[75]

245. Professor Duflou considered that all four injuries on Justin's left wrist and hand were "readily classifiable as likely being the result of self-harm in a similar way to the more typical means of self-harm by wrist slashing with a sharp object such as a knife blade".[76] He explained that by more "typical" he meant that most commonly, where a wrist had been slashed with a knife, one would see multiple parallel incisions on the surface of the wrist. They are often of variable depth, but many are very superficial. They may be longitudinal, and on occasion, they may be slightly angled. It all depends on how the person is holding the cutting implement they are using and how they decide to self-harm.[77]

246. Professor Duflou considered other possible causes of these injuries. He considered whether they could be due to handcuffs. He thought this unlikely as typically, handcuff marks are parallel to each other, meaning that there would be two parallel marks next to each other. They do not tend to be such sharp incisions as are seen in these images. He said there was also often bruising associated with handcuff marks, especially if they have been applied tightly, which were not present here. They also tend to be over the bony prominences around the wrist and are visible on the front of the wrist as well.[78]

247. Another possibility was that the marks were the result of incidental contact with surfaces or objects. He opined that it was uncommon to have an injury on the wrist that was accidental and said that by far the most common cause of such injuries was self-inflicted injury.[79]

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[72] Exhibit 1, Brief AAA, p. 453.
[73] Exhibit 11.
[74] Exhibit 11.
[75] Exhibit 1, Brief AAA, p. 6574.
[76] Exhibit 1, Brief AAA, p. 6574.
[77] T.540: 1 – 10.
[78] T540.16-35.
[79] T540.35-40.

248. Professor Duflou could not exclude that the marks were caused by something other than the blade of a knife, but thought an attempt at self-harm was the most likely explanation.[80]

249. As to the timing of these injuries, Professor Duflou referred in his supplementary report to a clinical record created at 15:39 hours on 25 February 2023 at the Hume Health Centre at the AMC, noting "multiple skin laceration and bruises noted on bilateral arm and body". This note was prepared by RN Jose during or shortly after Justin's induction.[81]

250. Professor Duflou said that he assumed RN Jose was referring to incisions on the inside of Justin's left wrist. That is because it refers to lacerations on Justin's "bilateral arm and body". There were no lacerations on Justin's right hand.[82] This is evidence that the incision marks were on Justin's left wrist when he arrived at the AMC.

251. Professor Duflou also said that the images of these injuries in post-mortem photographs taken at the AMC showed a degree of healing that was probably over a day old and could be multiple days old.[83]

252. When shown the footage from the arrest captured on the BWC of Constable Graydon, Professor Duflou said it was possible that the markings were the signs, or result, of the superficial incision that he identified post-mortem on the inside of Justin's left wrist, although he could not be definitive about it.[84] He thought that the stills from the footage of Constable Cross' BWC (recorded during the examination at TCH) appeared to be the same injuries that he identified on Justin's left wrist and hand in his post-mortem report[85] although he accepted that he could not exclude the possibility that they showed blood from other parts of Justin's body.[86]

253. The CCTV footage taken at the Watch House while Justin is undergoing the intake shows him facing the charge counter. At 15:40 hours an officer assists him to remove the cardigan he is wearing and as Justin turns, red marks or cuts are visible on the inside of his left wrist.[87]

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[80] T548.29-31.
[81] Exhibit 1, Brief AAA, p. 5291.
[82] T541.10-27.
[83] T541.38-48.
[84] T542.42-47.
[85] T543.15-42.
[86] T549.15-18.
[87] Exhibit 1, Tab 7.3.6, 02 Charge 1 facing.

254. Professor Duflou thought that the footage from the Watch House showed the injuries that he identified (post-mortem) on the inside of Justin's left wrist as well as the injuries that he identified in the stills taken from TCH.[88]

255. I find that, by Sunday 26 February, the cuts to Justin's left wrist were two days old, having been inflicted at the time of his arrest at 12:45 hours on Friday, two days prior.[89]

256. The AFP, in submissions, opposed these findings of fact. The AFP drew my attention to Professor Duflou's evidence about how long the cuts would be likely to bleed.[90]

257. The AFP have further answered criticism directed at their lack of care about Justin's physical and mental wellbeing by reminding me that they called an ambulance.[91] It is true that they called an ambulance for Justin, which he had requested.

258. The single paramedic arrived at about 13:03 hours and had driven away, written and submitted his notes of the attendance by 13:16 hours.[92] Assuming it would have taken the paramedic at least three minutes to drive away, write and submit his notes, he was therefore with Justin for up to ten minutes.

259. When he arrived at the scene, Constable Graydon briefed him. This briefing concerned a cut on Justin's finger on his right hand.[93] The paramedic was not told anything about either motor vehicle accident, nor about a knife being held to his wrist. It was not an adequate briefing, however I note there were much more senior officers on site when the paramedic arrived, and none of them gave the paramedic any kind of briefing.

260. I clarified the briefing Constable Graydon gave to paramedic who attended the scene of arrest, shortly after arrest on Friday:[94]

> THE CORONER: And I remember that you said that part of your briefing didn't contain the knife on the wrist? Was that part of your evidence?
>
> GRAYDON: I believe that I said that in the briefing to ACTAS I – I don't remember what I – what I told them.[95]

261. I accept the paramedic's evidence that he was only told to see to the cut on the finger, and nothing else, besides possibly being told or guessing that Justin was tackled to the

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[88] T544.6-27; T545.11.
[89] Exhibit 11.
[90] AFP submissions [60]-[61], citing T545-550.
[91] AFP submissions [67].
[92] Exhibit 16, [11] and [16].
[93] Exhibit 16, [14].
[94] T145.
[95] T145.06.

ground when arrested, which is not accurate.[96] It is possible the paramedic assumed Justin had been tackled to the ground rather than being told that by any AFP officers, as it was not the case that anyone tackled Justin. There was an insufficient briefing given to the paramedic by the AFP.

262. The paramedic did not consider Justin needed to attend a hospital.[97] The paramedic recorded this in his notes as "No transport required – mutual decision". The paramedic recalled that Justin told him "to fuck off and did not ask for any further treatment or raise any other issues".[98]

263. I agree with the AFP's submissions that there is evidence to indicate Justin had reported being suicidal since being released from custody on Tuesday 21 February 2023. His girlfriend told police her concerns about his suicidal ideation. This may explain why he drove the Navara into a power pole at speed. It may have caused him to ingest significant amounts of illicit substances, or the consumption of illicit substances may have exacerbated his suicidal ideation. It is true, and appears likely, that Justin could have self-harmed at any time after his release on 21 February 2023. However the evidence establishes that he had not cut his wrist by at least 11:15 hours on the day of his arrest. To find that he inflicted the four cuts to his wrist, while actively on the run from police, between 12:15 hours and 12:45 hours, when the knife had no blood on it, is not supported by the evidence. To find he inflicted the cuts to his wrist when driving the stolen Navara between 11:15 and 12:15 hours is not supported by any evidence, including that he did not, when driving the car, have a knife. He took the knife from a residence during his foot pursuit with police.[99]

264. I find that he cut his wrist with the knife he was holding against his wrist, whilst saying "I'm going to kill myself" and "I've already cut myself" at a point in time when two police officers were within metres of him and independently formed the view he was threatening self-harm.

265. The AFP submitted that Justin did not tell any of the officers he had used the knife to cut his wrist, and this proves Justin did not use the knife to cut his wrist at the point of arrest.[100] Justin was heavily drug affected at the point of his arrest. The BWC footage

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[96] Exhibit 16, [16].
[97] Exhibit 16, [34].
[98] Exhibit 16, [34].
[99] Exhibit 1, Brief AAA, p4003.
[100] AFP submissions, [67].

records the difficulty Constable Graydon had delivering the caution to Justin.[101] Justin says he is "fucking out of it" and felt "dizzy" and could not understand the caution. He was requesting water and an ambulance, but he did not want any police to touch him. He was contrite; repeating he was sorry a number of times. The submissions of the AFP presume a rational, clear thinking patient which, at the point of his arrest, Justin was not. I do not accept the submission that had Justin used the knife to cut himself in the minutes before his arrest, he would have told the officers this *after* his arrest. He had just been shouting at them "I have already cut myself" minutes earlier.

266. I agree with the AFP that at the time the paramedic examined Justin, between about 13:03 to 13:13 hours, his wrists, if cut at the point of arrest, would have been "at least wet", and that the paramedic was confident this was not the case.[102] However, Justin also had cuts to his midsection and shoulder, and the only action taken by the paramedic was putting a dressing on one of Justin's right fingers.[103] The paramedic's attendance was "a quick head to toe exam"[104]. When the paramedic arrived, police did not tell him about the threats of self-harm at arrest, nor did police suggest the paramedic inspect his wrist. However the paramedic gave evidence that he would not have attended to Justin's wrist even if told Justin had used a knife to cut it.

267. The fact the paramedic did not attend to many of Justin's cuts, including those on his left wrist, does not prove his wrists were not cut, or were not actively bleeding or wet, or had not been inflicted within 30 minutes of the paramedic's attendance. The paramedic's evidence was he performed a "quick head to toe exam looking for dangerous bleeds" and that the only cut he noticed was to the right finger.[105]

268. The paramedic said in his statement "I cannot recall if [the post-mortem images of Mr Cordy's left hand which show some superficial marks on his hand and wrist] were on Mr Cordy at the time I saw him. I may have seen them and taken no notice, though I would have noted it if any were actively bleeding".[106] Given the quick body sweep performed by the paramedic, in the few minutes he was on site, I consider it more likely than not the paramedic did not look under the handcuffs to Justin's left wrist. It is acknowledged Justin repeatedly told the paramedic he was fine and asked him to "fuck off".[107]

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[101] Exhibit 1, Tab 7.2.7 at 1:46:03Z and T102:19-21.
[102] AFP submissions, [60].
[103] Exhibit 16, [17], [32], [35].
[104] T883.
[105] T883.
[106] Exhibit 16, [36].
[107] Exhibit 16, [21].

269. Not only did the AFP not adequately brief the paramedic, none of the AFP members looked at Justin's left wrist to ascertain if he had in fact cut himself. Whatever gave the arresting officers the impression Justin was threatening self-harm whilst holding a large knife to his left wrist, that impression justified, in their words, use of force. That impression should also have prompted them to look at his wrist to ascertain if he had indeed self-harmed, as he had threatened to do and was equipped to do. Constable Saunders had an opportunity to look at his wrist when applying handcuffs over the cuts.

270. The AFP submitted to "the extent that the handcuffs may have obscured any cut on Justin's wrist, it was inadvertent".[108] This is accepted. It does not detract from the finding that, when applying the cuffs to Justin, the arresting officer should have looked at the wrist where he had been holding a knife, and if not positively checked to see if he used the knife to cut himself, should have noticed he was bleeding and therefore had cuts on his wrist.

271. The Court accepts Counsel Assisting's submissions that the proper approach at this time would have been for at least one of the several AFP officers to inquire as to Justin's wellbeing, and not just his physical wellbeing. Only Constable Graydon asked Justin about "what he was going to do with the knife". He did not, however, go the next step and look at Justin's wrist to see if he had *in fact* used the knife to cut himself prior to deploying his taser.

272. The fact that no AFP officers considered it appropriate or necessary to check if Justin had cut himself is a matter of public safety. Without looking at his wrists they cannot brief the paramedic, or doctor when Justin was taken to TCH, about the cuts and also his mental health. Further, the information that he cut his wrists is information which should lead officers to take care of the detainee's mental health (see below) and tell the court in a s 309 minute and the police bail consideration form.

Consideration of Justin's mental health once in police custody

273. Justin is recorded in the BWC footage telling Senior Constable McLean that he was not thinking straight[109] and that he did not remember much and did not know what was going on.[110] The attempts of Constable Graydon and Senior Constable Fergusson to caution Justin were met with a response that he did not understand what they were telling him.

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[108] AFP s 55 subs para 12(b).
[109] This exchange occurs just prior to timestamp 1:45:19Z.
[110] At timestamp 1:48:22Z.

274. As for Justin's cognitive state, Constable Graydon described Justin as incoherent, unable to maintain a normal conversation or understand questions.[111] Senior Constable Fergusson believed that Justin was not coherent enough to understand what was occurring.[112] Other AFP officers described him as appearing "confused and disoriented", [113] "confused and dazed" and not knowing where he was or what was going on [114] and "incoherent" and unable to understand questions. [115]

275. The AFP National Guideline on persons in custody and police custodial facilities (AFP Custody Guideline) contains several provisions relevant to these circumstances.[116] Clause 18.1 provides that a member responsible for a person in custody must take reasonable steps to ensure the person receives proper medical attention if that person shows signs of impaired sensibility, shows signs of recent injury, is depressed or disturbed, or presents in a manner that raises any doubt about their health.[117] Clause 18.4 explains that symptoms and signs of serious conditions can be confused with less serious conditions, including alcohol or drug use. It is noted that medical conditions that require careful assessment and monitoring included conditions such as head injury, misuse of illicit drugs and other psychological illnesses. [118]

276. Clause 20 of the Guideline provides that where a risk of suicide or self-harm is identified in relation to a person in police custody, members "must" seek advice from the relevant jurisdiction's mental health service.[119] Detective Inspector Hawkins, based on assumptions put to him, said this provision was relevant to the circumstances in which the arresting officers found themselves. He agreed that it would be reasonable for the arresting officers to have identified a risk of suicide or self-harm, based on what he had seen in the BWC footage.[120]

277. The arresting officers were entitled to believe that drug use was at least a possible explanation for Justin's apparent confusion. Justin told Constable Graydon that he could not remember what he had done and that he had drunk about "8mls of jeebers [GHB]

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[111] Exhibit 1, Brief AAA, p. 4012, [44]; T105.
[112] T167.
[113] Exhibit 1, Brief AAA, p3973, [39].
[114] Exhibit 1, Brief AAA, p3941, [25].
[115] Exhibit 1, Brief AAA, p4016, [44].
[116] Exhibit 1, Brief AAB, p190 (p. 6792).
[117] Exhibit 1, Brief AAB, p199 (p. 6801).
[118] Exhibit 1, Brief AAB, p200 (p. 6802).
[119] Exhibit 1, Brief AAB, p201 (p. 6803).
[120] T900.

earlier in the day".[121] He also told Constable Graydon that he could not remember when he had taken the drugs and that he was heavily affected by drugs.[122]

278. It is also necessary to acknowledge that both arresting officers knew that Justin had managed to run some distance through several properties, jumping fences. This would reasonably have influenced their assessment of whether Justin had suffered any serious injury in either of the motor vehicle accidents. Constable Graydon also attributed Justin's apparent confusion to a desire to avoid answering police questions.[123]

279. Clause 18.4 of the Guideline cautions about the risk of mistaking head injuries for other more benign conditions, and it is noted that AFP members are not medically trained. Clause 18.4 requires members to "be alert to medical conditions which can be life threatening and require urgent medical attention".[124] Examples include head injury and misuse of drugs as well as other psychological illnesses/ conditions.[125] It is noted some of these conditions can co-exist.[126]

280. Constables Cross and MacDonald were requested to go to the scene of the arrest to take Justin to the Watch House.[127] Before they arrived, Constable Cross heard a radio communication that a vehicle driven by Justin had reversed into a police vehicle in a carpark as police were attempting to intercept him.[128] He had no involvement with Justin, other than to pick him up from the scene of the arrest.[129] Senior Constable MacDonald does not describe hearing any radio transmissions before the arrest.[130]

281. Constable Cross recalled that he had a discussion with Senior Constable Saunders at the scene.[131] Senior Constable Saunders, however, said that he did not brief either Constable Cross or MacDonald and did not know who did.[132] The content of the briefing is addressed below.

Lack of information sharing including about previous threats to kill himself

282. Clause 18.5 of the AFP Custody Guideline includes:

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[121] Graydon BWC at timestamp 1:47:20Z; T103.35 – 40.
[122] At or around timestamp 1:47:20Z; T103.40 – 45.
[123] At or around timestamp 1:47:20Z; T103.40 – 45.
[124] Exhibit 1, Brief AAB, p200 (p. 6802).
[125] Exhibit 1, Brief AAB, p200 (p. 6802).
[126] Exhibit 1, Brief AAB, p200 (p. 6802).
[127] Exhibit 1, Brief AAA, p.3992.
[128] Exhibit 1, Brief AAA, p.3992.
[129] T224.45 – T225.2.
[130] Exhibit 1, Brief AAA, p. 4051.
[131] Exhibit 1, Brief AAA, p.3993.
[132] T832.25 – 30.

> A member who has custody of a person and acquires information relating to the medical condition of the person (through observation or voluntary disclosure by the person) must ensure the information is recorded To inform members who later assume custody responsibilities.

283. Some of the police at Justin's arrest knew that he had made threats to kill himself the previous day. They should have informed their colleagues of the threats and the concerns, rightfully held, that had led them to write the s 309 Minute and write "yes" on the bail consideration form to a s 309 order request the previous day.[133] The police who were involved in the Thursday investigation, such as Senior Constable Fergusson and Acting Sergeant Jarvis, should have informed their colleagues at Justin's arrest on Friday. Their reasons for not doing so were inadequate. Senior Constable Fergusson's answers to Counsel Assisting's questions demonstrate the inadequacy of the sharing of important information (emphasis added):

> Did you have a conversation with either of those officers [Detective Leading Senior Constable Tim Saunders or Senior Constable Michael McClane] concerning the precise circumstances of the arrest and how it had occurred?---My recollection is that Detective Leading Senior Constable Saunders advised me that they had located Justin during the foot pursuit, which eventuated in him being inside the vehicle … that you can see in the footage there that's in the garage in the driver's seat, and he produced a knife and made some threats in their presence.
>
> Did you understand what the nature of those threats were?---My recollection is that he threatened to harm himself by – with the knife by cutting himself.
>
> So you recall having a discussion with Senior Constable Saunders and … Senior Constable … McClane; is that correct?---Yes, that's correct.
>
> In those discussions, **did you inform either of those officers that as a result of the events that had occurred the previous day, a section 309 request was going to be made?---I can't recall if we had a conversation about that.**
>
> **Given the information that you just indicated you obtained in relation to the circumstances of the arrest, do you think it's likely that that is something that you would have told either of those officers?---If it had come to mind, I may have.**
>
> …
>
> If you didn't refer to … the fact that a section 309 was going to be prepared in relation to the events of previous days, is that something that you think you should have - - -? Not necessarily. By that stage, I had been informed that they were conducted their own brief of evidence. And **I had my own brief of evidence, which a 309 minute was being included in, and I have enough to deal with with my own investigation without having to worry about another investigation, and - and really, I would be out of line to be trying to instruct a member who's senior to me is a detective on what I think he should or**

[133] Exhibit 1, Brief AAA, p.4111.

> **shouldn't be including in his brief.** And as I said, I was focused on my own investigation, and I had been directed by the inspector to go and start working on that…[134]

284. Constable Graydon confirmed that he did not have a discussion with SC Fergusson about the circumstances of Justin's arrest nor about the threats of self-harm that Justin had made at his arrest nor the threats of self-harm made the day before.

