QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Tyson Lee Jessen
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO:	2018/5014
DELIVERED ON:	26 April 2022
DELIVERED AT:	Brisbane
HEARING DATE(s):	6-8 September 2021, written submissions 20 September 2021 to 5 November 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, police shooting, prisoner arrested on interstate warrant, cardiac event, detained in hospital setting, application of handcuffs, risk assessment.

REPRESENTATION:

Counsel Assisting:	Ms Melinda Zerner and Ms Grace Devereaux
Senior Constable Richardson Senior Constable Collihole Queensland Police Union of Employees:	Mr Calvin Gnech, Gnech and Associates

Commissioner of Police:	Ms Avelina Tarrago, instructed by Jonathon Paratz, QPS Legal Unit
Sgt Lisa Shilton:	Mr Craig Pratt, Gilshenan and Luton
Detective Sgt Cunningham Senior Sgt Burns-Hutchinson Senior Sgt David McDonald Sgt Ronald Heene Constable Daniel Whalin Senior Constable Kolera:	Mr Angelo Venardos, FC Lawyers
West Moreton Health:	Ms Holly Ahern, instructed by Prudence Fairlie

Contents

Introduction

1. Mr Tyson Lee Jessen was a 28 year old man.[1] In late 2018 he came to Queensland from Victoria to Queensland and was living with his partner and her young daughter near Ipswich. Mr Jessen had an extensive criminal history in Victoria where he had served a sentence for arson and was wanted for allegedly committing an armed robbery with two others.

2. On 9 November 2018 Mr Jessen was arrested under a warrant to return him to Victoria. After he reported that he was suffering cardiac symptoms, he was transferred to the Ipswich Hospital, where he was supervised by Queensland Police Service (QPS) officers. On 10 November 2018 he was left alone with a female officer. Mr Jessen attempted to escape from police custody by attacking that officer and trying to take possession of her service revolver. Mr Jessen died after being shot by the police officer in the course of that struggle.

3. As Mr Jessen died while in police custody,[2] s 27 of the *Coroners Act 2003* required an inquest into his death.

The investigation

4. Detective Senior Sergeant Ian Thompson of the QPS Internal Investigations Group, Ethical Standards Command investigated the circumstances surrounding Mr Jessen's death. A coronial report was provided in February 2020 with annexures, including witness statements, BWC recordings, QPS records and medical records.[3]

5. The investigation concluded that all the QPS officers involved complied with relevant legislation, policy and procedures, and should not be subject to any criminal or disciplinary action for their conduct.

6. A post-mortem examination was conducted on Mr Jessen's body by Senior Staff Specialist Forensic Pathologist, Dr Rohan