285. The AFP should have inquired about Justin's wrist, and should have shared the information about the collision with the pole with medical professionals who were tasked to review him. Had the doctor who inspected him at the hospital on Friday afternoon known of the self-harm to the wrist and the collision at speed into the pole, she said she would have conducted a mental health review, and she may have held Justin overnight for observation to monitor any head injury.[135] It is noted that a longer admission would only have delayed his attendance at Court from Saturday to Monday. He still would have been in custody on Sunday however he would have had the benefit of care and treatment on Friday night and Saturday (in hospital) and the benefit of MHCALS at court on Monday. It cannot be known if this would have prevented his death in the AMC on Sunday. He still would have had access to the ligature and ligature point, and still would have a razor to cut the sheets and a lunch lock during which he was not observed for over an hour. I do not find that the lack of briefing contributed to Justin's death. I do consider the lack of care by the AFP to be a matter of public safety, namely that detainees are not adequately cared for when in their custody.

286. There are MHCALS practitioners at Court on Monday, which are not available on Saturdays. Given Justin did not disclose to his solicitor any mental health concerns or a desire for a s 309 order, it is difficult to say whether a MHCALS practitioner would have recommended a s 309 order be made had he come to Court on Monday: see Issue 5. It is also relevant the two experts called in the inquest did not propose an established way by which to "treat" a person with suicidal ideation to prevent a person from completing suicide. Thus, even if Justin had come to Court on Monday, and there had been a s 309 order made, there is no guarantee any treatment or care provided pursuant to that s 309 order would have prevented his death.

287. The AFP urged me to consider the "circumstances as they appeared at the relevant time to the people who were there without the benefit of hindsight".[136] I agree this is the correct approach. What is being considered is whether the demands of the crime scene

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[134] T168-170.
[135] See Issue 3.
[136] AFP Submissions, [74].

investigations were so high in the immediate aftermath of Justin's arrest so as to excuse the AFP from properly considering a detained person's welfare. Sergeant Billing was able to list a number of tasks which would, ultimately, needed to be undertaken to investigate the various offences committed by Justin.[137] There were approximately a dozen AFP officers at the site of the arrest. Even with crime scene demands, one of the officers should have attended to Justin's welfare as required by the AFP Custody Guideline. Indeed Detective Sergeant Billing nominated the arresting officers as those who must comply with the AFP Custody Guideline.[138]

288. Detective Inspector Hawkins gave evidence on the last day of the hearing. He provided a statement about his expectations, as the officer in charge of the Watch House as he was on 19 September 2024, of the management of persons in custody before they arrive at the Watch House.[139] Inspector Hawkins referred in his statement and oral evidence to the AFP Guideline on persons in custody and police custodial facilities.[140]

289. The Inspector's statement included paragraphs 22 and 23 which he was questioned about extensively during the hearing.[141] Those paragraphs were:

> AFP Members have a duty of care for all people in their custody and must, on all occasions, be satisfied the person is fit to be in custody. The concept of fitness for custody is explained in the AFP National Guideline on persons in custody and police custodial facilities (AFP Custody Guideline) as follows:
>
> > 17. Assessing fitness for custody
> >
> > persons in custody are entitled to the same standard of medical care as any other member of the public. Members must be satisfied that persons are fit to be placed in or remain in, custody.
>
> If there is reason to be concerned about the physical or mental condition of a person in custody, that person must be treated as a 'person at risk'.
>
> An AFP member who takes a person into custody will ensure an initial assessment is carried out to determine the appropriateness of custody and whether the person is to be considered 'At-risk'. The arresting officer is responsible for this initial assessment which is separate to the further independent assessment undertaken by the Watch-house Sergeant at the time of intake and referred to in paragraph 16 above.

290. In paragraph 24, the Inspector summarised clause 7.2 of the AFP Custody Guideline which is:

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[137] T782.26-41.
[138] See s 55 AFP subs at para 26. No references provided by the AFP.
[139] T888-889 and pages 6605ff. The statement is dated 19 June 2024.
[140] T890 and page 6792ff.
[141] T890ff.

> Members uncertain about a person in custody's medical (including psychiatric) condition, or whether that person can make a rational decision on their need for medical treatment, should seek medical attention on their behalf. Particular care should be given to persons defined as 'at risk'.

291. Person at risk is defined in Clause 3 of the AFP Custody Guideline. That definition is a person in custody who is, or is suspected to be – among other categories - "highly intoxicated" or "showing, or believed by any person to show, any inclination to harm themselves or another person" or "causing any concern about their physical or mental wellbeing".

292. Given my findings above, Justin was a person at risk at and after his arrest.

293. The Inspector was asked a number of questions about the obligations he referred to in paragraphs 22, 23 and 24 of his statement, which are the obligations arising under clauses 7.2 and 17 of the AFP Custody Guideline. His oral evidence includes:[142]

> …you refer in paragraph 22 of your statement to AFP members having a duty of care for all people in their custody…? Yes.
>
> And you go on in paragraph 23 to refer to what an AFP member who takes a person into custody is required to do, and that includes an initial assessment to determine the appropriateness of custody and whether the person is to be considered at risk; do you see that? Yes.
>
> The performance of that assessment is part of the duty of care that you referred to in paragraph 22? Yes.
>
> If there is more than one arresting officer, do they both have the duty of care that you refer to in paragraph 22? Yes.
>
> And if one of those arresting officers is more senior than the other, is it the expectation of the AFP that, if that officer did not undertake the initial assessment himself or herself, that that officer would ensure that that initial assessment was undertaken?---If they are at the same location, the same incident, there would be an expectation that more senior, more experienced members, would ensure that it was undertaken where a junior one had not.
>
> …
>
> …in paragraph 24 that if there is doubt about a person's fitness for custody as a result of a physical or mental health condition, then the AFP member will seek medical attention on their behalf, and that's the AFP expectations of arresting officers; is that correct? Yes.
>
> And that obligation might be fulfilled by calling an ambulance to the scene? Yes, it may.
>
> … would the officer who makes the call, who's at the scene and has concerns, would it be the AFP expectation that they would give some background as to why the medical attention

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[142] T890-892.

was considered necessary? Yes. There's definitely an expectation that the information would be conveyed as to why medical attention was sought.

And if that medical attention was sought in the form of a call to an ambulance, would it be the AFP expectations that the arresting officer – one of the arresting officers would be in a position to brief the paramedic who arrived at the scene? Yes; and if they weren't, that someone else would.

And would that briefing include the officer's own observations of the person and the reasons of anything they saw that suggested that medical assistance would be required? Yes. Where that hadn't already occurred, there'd be an expectation that someone would provide observations.

… would that be the AFP expectation, that there would be some step taken to ascertain the severity of the accident? Yes.

… were other officers at the scene who had information as to the damage to the vehicle, would you expect the officer who is giving the briefing to the paramedic to obtain information about the damage to the vehicle? Where possible, there would be an expectation that that information would be readily shared.

… [assume there is] a detective sergeant who was more senior to the arresting officers, who wasn't present at the point of arrest but who arrived at the scene after the arrest and took command of the scene, or took command of the incident; can I ask you to make that assumption? Yes.

What would be the AFP expectations in relation to the more senior officer's responsibility for the wellbeing of the person in custody? That they would have a duty of care to make sure that any medical needs were met.

And would it be AFP expectations that that officer would undertake his own assessment of the medical needs of the person in custody? It would be an expectation that they would make an assessment.

And would it be AFP expectations that that AFP officer, the more senior AFP officer, would check with the arresting officers what assessment they had made? Yes, where possible, it would be the expectation.

294. Counsel Assisting played the BWC of Justin's arrest, and the moments before his arrest, to the Inspector. Counsel Assisting then asked the Inspector to assume the senior officer arrived some time after the arrest and shortly after he arrived he noticed a knife at the scene with blood on it and he assumed it was Justin's blood.[143] Counsel Assisting then asked:

> would it be AFP expectations that that senior officer with that assumption would make inquiries as to whether or not Justin had used the knife on himself?---Yes.[144]

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[143] T894.
[144] T895.

…

…you could see from that body-worn camera footage that Justin was holding a knife to his – in the vicinity of his wrist. Did you see that?---Yes.

And now I'm going to ask you to make some other assumptions. I'm asking you to assume that both arresting officers at the scene believed that at that point Justin was threatening self-harm. I'll ask you to make that assumption?---Yes.

And can I also ask you to assume that in the period after Justin's arrest, for a period of some six minutes while Constable Graydon's body-worn camera footage was activated, Constable Graydon, who was the arresting officer, observed Justin to be incoherent, unable to maintain a normal conversation or understand questions. I will ask you to make that assumption?---Yes.

Would it be AFP expectations in that situation, with all of those assumptions, that one of the arresting officers would seek specialist mental health advice in relation to Justin?---Yes, it'd – it'd be an expectation that, given what you've said, that medical advice should be sought at an early opportunity.[145]

295. The Inspector explained what he meant by medical advice or medical assessment:[146]

The expectation would be that medical advice should be obtained. In the absence of having all the resources available, the general approach would be that that medical advice may be ACTAS, it may be a nurse or a doctor at the watch house. It may be taking the person straight to hospital. It – it may be, if it's deemed that it's not, like, a metabolic, like a physical type response or crisis that then other support services like Access Mental Health may be approached to see if they can come and assist with an assessment. There are sometimes difficulties with getting Access Mental Health to attend to conduct an assessment in person, so the general response would be, based on the assumptions would be that they would seek general medical advice from a doctor or a nurse.

296. Such an assessment was not carried out by either of the arresting officers nor the more senior officer who took command of the scene.

297. The Inspector was then taken to Clause 20 of the AFP Custody Guideline which is:

Where a risk of suicide or self harm is identified in relation to a person in police custody, members must seek advice from the relevant jurisdictions mental health service.

298. The Inspector was then asked:[147]

…with all of the assumptions I've given you and I hope I don't have to repeat them, but you remember all the assumptions I've given you, and you've seen the body-worn camera footage?---Yes.

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[145] T896.
[146] T896-897.
[147] T900-901.

> Can you explain to her Honour whether or not in your view section 20 was applicable to those circumstances?---The National Guideline is applicable to the circumstances.
>
> … from the assumptions I have given you and what you've seen in the body-worn camera footage, would it be reasonable for the arresting officers to have identified a risk of suicide or self-harm?---Yes, it would be reasonable.
>
> And so does it follow that because these guidelines applied, and on the assumptions that I've given you, that it was incumbent upon them to seek advice from a mental health service within the ACT?---It's incumbent upon them to seek medical advice to address that risk and yes it should be within the ACT.
>
> The provision refers to a mental health service so when you say 'medical advice' does that mean mental health specialist advice or is it just general medical advice that you're referring to?---Within the ACT it's often difficult to isolate and identify just one singular service or mental health service, if you will. So that could be fulfilled in a number of ways. It could be fulfilled through a referral for a further assessment. Through a section 309 assessment. Or through other mechanisms. So, it will really come down to how they had assessed the urgency of the need and whether or not steps can be put in place to mitigate any risk of self-harm prior to being able to be assessed by the jurisdictional mental health service.

299. In relation to whether or not calling an ambulance would suffice under the AFP Custody Guideline, to undertake a medical assessment or advice from a mental health service, the Inspector said:[148]

> On the assumptions that you've provided me, it would still be like my personal view that a paramedic probably wouldn't be sufficient to have assessed, like, the enduring risk of self-harm. Paramedics from my understanding and my training cannot adequately assess, from a clinical perspective, the mental health of an individual. They are part of the response. They're part of ensuring the safety of an individual. But they can't provide us with sufficient comfort for – for specialist clinical advice in terms of whether or not someone is an enduring risk of self-harm or not.

300. I find that the attending officers at Justin's arrest did not meet their obligations under the AFP Custody Guideline by virtue of calling the paramedic. That action was insufficient, especially given the lack of briefing to the paramedic, to meet their obligations under the guideline.

301. Even if, which I reject, Justin had cut his wrists four times whilst running from police, it remains their duty to care for the wellbeing of detainees. That duty remains whether the detainee has self-harmed in the seconds before arrest, or in the minutes before arrest. On either scenario, the police failed according to their own standards.

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[148] T900 and see second statement annexed to this report in which the witness contextualised his evidence.

302. The AFP submitted that I have not explained why the lack of information sharing about the s 309 minute was inadequate.[149] I repeat that there was *no* sharing of the information (or mental health concerns) contained in the s 309 Minute by those who were involved in its creation, with the arresting officers or officer in command of the scene. The AFP submitted that this report does "not state what would have come from the AFP officers passing on that information at the arrest scene, or how it would have made any difference to the course of events".[150] As I have set out at [285] above, I do not find that lack of information sharing by the AFP contributed to Justin's death. I do find, combined with the other omissions of the AFP, that their lack of care of detainees is a matter of public safety.

The direction to take Justin to TCH

303. Senior Constable Saunders and Constable Graydon followed the caged vehicle in a separate car enroute to the Watch House.[151]

304. At 13:42 hours ACT Operations radioed Detective Sergeant Billing.[152] He was told that Justin needed to be cleared by a doctor at TCH. The exchange continued as follows:[153]

> **TORIC One [Detective Sgt Billing]**: Torric one, ambulance have already been here, he's fine, he's got a little tiny cut on his hand.
>
> **ACTOPS**: Copy Torric one. Uh, DOM's just advised that the Watch House won't accept him until he is being cleared via the hospital.
>
> **TORIC One [Detective Sgt Billing]**: Hospital is not needed. Can you get the DOM to call me?
>
> **ACTOPS**: Copy.

305. Detective Sergeant Billing said that the basis for his opinion that Justin did not need to be seen at the hospital was the fact that an ambulance had attended the scene.[154] He said that, at the time of this exchange, he had "forgotten" about the second accident, being the collision with the pole.[155]

306. The Duty Operations Manager (DOM) contacted Detective Sergeant Billing a few minutes later. Detective Sergeant Billing was told that the Watch House was very "risk adverse". The exchange continued as follows:[156]

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[149] Para 21 s 55 subs.
[150] Para 21 s 55 subs.
[151] Exhibit 1, Brief AAA, p. 4041.
[152] Exhibit 1, Tab 7.3.16, the transcript is at Exhibit 1, Brief AAB, p46.
[153] Toric One is Detective Sgt Billing: T760.32 – 35.
[154] T761.36 – 40.
[155] T762.4 – 7.
[156] Exhibit 1, Tab 7.3.16, the transcript is at Brief AAB, p.47.

TORIC One[Detective Sgt Billing]: Its fucking retarded, mate. There's nothing wrong with him. He's got a little cut.

DOM: No No, no. So, so what it's based on, uh, and by all means go direct with, um, the Watch House if anyone's been involved in a collision. Um, and it's……

TORIC One[Detective Sgt Billing]: It was a fucking tap

DOM: *<laugh>.*

TORIC One[Detective Sgt Billing]:**:** It was literally a tap.

DOM: So the information that we've got is that the engine block has been cracked. Um*,*

TORIC One[Detective Sgt Billing]:**:** Yeah, the ambos have been here, checked him out, but I know it's gotta be a doctor of the watch out, but he fucking, alright, we'll send him off to the Watch House then I mean to the, um, hospital.

DOM: To the hospital. <indistinct> Do you want us to call them ahead? See if we can't, I don't know if we can…

TORIC One [Detective Sgt Billing]:**:** Yeah, if, Yeah, see if they can fast track, but I mean, then it's gonna be a crime scene there. I need a patrol there, so that so the, um,

DOM: yeah, yeah, I can, I can start a uh, hospital guard. That's easy.

TORIC One [Detective Sgt Billing]:**:** Yeah. Yep. Alright. Okay.

DOM: And it's all downtime anyway, so

TORIC One [Detective Sgt Billing]:**:** Yeah, yeah, no, we don't need it, but it's just a waste of time. Alright, thanks mate.

DOM*:* Alright cheers mate.

….

307. Detective Sergeant Billing said when he described the accident in which Justin had been involved as a "fucking tap" or "literally a tap", he was thinking of the first accident, the ramming of the police car.[157] He said it "dawned on him" during the conversation that Justin had been involved in a major collision and one at speed and that he needed to go to the hospital to check for concussion and other injuries.[158]

308. The obvious difficulty with this evidence is that, even after being told that the engine block had cracked, Detective Sergeant Billing told the DOM that taking Justin to hospital was not needed and "just a waste of time". His explanation for this was that, based on his "observations" he did not think Justin was injured.[159] Further, the reference to the "ambos" or paramedic's attendance does not assist, as the paramedic was not told about

[157] T762.36 – 39.
[158] T763.1 – 9;28 – 40.
[159] T764.17 – 24, T765.6 – 10.

the more serious motor vehicle accident so his medical attention was not directed to an assessment after a collision.

309. This radio transmission was followed by one involving ACT Operations, Constable Andrew Cross, Detective Sergeant Billing and Senior Constable Saunders at 13:49 hours.[160]

310. In that transmission, Detective Sergeant Billing directs ACT Operations to "send the uh crew to the hospital, then with him, since he's been in a car accident, he has to go there apparently".[161] Senior Constable Saunders says:[162]

> I confirm that Tuggeranong crew taking him to the hospital, can be hospital guard while they put a Band-Aid on his hand and we can go to the Watch House.

311. Constable Cross acknowledged Senior Constable Saunders' message and then asked whether TCH can be given a "heads up" that they would be taking Justin to hospital.[163]

312. Officers Billing and Saunders did not comply with the AFP Custody Guideline, in particular clauses 18.1 and 18.4. Both were senior officers. I consider it a matter of public safety that senior AFP officers did not, individually or collectively, take reasonable steps to ensure Justin received proper medical attention. They both, in fact, resisted Justin receiving medical attention even after being reminded of the severity of the second motor vehicle accident and both having observed his confused state at the scene of his arrest.[164]

Consideration of emergency apprehension

313. Section 80 of the *Mental Health Act 2015* provides police officers and paramedics with powers of emergency apprehension. As at 23 February 2023, it provided:

> (1) A police officer or authorised ambulance paramedic may apprehend a person and take the person to an approved mental health facility if the police officer or paramedic believes on reasonable grounds that—
>
> (a) the person has a mental disorder or mental illness; and
>
> (b) the person has attempted or is likely to attempt—
>
> (i) suicide; or
>
> (ii) to inflict serious harm on the person or another person; and

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[160] Exhibit 1, Tab 7.3.16, the transcript is at Exhibit 1, Brief AAB, p.49 (p. 6651).
[161] T767.40 – 43.
[162] T767.10 – 29; T830.26 – 33.
[163] T220.23 – 28.
[164] The AFP apologised for disrespectful and uncompassionate remarks, which must include these transmissions.

(c) the person—

(i) requires an immediate examination by a doctor; and

(ii) does not agree to be examined immediately.

(2) In forming a belief about a person for subsection (1), a police officer or authorised ambulance paramedic is not required to make a medical assessment or clinical judgement about the person.

314. Detective Inspector Hawkins considered that s 80 usually applied where there had not been an element of criminality.[165] He gave further evidence about this in his second statement annexed to this report.

315. Constable Graydon did not say that he thought that s 80 had no potential application to Justin's circumstances, merely that the exchange that he had had with Justin after the paramedic had attended was sufficient for him to conclude that the threshold for emergency action was not met.[166]

316. Senior Constable Saunders also did not say that s 80 had no potential application to the circumstances because it involved criminality. He did not consider it because he did not think that the criteria under the section were met.[167]

317. As at 24 February 2023, Mr Tyrell was an authorised ambulance paramedic within the meaning of s 80(1) of the *Mental Health Act 2015*.[168] He said that if a patient in police custody expressed suicidal ideation or self-harm ideation and he thought they were unsafe, he would consider it necessary to exercise the power given to him under s 80 of the *Mental Health Act 2015*.[169] In those circumstances, there would be a discussion with the AFP about what was best for the patient.[170]

318. Mr Tyrell said that if he felt the criteria under s 80(1) were met, and the AFP had decided not to put someone on an apprehension order, but the person was in police custody, he would consider it within his power to apprehend the person.[171]

319. The understanding of AFP witnesses as to the potential for emergency action, where there is an element of criminality, was not consistent.

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[165] T899.
[166] T120; T121; T124
[167] T834; T836.
[168] T879.
[169] T879.
[170] T879; T880.
[171] T880.

320. There is some force in the evidence of Senior Constable Saunders that Justin would not, in any event, have met all the statutory criteria for emergency apprehension. However, because he was, in the event, taken by the AFP to TCH after his arrest, where he could have undergone a mental health assessment, this evidence does not need to be explored further. At such a hypothetical assessment, it would have been open to a doctor or mental health officer to exercise statutory powers to detain at the hospital Justin under s 81(2) of the *Mental Health Act 2015*, if he or she formed the beliefs referred to in that section. Justin did not need to be brought in under a s 80 order for that to occur.

321. The AFP submitted that there was "*no* evidence that any police officer dealing with Justin at the arrest believed: (a) that he had a mental disorder or mental illness; or (b) that he did not agree to be examined by a doctor, nor is there any evidence that any police officer *should have* formed a belief of either of those things."[172] I do not agree.

322. The day before his arrest police had been informed he had threatened to kill himself and about 30 mins before his arrest he had driven a vehicle into a pole. At his arrest at 12:40 hours on Friday 24 February 2024 he had shouted at police that he was cutting himself and had used a large knife to make four cuts to his left wrist. He was bleeding from these cuts when he was handcuffed and while he lay on the driveway with blood pooling under the cuts. Police officers moved the bloodied knife out of Justin's reach and seized it as an exhibit. Almost none of the attending officers, who numbered over a dozen, turned their minds to the fact Justin had attempted or was likely to attempt suicide or to inflict serious harm on himself. The junior constable who did turn his mind to Justin's mental wellbeing asked Justin within an hour of his arrest what he planned to do with the knife and Justin had apparently answered "I don't know man, I was just scared". This answer satisfied the Constable who did not pursue the matter further. None of the senior officers considered Justin's mental health.

323. Justin was confused and disoriented, which could be explained by the consumption of drugs, or may have indicated a mental disorder.

324. It is not true that none of the police officers at the arrest believed Justin had a mental disorder or mental illness. The day before, Constable Fergusson had overseen the preparation of s 309 minute about Justin's suicidal ideation. Both arresting officers had written in the Use of Force document that Justin was armed with a knife and threatening self-harm at arrest which is why he was tasered and why a firearm was drawn. These

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[172] AFP submissions, [19] (emphasis in original).

officers either believed Justin had a mental disorder or, on the evidence, they ought to have. If it were true that no police officers dealing with Justin at the arrest believed he had a mental disorder, this reflects very poorly on those police officers.

325. The AFP submitted that it cannot "be inferred from what is stated in the section 309 minute that any of the officers believed that Justin had a mental disorder. Notably, none of the officers gave evidence that they had that belief".[173] An order can be made pursuant to s 309 if the Court has reasonable grounds for believing that an "accused needs immediate treatment or care because of mental impairment". In the s 309 Minute the AFP explained their concerns from 23 February 2023 about Justin's mental health namely that he wanted to kill himself. The AFP set out the definition of "mental disorder" from s 9 of the *Mental Health Act*, without citing that Act.[174] The AFP do not include the definition of mental illness in s 10 of the same Act. What the AFP seem to submit is that the officers who created the s 309 Minute did not have a proper basis to consider Justin needed immediate treatment or care because of a mental illness causing him to express suicidal views.[175]

326. Section 309 refers to "mental impairment". The dictionary to the *Crimes Act* defines "mental impairment" as "see the Criminal Code". Section 27 of the *Criminal Code* is:

> "mental impairment" includes senility, intellectual disability, mental illness, brain damage and severe personality disorder.
>
> (2) In this section:
>
> mental illness is an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition (a "reactive condition") resulting from the reaction of a healthy mind to extraordinary external stimuli.

327. As to the submission that there was no evidence that any police officer believed Justin did not agree to be examined by a doctor, several officers witnessed the interactions between the paramedic who attended to Justin for a few minutes, during which Justin repeatedly told the paramedic to "fuck off". The main point is the officers did not consider taking emergency action at all; as opposed to considering taking emergency action and satisfying themselves that Justin would agree to be examined immediately (and thereby would not meet the criteria as it then was for emergency action).

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[173] Section 55 subs para 30.
[174] AFP s 55 subs at paras 31 and 32.
[175] See AFP s 55 subs at paras 31 and 32.

328. I find the officers at the arrest should have considered taking emergency action in relation to Justin, pursuant to s 80 of the *Mental Health Act 2015*. My finding is not that the officers *should have taken* emergency action, but I do find they should have *considered* taking emergency action. It was not the decision of any of the attending officers that Justin be taken to TCH; the attending officers resisted his attendance at TCH. It is no justification for not considering emergency action that Justin ultimately attended TCH, and the reason for the attendance was to check for any head injuries from the less serious of the two motor vehicle accidents Justin had caused.[176]

329. The paramedic who attended for a few minutes was not briefed about Justin's threats from the day before, nor the car accident into the pole, nor the cutting of his wrist while threatening self-harm. In these circumstances it is not fair to expect the paramedic to turn his mind to taking emergency action under s 80, especially given Justin was in the custody of police at the time and police had spent a substantially longer period with Justin that the paramedic.

330. The AFP further submitted that s 80 "*empowers* but does not *compel* a police officer … to take emergency action".[177] This is accepted. However, officers are required to care for the wellbeing of people in their custody. Part of that obligation is considering whether such persons have a mental disorder or mental illness and has attempted to inflict serious harm on themselves, which I find Justin did at the point of his arrest. His behaviour was such that I consider officers could have formed the view he had a mental disorder. While s 80 does not compel officers to take emergency action if the criteria is met, officer should at least be aware of the provision and consider it when confronted with a situation such as Justin's arrest, with his surrounding circumstances, known to police but not shared between them.

The Watch House

331. Issue 1 includes consideration of Justin's physical and mental condition by AFP at the Watch House. By the time Justin arrived at the Watch House, about 15:30 hours, he had been in police custody for almost three hours. He had been seen by a paramedic (briefly) and spent some hours at TCH. The Watch House intake was cursory, but it was in the context of admitting Justin after he had received medical attention.

332. The cuts on his wrist are visible on the CCTV footage. However I make no adverse comments about the intake officer not inquiring about those cuts given he had just spent

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[176] In the AFP's s 55 subs, the AFP submitted no AFP officers formed the view.
[177] AFP submissions, [121] (emphasis in original).

about two hours at TCH where one would expect any physical cuts to be attended to. Justin's answers to the intake questions did not indicate poor mental health and when he requested a phone call to the mental health team, this was facilitated.

333. No issues of public safety arise in relation to Justin's consideration at the Watch House.

Comments

334. I find the lack of care offered by various AFP officers, in whose custody Justin was on 24 February 2023, is a matter of public safety that arose in connection with the inquest. I have made comments on aspects of this matter of public safety above.

335. In response to the paragraph above, and to paragraph [284], the AFP submitted that my adverse comments "do not appear to fairly reflect that:

    (a) AFP officers respectfully removed Justin from the vehicle in which he was sitting when tasered and arrested at the end of a foot pursuit without touching him;

    (b) AFP officers called an ambulance to attend to Justin at the arrest scene (and as one of the first things they did);

    (c) AFP officers enquired of Justin about his welfare and injuries…

    (d) AFP officers took Justin to The Canberra Hospital for assessment by an emergency doctor prior to taking him to the ACT Watch House…"[178]

336. As to these submissions:

    (a) Constable Graydon opened the passenger side door, aimed his taser and, having told Justin several times to put the knife down, deployed the taser. Justin dropped the knife and got out of the vehicle, repeating that he was "sorry". It is unclear what is meant by a "respectful removal" of Justin. What the BWC shows is police yelling at Justin to drop the knife and get out of the car, one of whom had a firearm pointed at Justin, the other who then tasered Justin, which led to Justin getting out of the car with the knife (which was bloodied).

    (b) An ambulance was called as set out above at [257] to [259].

    (c) Only Constable Graydon asked Justin about "what he was going to do with the knife". I am unclear what other instances the AFP was referring to in subpara 9(c). There are not citations to evidence of other officers enquiring about Justin's

[178] Para 9 s 55 subs.

welfare or injuries. In fact there are no references in the AFP's s 55 submissions to any evidence, other submissions or the transcript.

(d) The AFP reluctantly transported Justin to TCH, only after being compelled to do so by the DOM. Detective Sergeant Billing and Senior Constable Saunders wanted Justin to be taken directly to the ACT Watch House, not via a hospital. This is set out in detail below. The transporting officer Constable Cross behaved with utmost respect and kindness to Justin. However, it is surprising the AFP included the transport of Justin to TCH as a reason why the adverse comments about their care of Justin were unfair; the officer with command of the scene (Detective Sergeant Billing) strongly opposed the hospital admission.

337. The AFP reminded me, in subparagraph 5(c), that the AFP apologised "for the disrespectful and uncompassionate remarks directed to and about Justin by members of the AFP on the day of his arrest". Included in these remarks is likely to be what Detective Sergeant Billing and Senior Constable Saunders said in transmissions opposing the transfer of Justin to hospital (before the Watch House). It is hardly surprising an apology was proffered for these, and other patently inappropriate remarks made by AFP officers to and about Justin. But an apology does not mean there is not a matter of public safety.

338. Counsel assisting submitted that the "evidence does not establish that the omissions of individual officers in this case represent a broader problem within AFP Policing".[179] The AFP embraced this submission.[180] I do not accept the failings were of individual officers only. The failings were of multiple senior officers, and questions about their awareness and compliance with obligations under their own guidelines did not indicate to me that the AFP was sufficiently complying with their obligations to persons in custody.

339. In their s 55 submissions, the AFP submitted at paragraph 14:

> The cut to Justin's wrist was not of physiological significance: as Professor Duflou explained, it was a superficial incision and nothing to do with the cause of Justin's death. In that regard, it was no different from cuts on Justin's mid-section and the fingers of his right hand which are noted in the Coroner's report but otherwise receive no attention or further comment.

340. There is a clear difference between a person making multiple cuts (incisions) to their wrist with a knife whilst calling out "I'm going to kill myself" and "I've already cut myself" and incidental cuts to their mid-section and hands incurred whilst running over fences and through residential yards. The fact that the AFP consider that there is no difference

[179] Para 394.
[180] See para 8 of the AFP's s 55 subs.

between such cuts enhances my view that training needs to occur to improve their care of persons in their custody.[181]

341. The AFP submitted that "the expert evidence was clear that Justin's mental state at the point of cutting his wrist was not a reliable predictor of Justin's mental state at a point [two] days later when he took his own life in AMC".[182] There was no reference to this expert evidence. In any event I have not found any actions, or omissions, of the AFP caused or contributed to Justin's death. I have not found that AFP officers should have "predicted" Justin's death 48 hours after his arrest. What I have found is that they did not comply with their own guidelines and this gives rise to a matter of public safety.

342. The AFP may wish to consider improving their compliance with their AFP Custody guideline in the following way:

(a) ACT Policing provide written guidance and further training to AFP members within ACT Policing, addressing:

i. The obligation to undertake an assessment of a person in custody, before the person in conveyed to the Watch House, including the need to specifically ask a person in custody questions to ascertain the nature and extent of any obvious injuries.

ii. The obligation of AFP members who have a person in custody to provide ACTOps with information relevant to any concerns they have as to a person's mental or physical condition.

iii. If a person in custody is to be assessed at a hospital for any reason, before being conveyed to the Watch House, the obligation of the member who has custody of that person, to request any assessment that the member reasonably considers is indicated by the person's injuries or behaviour at or after arrest.

iv. If a person in custody is to be assessed at a hospital before being conveyed to the Watch House, the obligation of a member who has or had custody of that person, to ensure that information relevant to the person's physical or mental health, is provided to the hospital.

v. The obligation of AFP members with custody of a person to ensure that information relating to the physical and mental condition of the person, whether through observation or disclosure by the person, is recorded to inform members who later assume custody responsibilities.

vi. The obligation ACTOps to ensure that any AFP member who has custody of a person who has been taken for assessment or treatment to a hospital,

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[181] The AFP go on to submit, at para 15 of their s 55 subs, that the "significance of the cut to Justin's wrist was that it was likely an indicator that Justin had self-harmed and was therefore an indication of his mental state". Then at para 16 they submit "the cut on Justin's wrist was but one indicator among many of Justin's mental state. It was not the only indicator, nor the most important indicator."
[182] Para 16 s 55 subs.

has information in its possession as to the person's physical and mental condition, including any s 309 request in respect of that person.

vii. The responsibilities of a senior officer who attends and takes command of an incident, to ensure that the medical and mental health needs of a person in custody at the scene, have been assessed and met.

viii. The circumstances in which AFP members should consider seeking advice or assistance from the AMHT or PACER where they have mental health concerns in respect of a person in custody, before the person is taken to the Watch House.

Issues 2, 5 and 6 – the relevance of a s 309 request by an AFP officer, the absence of a s 309 order by the Court and the role of the Mental Health Court Assessment and Liaison Service (MHCALS)

343. In the ACT, if police charge a person (defendant) with a criminal offence then refuse to grant them bail, the defendant is brought before the Magistrates Court within 48 hours. The Court can grant bail, dispense with bail, refuse bail, or make a s 309 order.

344. A s 309 order is an order made pursuant to s 309 of the *Crimes Act*, which was, relevantly, in February 2023:

> **309 Assessment whether emergency detention required**
>
> (1) If, in a proceeding in the Magistrates Court, the court has reasonable grounds for believing that an accused needs immediate treatment or care because of mental impairment, the court may, without requiring the accused to submit to the jurisdiction of the ACAT, order that—
>
> (a) the accused be taken by a police officer or corrections officer to an approved mental health facility for clinical examination for the purpose of deciding whether the accused needs immediate treatment or care because of mental impairment; and
>
> (b) the accused may only be released into the custody of a police officer—the person—
>
> (i) by the person in charge of the approved mental health facility; or
>
> (ii) if the accused is found to need detention and care because of mental impairment—by the person who is in charge of an approved mental health facility where the accused is detained for care; and…

345. A request that a Magistrate make a s 309 order can come from:

(a) the defence or prosecution lawyer, orally in Court; or

(b) a practitioner working with the MHCALS who reviews the defendant in the Court cells and then prepares an assessment form which recommends a s 309 order; or

(c) the defendant directly to the Magistrate in Court; or

(d) the AFP in several ways, including in a s 309 minute or by observations expressed in an ACT Police Bail Consideration Form, both of which are

provided to the DPP and defence, and can be given to the Magistrate by either of them during a bail hearing.

346. A Magistrate may make a s 309 order on their own initiative, i.e. without any request being made.

347. Issue 2 examines the relevance of the s 309 minute prepared by Constable Russell to the consideration given by the arresting officers when they prepared the paperwork for Court, including the ACT Bail Consideration form which asked whether a s 309 request should be made for Justin.

348. Issue 5 is the "absence of an order under s 309 of the *Crimes Act 1900* in respect of Mr Cordy on 25 February 2023 and the systems by which concerns of AFP officers as to the mental health of a person facing charges are communicated to the Watch House, the MHCALS, the DPP, Counsel appearing for defendants, the Court and Forensic Mental Health Services at the Alexander Maconochie Centre (AMC)."

349. Issue 6 is the role of the Mental Health Court Assessment and Liaison Service (MHCALS) and the limitations in the services it provides.

350. These three issues are interrelated and will be dealt with together.

351. On 23 February 2023 Constable Russell prepared a s 309 minute setting out AFP concerns about Justin's wellbeing, arising from words he said to his partner the day prior. Constable Russell also prepared an ACT Police Bail Consideration Form which recorded that a "s.309" was required, and a Statement of Facts arising from offences allegedly committed on 22 February 2023.

352. The arresting officers gave evidence that they held concerns for Justin's mental health, given his behaviour prior to and at arrest. Neither of the arresting officers prepared a s 309 minute.

353. On 24 February 2023, Constable Graydon completed a Statement of Facts in respect of 16 offences alleged to have occurred that day. He also prepared an ACT Police Bail Consideration Form. On the Bail Consideration form signed by Constable Graydon the section of the form that asked "Is a Section 309 required" was answered "N/A". It was vetted by Detective Leading Senior Constable Saunders.

354. Leading Senior Constable Milner vetted the two Statements of Facts, 'a section 309 request minute', and 'a Family Violence Bail consideration form'. He charged Justin with the charges listed on the two Statements of Facts.

355. All of the documents in relation to Justin were available to other officers through the AFP's shared drive.

356. Constable Graydon's evidence was that he was informed of the Russell s 309 minute sometime after his return to the City Police Station on the afternoon of 24 February 2023.[183] He could not recall Senior Constable Fergusson speaking to him at the scene of the arrest about Justin's previous threats of self-harm.[184]

357. Senior Constable Saunders said that at some point on 24 February 2023, he became aware that a s 309 minute had been prepared in respect of a threat of suicide that Justin had made earlier in the week. He could not recall when he received that information and said that it may have been at the scene.[185] Senior Constable Saunders thought it would be "doubling-up" to prepare a second s 309 minute.[186]

358. The Watch House sergeant prepares a physical file, referred to by the AFP as the DPP file, which is collected by the DPP and signed for on the morning of each court sitting day from the City Police Station. Occasionally, it is delivered to the DPP in court. It contains two copies of each document, so that a copy can, if necessary, be handed up in court. If there is a s 309 minute, it is included in this file.[187] The DPP file is also scanned and emailed to the DPP by the AFP on each Court sitting day.[188]

359. The "cut off time" for the provision of documents to the court on a weekday is 3pm. That is the time by which police must have defendant at court with their paperwork and ready to appear.[189]

360. As Justin was not ready for court by 3pm on the Friday, he was held overnight at the Watch House and taken to court on Saturday morning.

361. The DPP file includes documents that would, and documents that would not, be passed on by the DPP to a defence solicitor. A s 309 minute is one of the documents that would be passed on to defence.

362. The solicitor representing a person in custody is notified of the existence of a s 309 minute by the DPP. Usually, people in custody who appear before the bail court are

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[183] Exhibit 1, Brief AAA, p.4016 [48].
[184] T108.44-46.
[185] T838.33-42.
[186] T842 and 853.
[187] Exhibit 1, Brief AAB, p.11 (p.6613).
[188] Exhibit 1, Brief AAB, p.11 (p.6613).
[189] Exhibit 1, Brief AAB, p360 (p.6962).

represented by a Legal Aid duty solicitor.[190] On 25 February 2023, Justin and other defendants before the Saturday bail court, were represented by the Legal Aid duty defence solicitor. This solicitor does not have ongoing carriage of the defendants' matters, nor does Legal Aid necessarily keep carriage of any of the defendants' matters. They appear on a duty basis only to assist defendants to apply for bail if instructed to do so.

363. If there is a s 309 minute, it will be included in a PDF file attached to an email, that is sent by the DPP to Legal Aid before the bail hearing.[191] Also included would usually be charge sheets, statements of fact, criminal histories, and bail consideration forms.[192] The Magistrates Court Chambers Manager (Chambers Manager) said that, in her experience as an associate, she's "never heard of having two" separate bail consideration forms for a single defendant.[193]

364. The defence solicitor on 25 February 2023 gave evidence that sometimes, but not always, the covering email would note that a s 309 request has been made in respect of a person in custody.[194]

365. The prosecutor appearing in all the Saturday bail hearings on 25 February 2023 was responsible for sending these documents by email to the defence solicitor (and if there was a private solicitor appearing for any of the defendants, that lawyer as well, although it is rare for a private solicitor to appear for a defendant at the Saturday bail court[195]). On weekdays, it was the responsibility of DPP paralegals to email these documents to the defence solicitor appearing in bail court.[196]

366. At 05:36 hours on Saturday 25 February 2023, the Acting Watch House Sergeant on shift at the time, sent an email to several email addresses attaching the court list for that day. The attachment included a document, in the form of a table, entitled "Files to Court/DPP", which listed nine defendants, including Justin. The form included columns for entries to be made in respect of each defendant, including a column headed "s 309 Request". A "Y" (for yes) was entered in the column in relation to Justin. For all the other defendants, "N" was entered in that column.[197]

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[190] T207.
[191] T257.
[192] T258.
[193] T208.
[194] Exhibit 1, Brief AAA, p.4403; T257-258.
[195] T207.
[196] Exhibit 1, Brief AAA, p59-60, [5].
[197] Exhibit 1, Brief AAB, p.220 (p.6822).

367. The “Files to Court/DPP” document was emailed to court staff. On 25 February 2023, the Acting Watch House Sergeant emailed the document to the Chambers Manager. She was not working on 25 February 2023 and would not have accessed her email until the following Monday morning.[198]

368. The Chambers Manager said that she would only refer to this document if she was in court, rostered to sit in on the “Fresh in Custodies” (or bail) list. In those circumstances, she would look at the document to cross-check the names of defendants with another list provided by Corrections.[199] She did not have regard to the column relating to a s 309 request, in the sense that she would not convey that information to the Magistrate. She would look at it to prepare herself for what was going to occur in court that day. She would only speak to the Magistrate about a s 309 order in respect of any defendant after having a discussion with the prosecution or defence lawyer or both.[200]

369. The Chambers Manager said that, if she had a list that indicated a “Y” next to a name in the s 309 request column, but neither the defence nor the prosecution raised it with her in that preliminary discussion before court, then she would not tell the Magistrate about a s 309 request in respect of a defendant.[201] She further said that she was “pretty sure” there had been times in her experience where there was a “Y” in the column for s 309 request and the DPP did not make a s 309 request to the Court.[202]

370. On Saturday 25 February 2023, the Associate to the duty Magistrate did not receive a copy of the Acting Watch House Sergeant email or the attachment.[203] Her practice was not to look at the s 309 request column.[204] She considered that it was not up to court staff or the Associate to raise a s 309 request with the Magistrate.[205]

371. The evidence supports a finding that, at the time, the only way in which a s 309 request would come to the attention of the Court was if it was raised by a legal representative at the hearing (or the defendant speaking directly to the Magistrate). Although court staff were provided with a document which identified defendants who were the subject of a s 309 minute, it was not the responsibility or practice of those staff members to take any step to bring a s 309 minute to the attention of the Magistrate. Furthermore, the existence

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[198] Exhibit 1, Brief AAB, p.358 (p.6960).
[199] T197-198.
[200] T198-199.
[201] T199; T203.
[202] T210.
[203] Exhibit 1, Brief AAB p.379 (p.6981).
[204] Exhibit 1, Brief AAB p.381 (p.6983).
[205] Exhibit 1, Brief AAB p.383 (p.6985).

of an AFP s 309 minute does not mean either lawyer would make a s 309 order request. The minute brings matters to the attention of the lawyers who, on weekdays, would cause a defendant the subject of a s 309 minute to be seen by the MHCALS team. A s 309 minute is not required before a lawyer can ask for a s 309 order, nor is it required to refer a defendant to MHCALS.

372. MHCALS is a mental health service that provides mental health practitioners to speak with defendants appearing before the criminal courts in the ACT. It is operated by the FMHS which is a component of the ACT's Justice Health Service program within MHJHADS.[206]

373. The service screens for individuals who may be presenting with acute mental health needs which require immediate treatment and care beyond what they would receive in the community or in custody. The service can speak to any persons appearing before the ACT Courts including persons referred to them.

374. The MHCALS receives a daily list of everyone in police custody who will be appearing before court. The service sees all people who are the subject of a s 309 minute from the AFP, and is also available to defendants in custody who are not the subject of a s 309 minute and who wish to speak to someone from mental health.[207]

375. The service only operates on weekdays.[208] Accordingly, despite Constable Russell's s 309 minute and Justin's indication to the defence solicitor that he wanted to speak to someone from mental health, Justin was not seen by a MHCALS clinician on Saturday 25 February 2023 because the service was not available.

376. The prosecutor's evidence was that on days when MHCALS was not available, she would raise the AFP's s 309 request with the defence solicitor before the Magistrate commenced court for the day. Even when the defence solicitor indicated that their client was not inclined to have an order made, the prosecutor would raise it with the Magistrate, and provide a copy of the minute to the Magistrate for the purpose of determining whether a s 309 order should be made.[209]

377. On 25 February 2023 the prosecutor who appeared in all the Saturday bail matters was the only staff member in the DPP that morning.[210] She was required to attend the City

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[206] Exhibit 1, Brief AAA, p.3732.
[207] Exhibit 1, Brief AAA, p.4487; T297.
[208] Exhibit 1, Brief AAA, p.4487.
[209] T283.
[210] Exhibit 1, Brief AAB, p.60 (p.6662).

Police Station and collect files in relation to nine detainees; one each for the other eight defendants before the Court and two for Justin. She removed the staples and scanned each file to the defence solicitor. The prosecutor is not able to provide all documents in the DPP file to defence, and only scans the documents intended for defence. During this process she overlooked the s 309 Minute in Justin's family violence file (for the 23 February 2023 offences) such that it was not scanned to the defence solicitor. Nor did her email setting out the prosecutor's position on Justin's bail (which was that bail was opposed) refer to a s 309 request.[211]

378. While she was preparing documents to send to the defence solicitor, criminal histories continued to be emailed to the prosecutor during the morning, and the prosecutor had to read and prepare for each bail application. She also needed to locate each of the defendants' files, which may have been in colleagues' offices. It was a busy and demanding process for which the prosecutor had no legal or administrative assistance. Later in the morning the Watch House processed another defendant who was to appear before Court that morning, making the total number of defendants before the Court ten on this particular Saturday.[212] The prosecutor estimated she had one hour and ten minutes to prepare all ten matters, which commenced with Justin's matter at 09:00 hours.[213]

379. The prosecutor was asked about the two bail consideration forms that existed for Justin; the form prepared by Constable Russell which stated a s 309 request was required, and the form prepared by Constable Graydon which stated "N/A" next to the s 309 request.[214] Her evidence was that she must not have paid particular attention to that part of the Russell form, that is, she overlooked the request for a s 309 order.[215] I accept that, had the prosecutor been aware of the s 309 Minute or the s 309 request noted on the bail consideration form for the 23 February 2023 offences, she would have handed up the s 309 Minute to the Magistrate. She also would have provided a copy of the Minute to the defence lawyer in the bundle she scanned to her earlier that morning.

380. The evidence supports a finding that the prosecutor's oversight was due to the significant time pressure she was under to undertake all necessary administrative steps and prepare for the Bail list that Saturday morning. I accept the prosecutor's evidence that

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[211] Exhibit 1, Brief AAA, p.4174.
[212] T264.
[213] Exhibit 1, brief AAB, p.63 (p.6665).
[214] Exhibit 1, Brief AAA, pp.4369, 4350.
[215] T282.

the failure to provide the s 309 Minute to the defence lawyer was an inadvertent oversight, and not intentional.

381. The prosecutor also raised the lack of training about appearing in the Saturday Court. She said that there was no practical written guidance as to how the process was supposed to work. Nor was there anybody on call that the duty prosecutor could speak to for assistance or support on a Saturday, regardless of the case load. She said that it was something that she learned by doing and making mistakes.

382. The defence solicitor who appeared for Justin on a duty basis on 25 February 2023 had been employed by Legal Aid for one year prior.[216] She had been involved in the Saturday list on five prior occasions.[217] She received the documentation for the nine defendants by attachment to an email sent to her by the prosecutor at 07:27 hours that morning. At 07:32 hours she received a further email with the criminal histories for eight of the defendants in custody, including Justin, and particulars for the ninth defendant.[218]

383. The documents that were sent to the defence solicitor in relation to all defendants before the Saturday court totalled 278 pages across 26 documents, 79 pages of which concerned Justin.[219]

384. Saturday Court commenced at 09:00 hours, as it does every Saturday. Between 07:30 hours when she began to receive the paperwork, and 09:00 hours when Court commenced, the defence solicitor needed to read the paperwork to prepare to conference each of the nine defendants, and then conference with each of them. Plainly, as with the prosecutor, the defence solicitor was significantly time poor. This explains why she continued to read the 278 pages of documents as she walked from her office to Court at approximately 08:08 hours that morning.[220]

385. To use her time most efficiently, the defence solicitor was guided by the DPP's position on bail. Where the prosecutor was not opposing bail, she spent less time reading those files; where the prosecutor was opposing bail, she would read the documents to ascertain if she would recommend applying for bail or not. When she looked at Justin's file from the 24 February 2023 offences, she noted their seriousness as well as his

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[216] T256.
[217] T256.
[218] Exhibit 1, Brief AAB, p.68 (p.6670).
[219] Exhibit 1, Brief AAB, p.69 (p.6671) and T265.
[220] Exhibit 1, Brief AAB, p.69 (p.6671) and T265.

criminal history and formed the view there would be little prospect of a successful bail application that day.[221] She therefore stopped reading Justin's documents.

386. As already set out, Justin's defence solicitor was not aware that there was a s 309 minute in relation to Justin because that document was not included in the documents that were provided to her by the prosecutor. She had no recollection of reading the bail consideration forms in Justin's matters, one of which did request a s 309 order.[222] It is noted that, in the experience of the Chambers Manager, she had never seen two separate bail consideration forms for a single defendant.[223]

387. The defence solicitor conferenced with Justin between 08:34 and 08:39 hours.[224] In conference, she outlined the charges against him and informed him he had limited prospects of being granted bail. Justin instructed her not to apply for bail.[225] Towards the end of the conference, Justin told her that he thought he needed to speak to someone about his mental health. He said words to the effect of "my headspace is just fucked".[226]

388. The defence solicitor told Justin that because it was a Saturday, there were no mental health nurses at Court. She said that his options were to ask the Court to make a s 309 order or to speak to a nurse or doctor on intake at the AMC.[227] In explaining the option of a s 309 order, the defence solicitor outlined that this meant he would be taken to the hospital and kept there until a psychiatrist determined he was okay to return to Court. She believes that she would have specifically told him that he would be taken to the Adult Mental Health Unit.[228]

389. Justin's response was to ask how long it would take before he could get to the AMC. He said that he needed a cigarette. The defence solicitor told him that she could ask for the matter to be dealt with first and hopefully he would get to the AMC in the morning and not have to wait too long. Having been given that information, Justin said that he would wait until the AMC and speak to a mental health clinician on intake.[229]

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[221] T268.
[222] T268.
[223] T208.
[224] Exhibit 1, Brief AAB, p70 (p.6672).
[225] T269.
[226] Exhibit 1, Brief AAB, p80 (p.6682).
[227] Exhibit 1, Brief AAB, p80 (p.6682).
[228] Exhibit 1, Brief AAB, p81 (p.6683); T270.
[229] Exhibit 1, Brief AAB, p80 (p.6682).

390. The defence solicitor's impression was that Justin was not interested in going to hospital. He seemed content to go to the AMC and start that process.[230]

391. The defence solicitor said that she had no concerns about Justin's capacity to provide instructions.[231] She said he seemed oriented and understood the legal situation. He was pleasant and was easy to conference in the sense that he was receptive to advice and provided clear instructions. There was nothing in his presentation that day that made her think that Justin should have been marked as a prisoner at risk.[232]

392. Based on the instructions she received during the conference the defence solicitor did not make a bail application, nor did she request the Court make a s 309 order for Justin. His matter was the first matter called at 9am and since bail was not applied for, bail was formally refused by the Court. No documents were tendered or handed up to the Court. There was no reference to section 309 during the bail hearing.

393. I make no criticism of the prosecutor who omitted to notice the s 309 Minute in one of Justin's two files and therefore omitted to send it to defence or raise it with the Magistrate. It is noted one of the two bail consideration forms that was provided to defence did nominate that a s 309 request should be made. The defence solicitor spoke with Justin and there was nothing in his presentation or arising from that conference that made the defence lawyer consider a s 309 request was appropriate.[233] Further, as the defence solicitor explained, it was her experience that defence solicitors do not "initiate an application"[234] for a s 309 order; rather, that the Magistrate may raise the possibility of such an order and ask the defence lawyer "to submit as to whether or not a person opposes or doesn't oppose the making of that order".[235]

394. The defence solicitor formed an impression of Justin based on her conference with him, unassisted by a s 309 minute prepared by the AFP. The defence solicitor also did not have the benefit of an assessment by MHCALS because they do not work on weekends. She thought the lack of MHCALS support on Saturdays is "hugely detrimental … to defendants. It makes … our job as duty solicitors more difficult. It means that there is a broader scope of things that we're expected to deal with and that we don't have the support or the expertise of someone from mental health to call on when it's needed".[236]

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[230] T270.
[231] T274.
[232] T274.
[233] T271 and 274.
[234] T271.
[235] T271.
[236] T271.

If Justin had been assessed by MHCALS and that assessment had recommended a s 309 order be made for him, that assessment with that recommendation would have been given to the Magistrate[237] who then would have heard from the defence solicitor as set out above.

395. I accept that a s 309 request is generally made by the prosecution on the basis of information provided to the prosecution from the AFP, or by defence on the basis of instructions, or by a mental health practitioner after conducting a MHCALS assessment. The defence solicitor who appeared for Justin had no basis upon which she would have made a s 309 request to the Magistrate and there is no criticism of her for not doing so. I acknowledge the significant time pressure both lawyers were under on Saturday 25 February 2023 and the lack of support from administrative assistants and MHCALS.

396. Evidence from Tegan Murray, psychologist with the Forensic Mental Health Service (FMHS), was that a MHCALS clinician would make a recommendation that the court consider a s 309 assessment where, following their clinical assessment, there are significant concerns regarding mental health deterioration or risk to the person, and the person either requires further assessment to consider their immediate treatment needs, or their risk is such that they could not be safely supported by other community treatment pathways.[238]

397. Ms Murray explained that MHCALS clinicians do not need a s 309 minute from the AFP about a defendant in order to assess a defendant.[239] She explained that the clinicians would assess a defendant who requested to speak to the service, or any person whom a legal practitioner or Corrective Services referred to the service, the only qualification being balancing the requested assessment "with all the other work".[240] A s 309 minute was not a precondition to be seen by MHCALS.[241] Ms Murray gave evidence about the role of the spreadsheet emailed to MHCALS each court day listing "everyone who is currently in police custody and who will be brought before the court that day"[242]. She said a "Y" in the column headed "s 309 request" would give priority to the defendant marked "Y".[243]

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[237] Tendered by the prosecution: T205, T212. Ms Murray said "the [assessment] form would be completed and provided to the court": T301.
[238] Exhibit 1, brief AAA, p.4489.
[239] T297.
[240] T297.
[241] T302.
[242] Exhibit 1, Brief AAA, p.4486, [6].
[243] T298.

398. I find that, had MHCALS been operating on Saturday 25 February 2023, a MHCALS clinician would have assessed Justin based on the "Y" against his name in the daily court list spreadsheet. My finding is further supported by the fact Justin raised his fragile "headspace" with his lawyer and the fact that out of the ten defendants appearing in Court that day, only one of them – Justin - had a "Y" in the column for s 309 request. Given the only qualification for speaking to defendants is time pressures, and those marked "Y" are given priority, I can comfortably find Justin would have been spoken to by MHCALS. It is not known whether the MHCALS practitioner would have been provided or sought the s 309 Minute prepared by Constable Russell.

399. It is not possible to know whether MHCALS would have recommended that the Magistrate make an order under s 309. On the one hand, Justin wanted to speak to a mental health clinician on the Saturday morning before Court. There is an available inference that he would have told the clinician that his "headspace [was] fucked", as he had said those words to the defence solicitor. On the other hand, Ms Murray gave evidence that it was reasonably common for a clinician to recommend that an order *not* be made for a person who is the subject of a s 309 minute.[244]

400. If the MHCALS assessment had recommended a s 309 order be made, that assessment report would have been tendered by the prosecutor.[245] The Magistrate may have made a s 309 order, but this cannot be known.

401. Had a s 309 order been made by the Magistrate, this would have caused Justin to go, not to AMC, but to the emergency department of the Canberra Hospital[246] to assess whether he needed immediate care and treatment.[247] If the doctor who examined him "decided no immediate treatment, care or support is required" he would not have been admitted to the hospital.[248] If he was assessed as needing care he would have been admitted to the hospital and be detained under the *Mental Health Act*,[249] where he would have remained until discharged into police custody.[250] When he was discharged from hospital he would have been held on remand before coming back to Court as a "s 309 return", at which time bail could be applied for. If a s 309 order had been made by the Court on Saturday 25 February 2023, Justin would have spent at least Saturday morning

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[244] T302; further that was "a reasonably quite common occurrence".
[245] T205; T212.
[246] T304, also T303 and 305.
[247] T304.
[248] T304.
[249] T305.
[250] Exhibit 1, Brief AAA, p.3648.

at the hospital, but may not have been admitted in which case he would have been discharged as early as Saturday afternoon and held to re-appear in Court on Monday morning.

402. There is no possibility that, had a s 309 order been made on the Saturday morning, that Justin would have reappeared that same day in the Saturday Court, given the Saturday "cut-off" is around 8am.[251]

403. Those defendants or detainees who do not make the cut off for Saturday Court and must be held until Court on Monday morning are held in the AMC.[252] It is possible then, that had a s 309 order been made for Justin on the Saturday morning, he may not have been assessed as requiring admission to hospital, in which case he would have spent Saturday afternoon until Monday morning in the AMC.

404. Had a s 309 order been made and he was assessed as requiring hospital admission, it is unknown how long he would have remained in the care of the hospital before being discharged and appearing before the Magistrates Court again.

405. Every outcome after the hypothetical MHCALS assessment that would have occurred if Justin had come before the Court on a weekday, is mere speculation. No findings can be made about whether the assessor would have recommended a s 309 order, nor whether the Magistrate would have made a s 309 order, nor whether the hospital would have assessed Justin as requiring admission.

406. In conclusion to Issue 2, a s 309 request by an AFP officer should be relevant to the consideration given by other AFP officers about the need for them to request a s 309 order be made in relation to the same defendant. However, both arresting officers gave evidence that they were (or became) aware of Constable Russell's s 309 Minute and this did not compel them to write their own minute, nor did it persuade Constable Graydon to answer "yes" to the question whether a s 309 order was needed on the bail consideration form.

407. Had the arresting officers decided to author a second s 309 minute, there is no guarantee this would have been provided to Justin's defence solicitor, although it should have been. As MHCALS does not work on Saturdays, any s 309 minutes would not have been read

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[251] T796-7.
[252] T797. See p.5 of brief AAB (Hawkins statement para 10) which references s 30 of the *Corrections Management Act 2007* which provides a person can only remain in a police cell for up to 36 hours, after which a direction can be given for the person's admission to a correctional centre where they are taken to remain in police custody: s 30(4)(b)(ii) and (5).

by MHCALS. As the prosecutor did not tender the existing s 309 minute, there is nothing to say the prosecutor would have tendered a second or additional s 309 minute. The preparation of a second s 309 minute would not have guaranteed a s 309 would have been sought by either the prosecutor or defence lawyer, and its preparation would not have guaranteed a magistrate would make a s 309 order. In conclusion, nothing turns on the fact the arresting officers declined to author a second s 309 minute, despite being aware that Constable Russell's minute existed.

408. No matters of public safety arise in Issue 2. It is unusual for two bail consideration forms to be tendered at a bail hearing for one defendant. A s 309 minute is made at a point in time, which may be days, weeks or longer before the person is arrested. The issues when the minute is written may not exist as at the person's arrest or on the day they appear before the Court. It is not the case that an existing s 309 minute means that whenever the person appears before the Court, the AFP must ask the prosecutor to request a s 309 order. Had MHCALS operated on the day Justin came before the Court, the importance of a s 309 minute is reduced because the MHCALS practitioner's assessment would be made at the point of time Justin was before the Court, by a qualified practitioner rather than an AFP officer doing their best based on their knowledge of Justin's mental health in the preceding days.

Changes instituted in March 2024

409. Detective Inspector Hawkins gave evidence of relevant changes in processes since Justin's death.

410. One change is that, since 13 March 2024, the Watch House sergeant is responsible for emailing any s 309 minute as a separate document (as well as in the entire DPP file) to the DPP. The minute is also separately emailed to MHCALS.[253]

411. Detective Inspector Hawkins said that the change provides an additional level of comfort that it is provided to the most appropriate people who can draw it to the attention of the Magistrate and Legal Aid.[254]

412. The s 309 form itself has also been updated.[255] It prompts the officer to give an overview of the incident giving rise to the mental health concern.[256] The officer is also required to

[253] Exhibit 1, Brief AAB, p12 (p6614); T921.44 – T922.10.
[254] T923.1 – 9.
[255] Exhibit 1, Brief AAB, p43 (p.6645).
[256] T924.21 – 26.

complete an additional form which summarises their observations relevant to the clinical assessment.[257]

413. Detective Inspector Hawkins explained that the need to change to this new form was identified by court mental health clinicians. The object of the change included better informing clinicians as to the AFP's level of concern for each individual and any observations to support an assessment.[258] The new form is intended to enable clinicians to access all available medical records in a timely fashion to inform them when conducting their assessments.[259]

414. In conclusion to Issue 5, these are the systems by which concerns of AFP officers as to defendants' mental health are communicated:

(a) The Watch House: the AFP officers working within the Watch House have access to all AFP drives which contain paperwork about each detainee. This includes s 309 minutes, Statements of Facts and bail consideration forms. As was seen in this inquest, arresting officers can speak directly to the Watch House and communicate any concerns about a forthcoming detainee to Watch House officers. In this case, no concerns were raised, quite the opposite; the Watch House directed officers to take Justin to the hospital while the arresting officers expressed their lack of concern.

(b) The MHCALS: if the AFP has prepared a s 309 minute and/or raised a s 309 request on a bail consideration form, the daily court spreadsheet which is sent to MHCALS each morning they attend court, will record a Y for yes in the column entitled s 309 request. A "Y" entry in this list will prioritise that defendant being seen by the MHCALS clinician who may or may not recommend a s 309 order after the assessment. As the MHCALS does not operate on Saturdays, the AFP concerns which lead to the "Y" in the s 309 column is of no relevance.

(c) DPP: the prosecutor will see the "Y" in the s 309 column or may see the s 309 request on the bail consideration form. This may lead to the prosecutor locating a s 309 minute as if Y is nominated a minute may exist. On a weekday the prosecutor would also have the MHCALS assessment and any recommendations. On a Saturday, the prosecutor can make the s 309 request to the Magistrate based on the concerns of the AFP set out in any bail

[257] The form is at Exhibit 1, Brief AAB, p45 (p.6647); T924.28 – 39.
[258] T924.41 – T925.5.
[259] T925.11 – 20.

consideration form or minute. Equally, the prosecutor may review these documents and choose not to make a s 309 request to the Magistrate. On Saturdays, the duty prosecutor is under significant time constraints, such that, even if AFP documents setting out mental health concerns exist, they may not have adequate time to read every page.

(d) Defence counsel: the defence lawyer will also see the "Y" in the s 309 column or may see the s 309 request on the bail consideration form. This may lead to the defence lawyer locating a s 309 minute as if Y is nominated a minute may exist. Defence counsel may consider any AFP documents provided from the DPP before seeking instructions from the defendant. On Saturdays, the duty solicitor is under significant time constraints, such that, even if AFP documents setting out mental health concerns are provided from the DPP, they may not have adequate time to read every page.

(e) The Court: The Magistrate receives documents which are tendered. If the defendant does not apply for bail, it is unlikely any documents are tendered. The Y in the court list, in the s 309 column, is not brought to the Magistrate's attention. If the Associate is informed by the lawyers that a s 309 order will be sought, the Magistrate may be informed of that, but it is still for the parties to decide what, if any, documents are to be tendered. AFP concerns are not relayed to the Court other than via documents tendered by lawyers.

(f) AMC: if the MHCALS assesses a defendant, a template report is created and this is attached to the defendant's file, which can be accessed by the FMHS in the AMC. Any concerns of the AFP, captured in documents provided to MHCALS for the purpose of their in cells assessment, could be included in their report. As MHCALS do not work on the weekend, no such report was created for Justin.

415. In short, the AFP can record their concerns in a s 309 minute and on the bail consideration form. The prosecution and defence lawyer should receive both of these documents. Either of them may tender the documents, which would place them before the Court. The MHCALS does not need either document to conduct an assessment of a defendant. The existence of these documents does not mean a lawyer will request the court make a s 309 order, nor do their existence mean a s 309 order would be made if requested. Section 309 orders can be made without a document setting out the concerns of the AFP, and a s 309 order may not be made even when the AFP requests one.

416. I cannot make any findings about whether a s 309 order would have been made, if either lawyer requested one. The Magistrate had no basis upon which he would have made the order of his own initiative as he had no MHCALS report or AFP paperwork pertaining to AFP concerns about Justin's mental health. His associate would not have raised the "Y" in the column of the court list with him.

417. It is mere speculation as to what would have occurred had a s 309 order been made. Justin may very well have been in the same remand cell, on the same Sunday night, even if he had gone there via the Canberra Hospital for an assessment under s 309. It must be remembered that Justin had spent Friday afternoon (approximately 2 – 3:30pm) at the Canberra Hospital, although not explicitly for a mental health assessment. Nonetheless doctors had discharged Justin into the care of police some 17 hours before he was before the Court.

418. The time pressures under which the DPP and Legal Aid operate on a Saturday, without the benefit of the clinical services of MHCALS, gives rise to a matter about the administration of justice and public safety connected with this inquest. On Saturdays, the communication of AFP concerns about the mental health of persons in custody to a Magistrate sitting on a Saturday bail list, by means of a s 309 request, depends upon legal practitioners who are under substantial time pressures to prepare matters for the Saturday bail hearing. The errors that led to the s 309 Minute not being brought to the attention of the Magistrate were, if not inevitable, at least ones that might reasonably be expected to have occurred.

419. Further, because MHCALS does not operate on a Saturday, it resulted in a lost opportunity for Justin to have a face to face assessment by a mental health practitioner, who would have had the benefit of an important aspect of his mental health history contained in the s 309 minute, namely a recent statement that he wanted to end his life.

420. The prosecutor felt she had insufficient time to devote to matters running in the Saturday Court and felt the time pressures gave rise to a conflict with her duties and responsibilities as a prosecutor. She described the situation as essentially having to "shortcut" preparation, with the risk, as eventuated in this case, that important matters were missed.[260]

421. The defence solicitor said that she did not feel that she had an adequate opportunity to review the documents for the purpose of representing her clients in court on the morning

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[260] T284.36 – 45.

of 25 February 2023.[261] She emphasised the role of Legal Aid in providing access to justice. She described the role of a Legal Aid lawyer as pivotal in enabling persons in custody to understand what was happening and would happen to them, to know what their rights were and how to exercise those rights. She said that her ability to do that on any day in a bail list is limited but it was particularly difficult when appearing in a Saturday bail list. She considered that those defendants did do not have the opportunity to be fully informed or receive comprehensive advice about their legal situation.[262]

422. The evidence of these witnesses strongly suggests that the pressures under which duty lawyers, both prosecuting and defending, are expected to operate in preparing for and appearing in the Saturday bail list gives rise to an issue as to the administration of justice in the Territory.

423. The DPP and Legal Aid should consider undertaking a review of their staffing arrangements for Saturday bail hearings in the light of the findings of this inquest, with specific consideration to whether administrative support is required, more than one practitioner should be rostered on to work or whether a system of "on call" support for practitioners rostered on is reasonably feasible

424. Issue 6 gives rise to matters of public safety, with subsequent suggestions to address these issues.

425. There are many benefits of the MHCALS for the court system, defendants and practitioners operating within the criminal justice system. It plays a critical role in the s 309 process, giving courts the benefit of advice and recommendations from qualified and experienced mental health clinicians. It reduces the risk that defendants who need immediate mental health care and treatment or referrals to community mental health services (if they are to be bailed) will not receive the treatment they need. It also reduces the risk that defendants who do not need such care and treatment will be made the subject of s 309 orders, thereby unnecessarily taking up the already limited hospital services.[263]

426. The presence of MHCALS in the Court not only means that a person who is subject to a s 309 minute will be seen by a member of the service but gives a degree of certainty that the minute will be brought to the attention of the Court.[264] The evidence supports a finding

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[261] T271. 39 – 44.
[262] T272. 1 – 20.
[263] As Ms Murray acknowledged, at T312.45 – T313.7.
[264] T307.

that, if MHCALS had operated on the day of Justin's bail hearing, the AFP concerns contained in the s 309 minute, would have come to the attention of the Court.[265]

427. The duty lawyer said, from her experience as a Legal Aid lawyer, MHCHALS played a hugely significant role in conveying to a Magistrate concerns about a defendant's mental health.[266] She said that it was hugely detrimental to defendants that it was not available on Saturdays. It increased the burden placed upon her and made the experience more difficult for defendants. She noted the unfairness inherent in the current system, whereby defendants were dealt with differently simply as a result of the timing of their arrest.[267]

428. For these reasons, the fact that MHCALS is not available to review defendants on any days other than regular weekdays gives rise to a matter of public safety.

429. As for the reason why MHCALS operates only on weekdays, Ms Murray said that it had been determined that it is not feasible or practical for MHCALS to operate a Saturday service, given that the court has a half day.[268] She said that the number of persons in custody on a Saturday morning varies significantly, which makes staffing of the service quite difficult. There was not a consistent number of people that might be brought before the court on a weekend or public holiday.[269] To her knowledge, the Magistrates Court has not requested MHCALS to be available on the weekend. It has not, to her knowledge, ever been raised as a concern that there has not been a representative available on a Saturday.[270]

430. However, the data provided by the Territory in relation to bail lists from 1 July 2023 to 30 June 2024 established that the number of defendants appearing in the 'fresh in custody' Saturday morning bail lists and the s 309 orders granted to defendants in those lists, both in terms of number and percentage, differs very little from the figures for the same bail lists on weekdays.[271] This data establishes that the need for MHCALS assessments on a Saturday is not materially different from a weekday.

431. Ms Murray said, in her evidence, that consideration had been given to the other mechanisms available to support people going through the criminal justice system and to support the court and the police, including Access Mental Health services, which are

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[265] T298; T284.
[266] T259.44 – 48.
[267] T271.26 – 37.
[268] T306.6 – 8.
[269] T306.24 – 39.
[270] T312.30 – 36.
[271] Exhibit 18.

available 24 hours a day. There was also the possibility of ACT Corrective Services calling an ambulance should that be clinically indicated.[272] Undoubtedly, these resources are available, but they are a far less effective, timely and clinically qualified mental health resource than MHCALS, both for defendants and the Courts.

432. There will of course be funding and administrative challenges to extending what is a weekday service to one that is also available on all days on which bail hearings are held. For the purpose of Saturday bail hearings, the DPP, Legal Aid and the Magistrates Court are required to meet those challenges. The evidence does not suggest that there are compelling reasons why MHCALS should not.

433. It is my view that Canberra Health Services should take the steps necessary to extend the operation of MHCALS to all days on which bail hearings are held, including weekends and public holidays.

Issue 3 – The Canberra Hospital (TCH) assessment on 24 February 2023

434. Justin was taken in police custody to TCH by two officers who had not been involved in his pursuit or arrest. Those transport officers were Constable Cross and Senior Constable MacDonald. They were not given a thorough briefing about why Justin needed to attend TCH. Constable Cross thought Justin needed a medical certificate to confirm that he was fit for custody. It appears both officers were told about Justin's car driving into a police vehicle but neither officer appears to have been told anything about Justin driving into the pole at speed.

435. The transport officers appear to have been told a taser had been deployed into Justin prior to his arrest.

436. At TCH, Justin was seen first by a nurse, and then by an emergency medicine registrar, Dr Bourke. Dr Bourke had, by that time, been working as a doctor for over ten years.[273]

437. Justin's presentation at TCH was captured on the BWC of Constable Cross. In the BWC footage, Justin can be heard answering questions. His answers give the impression that he was confused and unsure what had happened.[274] Justin did explain he had consumed GHB and alcohol since his release from gaol two days earlier.

438. Justin does not give medical practitioners any information about any car accidents. The source of a note taken by the nurse that Justin had been involved in a "low speed MVA

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[272] T306.10 – 16.
[273] T393.
[274] See BWC footage and Exhibit 1, Brief AAA, p.5930-5932.

prior to being arrested" does not appear to be Justin or either of the attending transport officers, as they were not captured telling the registered nurse anything about a motor vehicle accident.

439. Whilst being attended to by the registered nurse, prior to being taken to the emergency department, Justin can be heard saying he had drunk a whole bottle and had just tried to "neck himself".[275] It appears neither the nurse nor Constable Cross (whose BWC captured that statement) heard that utterance.

440. Before Dr Bourke examined Justin, she reviewed his clinical records and had a conversation with Constable Cross. In that conversation, Constable Cross told the doctor that Justin had been involved in a "minor collision". The doctor informed Constable Cross that she could not assess whether Justin was fit for custody but could clear him for discharge.[276]

441. Dr Bourke gave the following evidence:[277]

> Do you recall examining his wrists during the course of your examination of him?
>
> … I can see on the footage that I am trying to look at his hands and wrists when we were trying to clean them under the sink…
>
> Are you able to see [in shown exhibits] some red marks on Justin's left inner wrist in those exhibits?
>
> Yes.
>
> So do you recall noticing them during the time of when you assessed Justin?
>
> Not specifically…
>
> In the normal course of those marks that you would have raised… asked the patient some questions about? Yes… if I thought there was an injury there and wanted to explore it further I would have asked them about them.
>
> Are you able to provide… an explanation as to why you didn't ask any further questions in relation to those marks?
>
> I do recall on the video that when I found Mr Cordy he was wearing his – the hand cuffs and it may be that I did not notice the full extent of the marks beneath them.

442. Justin's bloodied left wrist, including a horizontal red smear, can be seen from various angles in the BWC footage. Dr Bourke did not recall seeing Justin's bloodied left wrist,

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[275] T229.
[276] Exhibit 1, Brief AAA, p.5930-31.
[277] T396.

despite attempting to clean blood off his hands and wrists, which cleaning he resisted. Dr Bourke suggested she did not notice his bloodied left wrist as it was obscured by handcuffs.[278]

443. I accept the AFP's submissions at paragraph 176 (footnotes omitted):

> … it is noted that for a period of time the hand cuffs are no longer attached to Justin's left wrist as his right wrist only was cuffed to the bed and that, in the course of Dr [Bourke] washing Justin's wants [sic] in a sink, Justin's left wrist was in clear view of Dr [Bourke] who stood on his right hand side.

444. As far as Dr Bourke understood, Justin had been involved in a "minor collision",[279] and this was the focus of her examination. Bloodied areas of the body might have warranted further investigation, and Justin's left wrists were noticeably bloodied.[280] They were not obscured by the handcuffs for the duration of his presentation in the ED[281] but they were when she was standing to the right of Justin while he washed his hands under the tap. Police told Dr Bourke an "ambulance came and assessed his hands and everything so he's… that's all extrinsic to the collision… he has bit of blood and all over him, he's got couple of cuts to his chest and then his hands, some injuries":[282]

445. The ACT submitted that it "was not put to Dr Bourke that her physical examination was … substandard" nor was it "put to Dr Bourke that she should have examined (other) bloodied areas of the body or that the bloodied areas warranted further investigation".[283] I find the substance of those propositions were put to Dr Bourke as set out above (in T396). Dr Bourke accepted that if she saw the red marks on the wrist she would have asked the patient some questions about them.[284] The doctor accepted that, at least, she would have asked the patient about the marks- or injury as the doctor said- and this could be considered "attention". I agree with the doctor that, in the normal course, if she came across cuts on a patient's wrist she would (and should) ask the patient about those. The

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[278] T396.
[279] BWC of Cross 43:13.
[280] The ACT further submitted that there "is no evidence that Justin's wrist was actively bleeding or otherwise needed attention": Para 27 ACT s 55 submissions.
[281] Removed at 1:00 of Cross BWC. Dr Bourke spoke to Justin at 1:10 when his left elbow was resting on the bed and his left wrist was facing towards her but she was talking about discharge papers but performing an examination at the time.
[282] Police told Dr Bourke "ambulance came and assessed his hands and everything so he's… that's all extrinsic to the collision… he has bit of blood and all over him, he's got couple of cuts to his chest and then his hands, some injuries": BWC of Cross 43:00ff.
[283] Paras 24 and 26 ACT s 55 submissions.
[284] T396.

medical experts found Dr Bourke's examination met acceptable standards[285] and her physical examination of Justin was reasonably comprehensive.[286]

446. Given her answers about what she would have done had she received information that Justin threatened self harm with a knife at the point of arrest, one could surmise she might have undertaken a mental health assessment of Justin if she located fresh cuts to his wrists. However, this is speculation as she did not, despite completing an examination of him over a period of time, notice his bloodied wrists, nor was she told about his threats of self harm at arrest.

447. She explained that she did not perform a mental health examination because she had no background that raised concern about his mental health.[287] She acknowledged she could perform such an assessment and she could also refer a patient to a psychiatric registrar or for a mental health consultation.[288]

448. Dr Bourke did not record completing the Glasgow Coma Score for Justin, although she did perform the requisite tests for that score. She did not perform an Abbreviated Westmead Post-Traumatic Amnesia scale (A-WPTSA) test for concussive injury nor any mental health assessment.

449. I accept Counsel Assisting's submission that Justin should have had an A-WPTSA test before he was discharged from TCH on 24 February 2023.[289] The evidence in support of this finding includes the supplementary report of Dr Bourke, in which she accepted it would have been reasonable to have administered the test on Justin to ascertain whether his poor memory was more consistent with substance misuse or head injury. The test would have required that he be observed for one to four hours.[290]

450. The other evidence which supports this finding is the expert opinions of Dr Lee and Dr Day. Both doctors considered the test should have been administered, but differed on the likely outcome of the test. It is possible, but not likely, that Justin would have failed the test which would have resulted in his admission to hospital overnight. Even if he was admitted and held for observation overnight, it is still likely he would have appeared before the Magistrates Court the next day.

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[285] Dr Day: Exhibit 1, Brief AAA, p.6930-31.
[286] Exhibit 1, Brief AAB, p.6693.
[287] T402.
[288] T403 and Exhibit 1, Brief AAA, p.3918-19.
[289] CA Submissions, [475].
[290] Exhibit 8.

451. Dr Bourke's evidence included that she was told about one motor vehicle accident which was minor or low speed.[291] Both expert doctors, Dr Lee and Dr Day, agreed it was important for ED doctors to know the details of a motor vehicle accident in order to properly assess the patient.[292] As Justin could not remember the details, Dr Lee considered those details should have been obtained from police, and Dr Day pointed out that such information would have needed to be obtained from the police, via the attending officers (who did not have knowledge of the two accidents).[293] Professors Ryan and Large also opined that it was important to have more information about the car accident. Professor Ryan was concerned that one or both of the car accidents might explain Justin's confusion, and could have been a suicide attempt.

452. The evidence comfortably supports a finding that the doctor should have asked for more details about the motor vehicle accident, and such information would have had to come from the police. Once the attending officers had ascertained more information, it should have come to light that Justin had been involved in two accidents, the latter being a single vehicle accident into a pole at speed. Had this information been relayed to Dr Bourke she ought to have performed the A-WPTSA and she may have been concerned about Justin's mental health, if she perceived the accident into the pole as a potential self-harm attempt. The Territory noted Dr Bourke's concession that conducting an assessment such as an A-WPTSA would have been reasonable.[294]

453. Further, separate to the need to conduct the A-WPTSA, Drs Lee and Day considered Justin should have been observed in hospital for longer.[295] Dr Lee suggested 8 to 24 hours whereas Dr Day considered until later that evening. They considered this necessary because of Justin's confusion, poor memory and elevated heart rate.[296] Professor Ryan expressed a similar view.[297]

454. Dr Bourke rejected these criticisms, stating her impression was that Justin needed sleep and she was aware he was going to the Watch House once discharged, where he could sleep. She may have held him in ED to allow him to sleep if she was concerned he would otherwise have nowhere to go, but that was not the case.[298]

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[291] T413.
[292] T427.
[293] T427.
[294] Territory submissions, [6], and s 55 subs para 30 and 31, citing T405.
[295] T445-6.
[296] T445.
[297] Exhibit 1, Brief AAA, p.6157-58.
[298] T414-415.

455. Professor Large disagreed with Professor Ryan's view that Justin was not fit for discharge due to his memory issues.[299]

456. I have found that Justin should have been given the A-WPTSA, which would have required he remain in hospital up to four more hours. Added to this is the expert opinion which supports a finding that Justin should have been observed in hospital for a further period, four hours being a period most of the experts could agree. On either or both bases, I find Justin should have been kept in hospital for a longer period than he was.

457. Dr Lee was critical of Dr Bourke's lack of mental health assessment or questioning. He considered Justin's risk factors – such as recent release from gaol, taking drugs and at least one car accident – should have prompted Dr Bourke to ask some screening questions.[300]

458. Dr Day, with whom Professor Ryan tended to agree, did not think it was necessary for Dr Bourke to conduct a mental health assessment largely because she was unaware of Justin's mental health concerns or vulnerabilities.

459. I accept Counsel Assisting's view that the weight of the evidence does not support a finding or comment that Dr Bourke should have conducted a mental health assessment of Justin while he was in the ED of TCH, given the information she was provided including the explanation for his attendance at the hospital and his presentation.

460. However, had Dr Bourke been provided with more fulsome and accurate information, her treatment of Justin should (and I have found would) have included a mental health assessment or referral.[301] Dr Bourke gave evidence that had she known Justin threatened self harm whilst holding the knife to his wrist and then used the knife to cut his wrist, she believes she would have arranged for a mental health consultation regardless of the answers to her questions. The outcome of any assessment or any referral is unknown.[302]

461. Professors Ryan and Large were asked about the potential outcome of a hypothetical psychiatric assessment of Justin on the afternoon of 24 February 2023. Their evidence included:

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[299] Exhibit 1, Brief AAB, p.188 (p.6790).
[300] T430, 433.
[301] Exhibit 1, Brief AAA, p.3918-19.
[302] AFP submissions, [182].

(a) It is uncertain whether Justin would have met the criteria under s 80 of the *Mental Health Act* for being further detained at hospital. There is uncertainty about whether s 80 applied to Justin, who was already in police custody during his assessment.

(b) Professor Large considered Justin would not have required additional care or treatment because his confusion was more likely due to his substance misuse.[303]

(c) If the history included the threat of suicide earlier in the week and at the point of arrest, these threats would need to be carefully explored in the consultation.[304]. As would, the experts agreed, the details about the crash into a pole earlier that day.[305].

462. Professors Large and Ryan agreed that documentation about the clinical assessment that takes place in hospital must be communicated to those assessing Justin within the prison system.[306] The Professors' opinions about the communication from a (hypothetical) hospital assessment to prison staff did not change depending on whether, at arrest, Justin did use the knife to cut his wrist.[307]

463. Both Professors expressed the view that if a psychiatric assessment had occurred, with fulsome information known to the assessor, the assessor should then have provided a letter setting out significant risk factors to the forensic mental health service within the AMC.[308]

464. While there were individual failings in the management of Justin at TCH, acknowledged by Dr Bourke, these do not give rise to matters of public safety connected with the inquest.

465. While persons in custody are a vulnerable group, not all arrested persons are brought to hospital prior to admission to the Watch House. There must be a reason to take an arrested person to hospital, and in Justin's case, it was his involvement in a motor vehicle accident. The role of his hospital visit was not a mental health screening. Whilst it would have been optimal in Justin's case, given his recent history concerning self-harm, for the doctor to have undertaken a mental health assessment, I do not recommend all patients in custody be routinely administered mental health screening. As Counsel Assisting

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[303] T651-652.
[304] T652, 654-655.
[305] T656, 663.
[306] T652-3.
[307] T662-63.
[308] T664-65.

rightly submitted, there are "mental health services already available at the Watch House, the Courts and the AMC" and a recommendation that all patients in custody be subjected to a mental health assessment could "impose a potentially unworkable burden on already overstretched emergency departments".[309]

466. The AFP submitted that a lack of recommendation about the failure to administer a mental health assessment in TCH is at odds with the recommendations about the AFP addressing Justin's mental health at his arrest.[310] The difference is the ED doctor did not have the information available to police who were present at his arrest, nor was the doctor bound by the AFP Custody Guideline. The most pertinent of such information being that as he was approached by police Justin called out "I'm going to kill myself" and "I've already cut myself" and then used the knife to cut his left wrist several times. The AFP were also aware that days earlier Justin had told his girlfriend he wanted to end his life. As Counsel Assisting submitted in reply submissions at paragraph 135 (emphasis in the original):

> On 23 February, AFP officers prepared a minute requesting that the DPP seek an order that Justin be taken to a hospital to undergo a mental health assessment to determine whether he needed immediate treatment or care. The following day, Justin was taken to a hospital by AFP officers after he had been tasered and arrested, having held a knife to his wrist threatening self-harm… Yet the AFP did not ask that he undergo a mental health assessment at TCH or give the hospital information to suggest he needed one.[311]

467. The primary purpose of Justin's admission to TCH was to check his health following a single motor vehicle collision, which was communicated to health staff as "minor" whereas when Justin was apprehended his mental health should have been at the forefront of the police officers' minds.

Issue 4 – the mental health assessment by Access Mental Health on 24 February 2023

468. After Justin was discharged from hospital he was admitted into the Watch House. That evening, being Friday 24 February 2023, he requested to speak to someone about his mental health. An officer provided him with a phone at about 5:50pm which Justin used to speak to Registered Nurse de Jesus for about 8 minutes. RN de Jesus was part of the Access Mental Health Team (AMHT) which is operated by Canberra Health Services. By that date, RN de Jesus had been employed in AMHT for about 3 years.[312]

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[309] CA submissions, [536].
[310] AFP submissions, [187].
[311] CA submissions, [135].
[312] T318.

469. The conversation took place in Justin's cell with the phone on speaker. The CCTV of the cell captures audio but it is difficult to hear the entirety of the exchange between Justin and RN de Jesus. In evidence, he does not recall the phone call and relied on the clinical notes that he had made at the time. The clinical notes appear consistent with the phone call, but incomplete. For example, the notes make no mention of the discussion about Justin's court appearance the next day or the nurse suggesting Justin speak to someone "in the morning". If the nurse was referring to Justin speaking with a member of the MHCALS at court the next day, he was mistaken, as that service did not operate on Saturdays. He told the inquest he did not know when the MHCALS was available.[313]

470. RN de Jesus' did not have any acute concerns about Justin following the phone conversation, nor was he informed by any Watch House officers of any concerns they had. He primarily relied on the fact that Justin was in a safe and structured environment (the Watch House) to reach his conclusion that Justin was not at risk.[314] This conclusion was not impacted by whether MHCALS was available at court the following morning.

471. The psychiatric experts, Professors Ryan and Large, both considered the phone call and conclusions which flowed from it to be reasonable. They explained the limitations of such calls and were not particularly critical of the fact the nurse advised Justin to speak to mental health at court when no such service was available at Saturday court. Professor Ryan considered the nurse should have known what services were available.[315] I agree, particularly when the nurse recommended Justin access those services "in the morning".

472. It must be remembered the call was not standard procedure; it only occurred because Justin requested it. One might have expected a fuller exploration of Justin's concerns given he asked to speak to mental health.

473. In the end, I accept Counsel Assisting's submission that no matters of public safety connected with this inquest arise from the nurse's ignorance about the availability of MHCALS at Saturday court.[316]

474. To address this issue, it may be that CHS chooses to provide written guidance to AMHT clinicians that MHCALS presently only operates on weekdays. CHS accepted this suggestion in submissions.[317]

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[313] T346.
[314] T347.
[315] T639.
[316] CA Submissions, [562].
[317] Territory submissions, [19].

Issue 7 – the mental health assessment at the AMC on 24 February 2023

475. As set out under the heading "Background" above, Justin's health induction into the AMC was conducted by two registered nurses. RN Jose did the physical assessment while RN Silwal conducted the mental health assessment. Dr Jehne completed a handover, by telephone, from RN Silwal and RN Jose.

476. Experts Professors Ryan and Large considered RN Silwal's assessment of Justin to be reasonable. Both commented that a consultation of between 8 and 10 minutes was very short, in the circumstances of a new patient being inducted into custody, and Dr Jehne considered it would be hard to do a good mental health examination and risk assessment in less than 20 minutes. RN Silwal spent about 8 to ten minutes speaking to Justin, and a total of 16 to 17 minutes on Justin's assessment.

477. Nevertheless, I agree with the expert opinions that RN Silwal's assessment was reasonably competent, based on the information available to him at the time.

478. The experts were not critical of Dr Jehne's clinical decision to endorse RN Silwal's recommendations.

479. At the time of their assessment of Justin, and as a result of earlier events, neither RN Silwal nor Dr Jehne were aware of the following aspects of his history:

    (a) Earlier in the week, Justin had expressed a desire to end his life, prompting a concern for his welfare on the part of the AFP (the subject of the Russell s 309 minute).[318]

    (b) Before his arrest, Justin had been involved in two motor vehicle accidents. One was minor and the other was a high speed single vehicle collision into a pole, which had cracked the engine block of the vehicle.[319]

    (c) At the point of his arrest, Justin had held a knife to his wrist threatening self-harm.[320]

480. The evidence supports a finding that if Dr Jehne had known or understood all the information referred to in paragraph above, she would have given Justin a rating of S2 and recommended that he be placed in the CSU[321] She would have reached the same decision if the information she had received was that at the time of his arrest, Justin had not only threatened self-harm but had self-harmed.[322] Individually, each piece of

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[318] T603.
[319] T606.
[320] T604.
[321] T608 and T617.
[322] T604-606.

information would have been relevant, but not sufficient to cause her to make a different clinical decision[323]. Combined, the information would have resulted in Justin being placed in the CSU.

481. On the basis of this evidence, if Justin had been given a suicide rating of S2, he would have been placed in the CSU, on 30-minute observations until Monday 27 February 2023. It cannot be known how long Justin would have remained in the CSU. As Counsel Assisting submitted, it is entirely possible that he would have been moved to SCC West or perhaps into the general prison population after a meeting of the High Risk Assessment Team on 27 February 2023. Whether his suicidal thoughts would have dissipated by then or, if they had not, whether he would have found the means and opportunity to take his life after that point, is impossible to say.

482. Nevertheless, the evidence does support a finding that, if Justin had been placed in the CSU after his induction on 25 February 2023, he would have been placed in a cell monitored from the inside by CCTV. He would not have had access to the particular ligature point (the broom handle) that he found in the communal laundry in SCC West. It is therefore unlikely that he would have had either the opportunity or the means to complete suicide whilst housed in the CSU.

483. Both Professors Large and Ryan expressed opinions as to the limited utility of a system of suicide risk ratings. Professor Large referred to literature that found that the accuracy of suicide prediction models in predicting suicide was near zero.[324] Professor Ryan said that it was not possible to usefully stratify or categorise patients into those at relatively higher and those at relatively lower likelihood of future suicide or serious self-harm.[325]

484. Dr Jehne accepted that it is very difficult to accurately predict suicide risk. Nevertheless, she considered it to be necessary for some degree of risk stratification from the point of view of the decisions that Corrections staff were required to make as to a detainee's accommodation and frequency of observations.[326] She accepted that a clinician's recommendation as to where a person should be accommodated and the level of observation could be communicated to Corrections without the necessity to accord a suicide ranking to the decision.[327]

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[323] T604-606.
[324] Exhibit 1, Brief AAB, p183 (p. 6785).
[325] Exhibit 1, Brief AAA, p. 6142.
[326] T612.
[327] T612.

485. Professor Ryan noted that the Suicide Vulnerability Assessment Tool (SVAT) form was not found in any jurisdiction other than the ACT[328]. He thought that it lacked any clinical utility.[329] He described the section of the form headed "identifying suicide vulnerability" as "extremely difficult to understand".[330] While it might have some utility as an aide memoire for inexperienced staff, its arrangement was "chaotic" and risked "erod[ing] the clinical judgment of staff as they strived to fit individuals into its "disorganised procrustean framework". He recommended that it be abandoned or replaced by a new document specifically designed as an aide memoire.[331]

486. RN Silwal said that the matters set out in the SVAT directed the clinician to considerations that need to be taken into account but ultimately the assessment of suicide risk is a matter of clinical judgment.[332] In effect, despite its description as a "tool", RN Silwal said that it was used to direct clinicians to relevant considerations.

487. Dr Jehne's evidence was to a similar effect. She said that she thought the SVAT had "some utility" as a prompt.

488. Professor Large's support for the SVAT as a tool was muted and reflected the views expressed by Dr Jehne and RN Silwal, insofar as he noted that it encouraged the clinician to think broadly about the patient without defaulting to notional risk categorisation.[333]

489. The assessment of Justin's suicide risk by RN Silwal and Dr Jehne, was the foundation of the Justin's care and supervision on 25 and 26 February 2023 at the AMC. The evidence does not support a finding that there was any material failing in their assessments, given the information available to them. Thus, I do not make a finding that in this respect the quality of Justin's care and supervision contributed to his death.

490. The evidence does not indicate any issue of public safety arising in relation to the manner in which detainees' suicide risk is assessed at the AMC.

491. A matter of public safety also does not arise in relation to the provision, or otherwise, to the AMC of a s 309 minute made about a detainee. As set out in this report, s 309 minutes are made by officers when they are concerned about a future detainee's risk of self-harm. The subject of the minute – the detainee – may not be apprehended soon after with the creation of the minute. The minute is for the benefit of MHCALS at Court, and

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[328] Exhibit 1, Brief AAA, p.6197.
[329] Exhibit 1, Brief AAA, p.6180.
[330] Exhibit 1, Brief AAA, p.6196.
[331] Exhibit 1, Brief AAA, p.6198.
[332] T358-359.
[333] Exhibit 1, Brief AAB, p186 (p.6788).

may be handed up to the Magistrate in Court, for the purpose of deciding whether to grant bail or make a s 309 order for the subject's immediate care and treatment. By the time a detainee is inducted into the AMC the information in the minute may be outdated. Further, both Dr Jehne and RN Silwal gave evidence about the information they reviewed about Justin before concluding their assessments. A s 309 minute does not appear to rank higher than other information, some of which the practitioners did not review. It seems providing practitioners with more background information, which may be outdated, would not reduce the risk of self-harm by detainees.

492. Much more pertinent to a detainee's induction are any contemporaneous mental health documents. For example, in this inquest, the evidence shows that several opportunities were lost for Justin's mental health to be assessed, and that assessment to form part of his health records available to the AMC upon induction. Those opportunities include at TCH (Issue 3), the telephone assessment by RN de Jesus (Issue 4), and the lack of MHCALS at Court on the Saturday Justin appeared (Issue 6).

493. Dr Jehne accepted that the paperwork burden imposed on clinical staff in relation to new admissions was "pretty high".[334] She accepted that it was a concern that it might restrict the time that clinicians have to take a history and undertake a clinical assessment of a detainee[335] and that a more streamlined document would be of assistance to the clinicians undertaking the assessment.[336]

494. There is insufficient evidence to support a finding that the volume of paperwork that clinical staff are required to complete during an induction gives rise to an issue of public safety. As Dr Jehne said in her evidence, it is necessary that assessments be documented.[337] Nevertheless, the evidence suggests that clinicians' capacity to conduct assessments that are sufficiently comprehensive to make the clinical decisions they are required to make, would be improved by the removal of duplication in the required paperwork. It may be that MHJHADS finds it appropriate to review the various forms that FMHS staff are required to complete as part of an induction to reduce the number of forms to be completed and remove duplication.

495. It also appears useful, in the light of the concerns raised in Professor Ryan's report, for MHJHADS to review the SVAT form currently in use, in particular whether it should state that its main function is as a prompt or aide memoire for clinicians and the contents of

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[334] T611.34 – 39.
[335] T611.41 – 47.
[336] T612.4 – 6.
[337] T611.46 – 47.

the form could be reviewed so that it is easier to understand and better directed to serving that purpose.

Issue 8 – observations of Justin at the AMC

496. The detainee observation forms in respect of Justin, dated 25 and 26 February 2023, noted that he was a new reception, on an S3 rating, which required 60 minute observations.[338]

497. The evidence in this inquest establishes that, in February 2023, the practices of officers with respect to the conduct and recording of observations did not accord with ACTCS expectations and approved practice, in the following respects:

(a) Observations were recorded in the detainee observation form on the hour every hour, irrespective of when an observation was in fact conducted.[339] They were not, as the detainee observation form directed, made contemporaneously.[340] Not all Corrections officers had, in February 2023, an understanding, that it was a requirement that the recording of observations must be made contemporaneously at the time of the observation.[341]

(b) There was a practice for corrections officers to record observations that they had not personally performed.[342] There is evidence that this was not even understood by Corrections officers to be a departure from expected practice.[343]

(c) The direction to record a detainee's behaviour in the form was not generally followed. Officer Leskinen said that the general practice was to record anything out of the ordinary that was observed, but not otherwise.[344] Officer Viertel was not aware of the requirement that observations of detainees must describe the detainee's behaviour as observed by the corrections officer.[345]

498. Each of these deficiencies was evident in the observations of Justin, conducted and recorded on 25 and 26 February 2023.

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[338] Exhibit 1, Brief AAA, p.2666-2668.
[339] T504-506; T560.
[340] Exhibit 1, Brief AAA, p.5117.
[341] T561.
[342] T505-506; T560.
[343] T561.
[344] T469.
[345] T562.

499. The last time that Justin was seen alive was at 11:40am on 26 February 2023 when Officer Leskinen was undertaking the muster round with Officer Morton. He was not checked again until after the lunch time lock in at 1pm.

500. Given that he had previously been incarcerated at the AMC, it is likely that Justin knew about the lunch time lock in and that there would be no check between 12 and 1pm.[346]

501. If Justin was not to be checked until 1pm, he should have been checked at 12pm. This was required by the suicide/self-harm rating that Justin had been given by clinicians at induction. The risks associated with his likely knowledge that he would not be checked for an hour before 1pm, made this imperative. It did not occur. This was a departure from the expected and required standard of care and supervision.

502. The photographs taken of Justin's cell after he was removed on 26 February 2023, show that the observation hatch was covered by paper fixed together with Band-Aids.[347]

503. On the assumption that Justin was last seen alive at 11:40am on 26 February 2023, Professor Duflou expressed the opinion that Justin suffered a cardiopulmonary arrest sometime between then and 1pm, when he was found hanging in his cell.[348]

504. Professor Duflou noted that such an arrest is rapid in hanging and probably occurs within a few minutes of commencement. There were several features suggesting that, in this case, the hanging had likely commenced earlier, rather than later, during the one hour and twenty minutes between 11:40am and 1pm. These included that Justin was in asystole during the resuscitation, his heart did not respond to CPR, and the presence of extensive bleeding into the airway identified during resuscitation and at autopsy. Professor Duflou concluded that it was more likely than not that the ligature and associated neck compression was applied some considerable time before Justin was discovered, with the time extending from 11:40 am to "probably many minutes" prior to being found.[349] He was not able to be any more precise than "many minutes", although he said that it was very likely that it was more than five minutes before he was discovered at 1pm. The longer the hypothetical interval before 1pm, the "more comfortable" he felt in relation to the timing.[350]

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[346] T521; T564-565.
[347] Exhibit 1, Brief AAA, p.5791.
[348] Exhibit 1, Brief AAA, p.6573.
[349] Exhibit 1, Brief AAA, p.6573.
[350] T537.

505. Some inferences can be drawn as to the steps that Justin took to prepare a ligature. They likely included the covering of the observation hatch with paper, [redacted]. There is also evidence to suggest that Justin prepared a ligature which he then discarded before he prepared the ligature used in his suicide.[351]

506. While these steps would have taken time, there is no evidence supporting a finding as to how long they took. There is no firm basis for a finding that they were commenced before 12pm and would have been seen by a Corrections officer if an observation had been carried out then. Nor does the evidence support a finding that all the steps that led to Justin's death could not have been completed within an hour. There is no evidence supporting a finding that a check performed at 12pm would have enabled Justin to have been resuscitated after he was found at 1pm.

507. Accordingly, while there were failings in the observation regime of Justin in the period before his death, the evidence does not support a finding that they contributed to his cause of death for the purposes of s 74 of the Act.

508. While the evidence does not support findings under s 74 in respect of the observation regime and timing of observations, the failure to observe as part of that regime or otherwise that Justin had removed a pole from the laundry, that a pole had been removed from the laundry for some time and not returned, and that Justin had retained the pole in his cell since the day before his death did contribute to his cause of death, as addressed in Issue 10 below.

509. There have been changes made to the observation regime since Justin's death. They include:

    (a) Directions to staff that observations be conducted at required intervals, in person, with guidance around who should complete the observation form and when;

    (b) The introduction of a new observation form;

    (c) Random spot checks of compliance with the directions and guidance;

    (d) The development of an operating procedure about observations.

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[351] T41.

510. Counsel Assisting further pointed out that on 22 August 2024, Coroner Archer handed down his findings in the *Inquest into the death of Luke Anthony Rich* [2024] ACTCD (Rich).

511. Mr Rich died at the AMC on 1 February 2022. He took his own life by hanging himself from a ligature in the form of a bedsheet secured to a rear door in his cell in the management unit.

512. Coroner Archer made findings in relation to the observation regime in place at the time Mr Rich died. He found that the regime was inadequate. One of the deficiencies identified by Coroner Archer was the lack of detail as to the behaviour of the detainee in the observation form. Coroner Archer found the practice of Corrections officers was simply to write "in cell".

513. The evidence in this inquest establishes that this same deficiency in the practice of recording observations remained more than a year later, at the time of Justin's death.

514. There have been two inquests into deaths in the AMC, a year apart, where the evidence has established the existence of significant deficiencies in the practices of corrections officers in conducting and recording observations. However, it must be observed that Justin's inquest took place in July and September 2024 with the statement of Mr Taylor-Dayus regarding the changes since Justin's death being dated 5 July 2024. Mr Taylor-Dayus appeared at the inquest on 19 July 2024. There was no evidence called on the issue of observations on the last day of the inquest, namely 11 September 2024. The Territory did not have the benefit of the findings and recommendations in *Rich* as at the time of preparing for, and appearing at, Justin's inquest.

515. The practices of corrections officers in conducting and recording observations of detainees in February 2023, gives rise to an issue of public safety.

516. The assessment of a detainee's required observation level is made by a clinician with relevant expertise, in accordance with a mandatory process designed to protect detainees from the risk of self-harm including suicide and medical risks. It is self-evident that the failure to conduct observations at the required intervals exposes detainees to those risks.

517. The failure to record observations contemporaneously meant that a corrections officer undertaking a later observation could not know whether they were conducting an

observation at the required interval, as Officer Leskinen acknowledged in his evidence.[352]

518. The practice of corrections officers recording observations that they had not personally performed, resulted in the creation of a false record not only of the *time* of the observations, but also the *person* who had undertaken them and, potentially, where the detainee was and the detainee's behaviour at the time recorded in the form.

519. As Mr Taylor-Dayus acknowledged, the direction to officers to include details of the detainee's behaviour at the time of the observation is a safeguard that the observation is being undertaken not only to check that a detainee is there, but also to require that some care is taken to ascertain the wellbeing the detainee.[353] The failure of officers to follow that direction undermines that objective.

520. In *Rich*, Coroner Archer recommended that the ACTCS publish guidance to staff, pursuant to section 14 of the *Corrections Management Act 2007* (ACT) that addresses various matters. It is not necessary to repeat those recommendations, which I endorse.

521. In light of the findings of this inquest, the guidance should extend to:

    (a) The requirement to undertake a briefing at the commencement of each shift in each unit in which it is there is a discussion and agreement as to the staff who will be responsible for conducting observations.

    (b) Each of the instructions in the new detainee observation form.

    (c) The manner in which observations are to be undertaken and recorded, including the requirement that a Corrections officer undertaking an observation round take the form with them and complete it as they check on each detainee.

    (d) The requirement to include details of a detainee's behaviour, with specific examples to give guidance to Corrections Officers.

522. The Territory accepted in submissions that this guidance was appropriate.[354]

523. I do not suggest that the guidance should extend to the acceptable period before or after the specified interval for observations.[355] The detainee's classification sets the timing of

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[352] T510.
[353] T862.
[354] Territory submissions, [32] – [35].
[355] CA submissions, [853(e)]; and reply submissions, [154].

observations, and a regime with a minimum window around which the observation must occur seems unnecessary and may inform detainees of the timing of their observations more specifically, which, as the Territory submitted, may be counterproductive.[356]

Issue 9 – the pack provided to Justin at the AMC

524. Mr Taylor-Dayus gave evidence that detainees are provided with an induction pack that includes sheets and blankets.[357]

525. While the evidence of Mr Taylor-Dayus and Officer Leskinen was not entirely consistent about how detainees are provided razors, the evidence supports a finding that detainees in SCC West were permitted, at the time of Justin's death, to keep a razor in their cell, regardless of whether it was being used for the purpose of shaving. There was no evidence that this position has changed since February 2023.

526. Mr Taylor-Dayus gave evidence razors are not provided to detainees who are placed "at risk".[358] This evidence was not challenged and is accepted.

527. The ligature used by Justin was a strip of material that appeared to have been removed from a larger piece of material, two sides of which appeared to have a been torn or cut to create strips.[359]

528. When First Constable Bishop searched Justin's body after his death, a single razor blade fell out of the top part of Justin's pants.[360] The items seized by First Constable Bishop from the AMC after Justin's death included a blue plastic three blade razor on the ground inside the cell which appeared to be missing a couple of blades.[361]

529. First Constable Bishop referred to the material from which strips had been cut as a bed sheet. Officer Leskinen, having been shown photographs of the material, thought that it was one of the blankets used in SCC West.[362]

530. Constable Bishop said that he suspected that Justin had used blades that were missing from the razor to assist in cutting his bed sheet. The basis for that suspicion was that the blade looked like it matched the ones that were in the razor, which had a missing spot for a blade and the sheets were "very hard to cut". He thought that, at a minimum,

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[356] Territory submissions, [35].
[357] Exhibit 1, Brief AAB, p447 and 574 (p.7049 and 7176).
[358] Exhibit 1, Brief AAB, p447 (p.7049).
[359] Exhibit 1, Brief AAA, p.38 and p5883-5887; T42.
[360] Exhibit 1, Brief AAA, p.37, p.5978, p.5979; T39-40.
[361] Exhibit 1, Brief AAA, p.38, p.5888; T41.
[362] T527.

the blade was used to create a tear in the sheet which Justin then used to pull the strip away.[363] He also gave evidence that there were no other sharp instruments that he could find in the cell.[364]

531. Constable Bishop accepted that he had not conducted any investigation or trials with the bed sheet or any other items to test that suspicion.[365] Further, he accepted that the Brief of Evidence did not include any measurement comparing the blade with the razor and that there had been no forensic testing to determine whether there were fibres of the sheets on the blade or the blue razor.[366]

532. Nevertheless, it was not directly put to Constable Bishop that his beliefs about the use of the blade to create a strip of material and the origin of the blade, were unreasonable.

533. I find that Justin used a blade from the blue plastic razor found in his cell, to cut strips from a larger piece of material, that was either a sheet or a blanket, or to make an initial cut in the material to enable him to tear strips, to use as a ligature, based on the following evidence:

    (a) Constable Bishop's evidence that the sheets were "very hard to cut";

    (b) No other sharp instrument was found in Justin's cell;

    (c) The fact that a blade was found on Justin's person after his death; and

    (d) Constable Bishop's evidence that the razor found in Justin's cell had a missing blade.

534. While forensic testing of the blade or the sheet or the taking of measurements of the blade or the razor, would certainly have assisted in making findings in respect of this issue, the evidence that was admitted satisfies me on the balance of probabilities that the razor was used in creating the ligature.

535. Justin's possession of a razor contributed to his cause of death, insofar as it is found that he used it to fashion, or assist in fashioning, a ligature from the standard issue bedwear.

536. There is, however, no evidence supporting a finding that ACTCS staff should have anticipated, before Justin's death, that a blade from a plastic razor could be used for this purpose. The evidence does not support a finding that the system in place at the time, that allowed detainees to keep a razor in their cell, was known to pose a risk to safety.

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[363] T41.
[364] T51.
[365] T41.
[366] T51.

There is no evidence that Justin's possession of the razor was the result of the conduct of any corrections officer that fell below the expected standard.

537. Accordingly, it does not follow from the fact that Justin was permitted to possess the razor that was found in his cell, that there is a basis for a finding under s 74 of the Act.

538. While it was not something that ACTCS staff could reasonably have anticipated at the time, the evidence in this inquest indicates that a system that permits detainees in SCC West to keep a razor in their cell for an unrestricted period, poses a risk to detainees' own safety. A system that provides detainees with the means to fashion, or assist in fashioning, a ligature gives rise to a matter of public safety.

539. A detainees' right to be treated with dignity and respect, requires that they be given access to shaving equipment. That right does not require that the access be unrestricted, such that detainees are permitted to keep razors in their cells indefinitely.

540. It is not clear from the evidence why the system that applies to detainees in another part of the SCC (SCC North) could not be extended to detainees in SCC West. I recommend that ACTCS extend the system that applies in SCC North, whereby razors are handed out to detainees by Corrections officers and then signed back in, when they have been used, to SCC West. This recommendation was accepted by the Territory in its submissions.[367] There appears no reason why the recommendation could not be implemented forthwith.

Issue 10 – Access to the communal laundry

541. The ligature point used by Justin was a wooden pole that he [redacted].[368]

542. The laundry was located next to Justin's cell (Cell 1). At the time it stored brooms, mops and cleaning materials as well as a washing machine and dryer. In February 2023, detainees had free access to the room. They were permitted to use items in the laundry room to clean their cells, and could use items from the room to clean their cells over lunch. At the time, it was not unusual for detainees to have mops and brooms in their cells.[369]

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[367] Territory submissions, [38].
[368] Exhibit 1, Brief AAA, p.38; T40-41.
[369] T866.

543. Justin can be seen in the AMC CCTV footage entering the laundry room at around 5:02pm on 25 February 2023 and leaving with a wooden a pole which appears to be the handle of a mop or broom. He re-entered his cell with the pole.

544. Photographs taken during the coronial investigation indicate that a broom or mop handle was missing from a rack in the communal laundry.[370]

545. I find that a broom or mop handle was used as a ligature point by Justin on 26 February 2023, which was the pole he obtained from the communal laundry the previous day.

546. The evidence establishes that, at the time, detainees used the mop and broom handles as weights for exercise and Corrections Officers would not normally remove the mop or broom from a detainees' room. There did not appear to be routine stocktakes of the equipment in the laundry room nor corresponding cell checks to ascertain the whereabouts of missing equipment.

547. On 23 April 2024, the Assistant Commissioner of Custodial Operations, Jason Russell, circulated an email message to staff advising that brooms, mops and cleaning products are not to be in detainees' cells over lock-in periods in the new reception area, the management unit and the Crisis Support unit. It is now also a requirement that in these accommodation units, detainees sign out cleaning equipment, and custodial officers are to ensure that it is signed back in before lock-down periods.[371]

548. On the basis of the evidence of Corrections Officers, I find that these new measures are being implemented.[372] Items such as mops and brooms are now kept inside the officers' station. Detainees may ask an officer for such an item when their cells are unlocked but they must be returned and recorded to have been returned, before lock-in periods.[373]

549. There has been no change since February 2023 in the procedure for infrastructure checks of cells.

550. I find that Justin could not have created a ligature point in his cell without the use of the wooden pole. His possession of the pole in his cell on 26 February 2023, and the failure to have adequate systems in place to identify his possession of the pole, contributed to his cause of death.

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[370] T42.
[371] Exhibit 1, brief AAB, p446 (p.7048).
[372] E.g. T531.
[373] T532; T568.

551. As has been accepted, the "quality of care….and supervision of [Justin]" in s 74 extends to the reasonableness of relevant systems and practices in place at the AMC at the time of Justin's death. There are two systems or practices that require consideration. First, there is the system for checking the cells and laundry room within SCC West. The second is the practice of allowing detainees unrestricted access to brooms and mops from the communal laundry.

552. A s 74 finding is made in respect of both these systems. The failure, at the time of Justin's death, to have in place a system at the AMC for the signing in and out of cleaning equipment, such as mops and brooms, that also prohibited detainees from retaining such equipment in their cells during lock in periods, was a deficiency in the quality of care, treatment and supervision of Justin that contributed to his cause of death.

553. On broadly the same basis, it can be said that the practice in place at the AMC at the time of allowing detainees unrestricted access to brooms and mops from the communal laundry, given the lack of systems in place for checking the cells and laundry room, gives rise to a matter of public safety.

554. There are strong considerations, including a detainee's right to be treated with dignity and respect, in favour of allowing detainees access to the means to clean their own cells. These considerations could be met without detainees having unrestricted access to items that might pose a risk to their own and others' safety.

555. At the time the evidence in this inquest was received, the systems and procedures for checking cells has not changed since Justin's death. What has changed is the detainees' access to items in the communal laundry. This change substantially mitigates the type of risk that eventuated here.

Recommendations

556. I make the following recommendations:

(a) Correctional Officers in each unit conduct and document spot checks on the system for storing mops and brooms and recording their use by detainees to ensure that such items are not being retained by detainees for purposes other than cleaning their cells.

(b) The Deputy Commissioner Custodial Operations take such steps as are necessary to revise the *Corrections Management (Searching – Cell Infrastructure Checks) Operating Procedure* so that it provides that:

i. in performing such a cell infrastructure check, corrections officers are required to enter a cell to undertake the visual check; and

ii. excess property for the purpose of that operating procedure, includes items that are available to detainees within the AMC but are not being used for their intended purpose, such as broom or mop handles.

Conclusion

557. I find that Justin could not have created a ligature point in his cell without the use of the wooden pole. His possession of the pole in his cell on 26 February 2023 contributed to his cause of death.

558. As has been accepted, the "quality of care….and supervision of [Justin]" in s 74 extends to the reasonableness of relevant systems and practices in place at the AMC at the time of Justin's death. There are two systems or practices that require consideration. First, there is the system for checking the cells and laundry room within SCC West. The second is the practice of allowing detainees unrestricted access to brooms and mops from the communal laundry.

559. A s 74 finding is made in respect of both these systems. The failure, at the time of Justin's death, to have in place a system at the AMC for the signing in and out of cleaning equipment, such as mops and brooms, that also prohibited detainees from retaining such equipment in their cells during lock in periods, was a deficiency in the quality of supervision of Justin that contributed to his cause of death.

560. On broadly the same basis, it can be said that the practice in place at the AMC at the time of allowing detainees unrestricted access to brooms and mops from the communal laundry, given the lack of systems in place for checking the cells and laundry room, gives rise to a matter of public safety.

561. A number of failings have been examined in this report. Some of those failings amount to matters of public safety. Chief amongst those is how Justin was treated by police whilst in their custody. It is not said that had Justin been treated in the way the AFP National Guideline on persons in custody and police custodial facilities describes, that he would be alive today. What is said is that the inquest revealed a matter of public safety which should be addressed by the AFP.

562. When citizens are arrested, they are in the custody of police. Police have a duty to care for them, whilst they are in their custody. They may have an innocent person within their care, or they may have a hardened criminal. The distinction should not, and does not,

make any difference to how the arrested individual is treated. Under the heading "6. Policy" in the AFP National Guideline on persons in custody and police custodial facilities (AFP Custody Guideline) it is written: "Any person in police custody must be treated with humanity, dignity and regard for their civil rights, and not be subjected to cruel, inhumane or degrading treatment."[374]

563. In Clause 7.2 of the AFP Custody Guideline, headed "Health or medical care", it is written

> Members uncertain about a person in custody's medical (including psychiatric) condition, or whether that person can make a rational decision on their need for medical treatment, should seek medical attention on their behalf. Particular care should be given to persons defined as 'at risk'.

564. Person at risk is defined in Clause 3 of the AFP Custody Guideline. That definition is a person in custody who is, or is suspected to be – among other categories - "highly intoxicated" or "showing, or believed by any person to show, any inclination to harm themselves or another person" or "causing any concern about their physical or mental wellbeing". Justin was a person at risk at the point of his arrest on 24 February 2023.

565. Clause 30 of the AFP Custody Guideline is:

> Where a risk of suicide or self harm is identified in relation to a person in police custody, members must seek advice from the relevant jurisdiction's mental health service.

566. An ambulance was called for Justin but the attending paramedic was not given a thorough briefing. No medical treatment was sought for Justin's "inclination to harm" himself. Arresting officers did not look at Justin's wrist where he had held the knife whilst threatening self-harm, to ascertain if he had harmed himself (by cutting his wrist). That is, none of the AFP officers at the scene of the arrest thought to seek advice from the relevant jurisdiction's mental health service. It appears none but Constable Graydon turned their mind to Justin's mental health or self-harm behaviour. Constable Graydon asked Justin what he meant to do with the knife, but did not check if Justin had used the knife on his wrist whilst seated in the driver's seat of the parked car.

567. Even those officers who, the day before, had been concerned enough to create a s 309 minute about their mental health concerns for Justin, did not "seek advice from the relevant jurisdiction's mental health service".

568. Constable Cross, one of the transporting officers who was redirected to TCH whilst on route to the Watch House, treated Justin with humanity and dignity. He was not briefed

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[374] Exhibit 1, Brief AAB, p193 (p.6795).

about Justin's condition at arrest or his involvement in the two motor vehicle accidents, or about the threats of self-harm the day before. He could not, therefore, identify a risk of self-harm from his transportation of Justin from the place of arrest to TCH.

569. It is a matter of public safety that the AFP did not comply with their own guidelines in relation to Justin. Officers involved in his pursuit and arrest and investigation were asked about their treatment of Justin and their obligations to attend to his mental wellbeing. Their answers revealed a lack of awareness of their obligations and, in some instances, a lack of care for Justin whilst in AFP custody. Some of these officers were senior. The only two officers – Graydon and Cross – who I have found tried to care for Justin, were among the most junior.

570. MHCALS should operate on each day the ACT Magistrates Court conducts its bail court. If that includes Saturdays, the service should operate on Saturdays. The data in relation to bail lists from 1 July 2023 to 30 June 2024 established that the number of defendants appearing in the Saturday morning bail lists and the s 309 orders granted to defendants in those lists, both in terms of number and percentage, differed very little from the figures for the same bail lists on weekdays.[375] This data established that the need for MHCALS assessments on a Saturday is not materially different from a weekday.

571. Without MHCALS, defendants who are brought before the Court on Saturdays are not seen by mental health practitioners and the Court does not benefit from reading reports about the defendants before deciding whether to grant bail, refuse bail or make a s 309 order.

572. There will of course be funding and administrative challenges to extending what is a weekday service to one that is also available on all days on which bail hearings are held. For the purpose of Saturday bail hearings, the DPP, Legal Aid and the Magistrates Court are required to meet those challenges. The evidence does not suggest that there are compelling reasons why MHCALS should not.

573. I recommend that Canberra Health Services take the steps necessary to extend the operation of MHCALS to all days on which bail hearings are held, including weekends and public holidays.

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[375] Exhibit 18.

574. I recommend that ACTCS extend the system that applies in SCC North, whereby razors are handed out to detainees by Corrections officers and then signed back in, when they have been used, to SCC West.

575. I make the following recommendations:

(a) Correctional Officers in each unit conduct and document spot checks on the system for storing mops and brooms and recording their use by detainees to ensure that such items are not being retained by detainees for purposes other than cleaning their cells.

(b) The Deputy Commissioner Custodial Operations take such steps as are necessary to revise the *Corrections Management (Searching – Cell Infrastructure Checks) Operating Procedure* so that it provides that:

i. in performing such a cell infrastructure check, corrections officers are required to enter a cell to undertake the visual check; and

ii. excess property for the purpose of that operating procedure, includes items that are available to detainees within the AMC but are not being used for their intended purpose, such as broom or mop handles.

576. This report contains discussion about what could have, and should have, occurred in relation to Justin's care, treatment and supervision from the time he entered AFP custody until his death in the AMC. Much of that discussion has considered hypothetical situations, the outcome of which cannot be known and I have found, if certain actions had occurred, they would not have prevented Justin's death.

577. The only finding that can be made with certainty, about the cause of Justin's death, is that had he not had access to a ligature and a ligature point, he could not have completed suicide. It was a failing of Corrections that he could bring a ligature point into his cell, leave it there for some hours, place it in a secure location and [redacted]. Corrections had, by the time of the hearing, already addressed detainees access to the same ligature points and made improvements to the observation regime.

578. It is my express wish that the failures in Justin's supervision which contributed to his death will not occur again, and no other family will have to suffer the anguish experienced by Justin's family from losing him too soon.

I certify that the preceding five hundred and seventy eight [578] numbered paragraphs are a true copy of the findings of Coroner Wilson.

Associate: Miguel Kanissery

Date: 29 October 2026

Annexure A: Witness List

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY
Inquest into the death of Justin Cordy [2026] ACTCD 19

8 July 2024
First Constable Andrew Bishop

9 July 2024
Constable Rachel Russell

10 July 2024
Constable Carl Graydon
Senior Constable Angus Fergusson

11 July 2024
Ms Elizabeth O'Brien
Constable Andrew Cross
[redacted]
[redacted]

12 July 2024
Ms Tegan Murray
RN Michael De Jesus
RN Abhisekh Silwal

15 July 2024
Dr Alison Burke
Dr Robert Day and Dr Mark Lee (concurrently)
CO Shane Leskinen

16 July 2024
CO Shane Leskinen
Professor Johan Duflou
CO Peter Viertel

17 July 2024
Dr Emily Jehne
Professor Christopher Ryan and Professor Matthew Large (concurrently)

Annexure A: Witness List

18 July 2024

First Constable Blaine Jarvis

Detective Sergeant Andrew Billing

Leading Senior Constable Saul Milner

19 July 2024

Leading Senior Constable Timothy Saunders

Mr James Taylor-Dayus

19 September 2024

Mr Christopher Tyrell

Detective Inspector Hawkins

Annexure B

IN THE CORONERS COURT
AT CANBERRA
IN THE AUSTRALIAN CAPITAL TERRITORY

INQUEST INTO THE DEATH OF JUSTIN JAMES CORDY
CD54/2023

SECOND STATEMENT OF DETECTIVE SUPERINTENDENT JOHN HAWKINS

Address: Belconnen Police Station, 100 Benjamin Way, Belconnen ACT
Occupation: Detective Superintendent, ACT Policing
Date: 9 October 2026

I, Detective Superintendent John Hawkins, swear:

1. The contents of this statement made by me accurately sets out the evidence 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 to be tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false or to not believe to be true.

Background

2. I am an employee and member of the Australian Federal Police (**AFP**) currently attached to ACT Policing.

3. I previously provided a statement in the Inquest into the death of Justin James Cordy (**Inquest**) dated 19 June 2024 (**First Statement**) and gave evidence at the hearing of the Inquest on Thursday, 19 September 2024.

4. Since providing my First Statement, I transferred in October 2025 from the role of Officer in Charge (**OIC**) of the Australian Capital Territory (**ACT**) Watch-house and Judicial Operations to the role of Superintendent of Vulnerable Persons and Community Engagement (**VPCE**).

5. In the role of Superintendent VPCE, I am responsible for:

Filed on behalf of	Australian Federal Police
Prepared by	Nathan Roberts
Law firm	McCullough Robertson
Tel	02 8241 5694
Email	nroberts@mccullough.com.au
Address for service	Level 32, 25 Martin Place Sydney NSW 2000

Annexure B

(a) Leading the tactical, operational and strategic outcomes, managing people, outcomes and performance of the portfolio;

(b) Building strong and diverse internal and external relationships, to create a cooperative and collaborative environment based on acceptance, respect and inclusion;

(c) Building and nurturing capabilities by setting clear expectations for ethical and professional behaviour;

(d) Supporting the ACT Government and ACT Policing Community Engagement Strategies through engagement and coordination with our vulnerable cohorts including First Nations people, Multicultural / Culturally and Linguistically Diverse (CALD) people, Seniors, and Young people, those impacted by Disability Justice considerations through a dedicated Liaison role, the LGBTIQA+ community Liaison, Victims of Crime Liaisons, Restorative Justice Liaison Officer, Drug and Alcohol Sentencing List Liaison, Drug and Alcohol Diversion Officers, Human Rights Commission Liaison, Child, Youth and Families Liaison Officers, other functions; and

(e) The portfolio engagement with community and key government / non-government organisations to solve long-term problems with the aim of reducing repeat calls for police service and improving life outcomes for those people in our community affected by the problem (whether a crime or not), this includes referral to other services and agencies.

Preliminary Findings

6. I have been provided with and reviewed:

(a) the Provisional Findings in the Inquest (**Provisional Findings** or **PF**); and

(b) the Notice under section 55 of the *Coroners Act 1997* (ACT) addressed to the AFP and dated 27 August 2026 (**Section 55 Notice**) which I understand also invites a response from individual officers referenced in the Provisional Findings.

7. This Second Statement is given to the Coroner in accordance with section 55(1)(b) of the *Coroners Act 1997* (ACT).

8. I request that the Coroner include this Second Statement in the Coroner's report of the Inquest pursuant to s 55(3) of the *Coroners Act 1997* (ACT).

Reliance upon assumptions

9. During my giving of evidence at the hearing of the Inquest, I was asked to provide my opinion on the basis of various assumptions put to me including my opinion as to, among

other things, whether provisions of the AFP National Guideline on persons in custody and police custodial facilities (**AFP Custody Guideline**) applied to the circumstances in which the arresting officers found themselves and the extent of the AFP's compliance with the AFP Custody Guideline.

10. I was also asked various questions, based on various assumptions, about the obligations referred to in paragraphs 22, 23 and 24 of my First Statement which related to the obligations in clauses 7.2 and 17 of the AFP Custody Guidelines.

11. While I am an experienced police officer with the AFP and can understand why my opinion may be sought in relation to matters that have been the subject of the Inquest, it is, in my view, more appropriate that the Coroner have regard to the terms of the AFP Custody Guideline and the application of established facts to those Guidelines, than my opinion derived from a series of assumptions regarding matters for which I had no first-hand knowledge.

12. The reliance upon my opinion evidence, and the manner in which some of my evidence has been understood, appears to have unfortunately resulted in conclusions that incorrectly suggest that I agreed that there was a failure of some officers to comply with the AFP Custody Guideline.

Compliance with AFP Custody Guideline

13. I refer to paragraphs 292, 297 to 298 of the Provisional Findings.

14. It is, of course, true that:

    (a) I agreed (and continue to agree) that clause 20 of the AFP Custody Guideline was applicable to the circumstances of Justin's arrest;[1]

    (b) I agreed (and continue to agree), based on various assumptions including that:

        i. both arresting officers at the scene believed that, at the point Justin was holding a knife in the vicinity of his wrist, Justin was threatening self-harm;[2] and

        ii. in the period after Justin's arrest, for a period of some six minutes while Constable Graydon's body-worn camera footage was activated, Constable Graydon, who was the arresting officer, observed Justin to be incoherent, unable to maintain a normal conversation or understand questions,[3]

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[1] T900.27.
[2] T896.11-14.
[3] T896.16-20.

that it was reasonable for the arresting officers to have identified a risk of suicide or self-harm.[4]

15. My further evidence included the following:[5]

> *And so does it follow that because these guidelines applied, and on the assumptions that I've given you, that it was incumbent upon them to seek advice from a mental health service within the ACT?---It's incumbent upon them to seek medical advice to address that risk and yes it should be within the ACT.*
>
> *The provision refers to a mental health service so when you say 'medical advice' does that mean mental health specialist advice or is it just general medical advice that you're referring to?---Within the ACT it's often difficult to isolate and identify just one singular service or mental health service, if you will. So that could be fulfilled in a number of ways. It could be fulfilled through a referral for a further assessment. Through a section 309 assessment. Or through other mechanisms. So, it will really come down to how they had assessed the urgency of the need and whether or not steps can be put in place to mitigate any risk of self-harm prior to being able to be assessed by the jurisdictional mental health service.*

16. Contrary to the implication in paragraphs 292, 297 and 298 of the Provisional Findings, I did not say, and I do not believe, that the attending officers at Justin's arrest did not meet their obligations under the AFP Custody Guideline by calling a paramedic to attend to Justin.

17. As I sought to explain in my evidence, it is my expectation that, in accordance with the AFP Custody Guideline and my own expectations, in circumstances where the AFP officers had concerns for Justin's mental health, they sought medical advice.[6] While I still maintain the view that calling a paramedic is not appropriate to be able to assess the enduring risk of self-harm of Justin, I observed and continue to remain of the view that their calling of a paramedic could be a part of that response.[7]

18. AFP officers also have a range of ways in which they can access a mental health service for a person in custody, directly or indirectly, including via:

    (a) calling a paramedic (as occurred with respect to Justin);

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[4] T900.30.
[5] T900.35-T901.3
[6] T900.1-12.
[7] Ibid.

(b) taking a person in custody to hospital prior to the Watch house (as also occurred with respect to Justin);

(c) requesting the attendance and/or assistance of ACT government programs such as PACER, although they are typically not utilised with respect to individuals involved in criminality or are in custody;

(d) completing a request for a Section 309 assessment (as also occurred with respect to Justin);

(e) providing a person in custody at the Watch house with access to a mental health telephone service (as also occurred with respect to Justin).

19. While the calling of a paramedic may not be sufficient to assess the enduring risk of self-harm (as explained in my evidence at T900.5-12), the fact that attending officers called a paramedic does not preclude a person in custody, and did not preclude Justin, from being provided with access to a mental health service either on referral of the paramedic or any of the other ways referred to in paragraph 17.

20. Accordingly, I respectfully request that paragraph 297 of the Provisional Findings be omitted, or at least amended so that it does not suggest that it is based on an agreement with my evidence.

Consideration of emergency action under the *Mental Health Act*

21. I refer to paragraphs 209(j) and 320 to 324 of the Provisional Findings and the Coroner's comments that the AFP officers did not consider taking emergency action under the *Mental Health Act 2015* (ACT) (**Mental Health Act**) in relation to Justin.

22. To the extent that these criticisms relate to or are connected with the Coroner's reference to my evidence at paragraph 273, and that the Coroner's comments suggest that she has rejected my evidence referred to at paragraph 310 and that reflects adversely on my reputation, I consider it appropriate to clarify my evidence in relation to that paragraph.

23. I gave evidence that where there is an element of criminality, I do not consider that emergency action under section 80 of the *Mental Health Act 2015* (ACT) (**Mental Health Act**) would have been applicable.[8] I continue to have that view.

24. What I meant by that was that Section 80 of the Mental Health Act is most applicable where a paramedic, doctor, mental health clinician, or police officer has reasonable grounds to believe a person has a mental illness or disorder and is at immediate risk of

[8] T899.7-26.

Annexure B

serious harm to themselves or others if action is not taken. The person does not need to have committed an offence or be facing active charges before the court.

25. The person is transferred into the care of health professionals, and after assessment, if they are not admitted under Section 85 of the Mental Health Act (involuntary medical detention), they are then free to leave. Section 80 of the Mental Health Act is a civil admission into care that sits outside of the criminal justice system which means that if a person is discharged into the community (un-admitted), they are not compelled to return to police custody, subject to bail or other considerations, and are not required to attend a court to resolve any criminal matters.

26. This is in contrast to a Section 309 minute where an accused person in police or corrections custody to be presented before a presiding officer for consideration of the reasonable grounds to believe the accused person needs immediate assessment, treatment or care because of a mental impairment or illness remains tethered to the criminal justice system. If the mental health facility determines they do not require immediate involuntary admission, the facility cannot just let them walk out; they must return the person directly back into the custody of police.

27. The accused may only be released from the facility back into police custody by the person in charge of the facility, or if found to need care and detention, by the person in charge of the facility where they are detained.

28. In the circumstances where Justin was on bail, was alleged to have committed serious domestic and family violence offences and had been apprehended after trying to evade police custody, I disagree with the Coroner's comments that the AFP officers failed in not considering emergency apprehension under section 80 of the Mental Health Act.

29. In my view, the section 309 minute that was completed by the AFP officers was, and continues to have been, the correct mechanism for them to have initiated an emergency clinical assessment and transport of Justin, not section 80 of the Mental Health Act.

Annexure B

Signature of Detective Superintendent

John Hawkins

9-10-2026

Dated

Signature of Witness

R. G. LESTER

Name of Witness

9.10.26

Dated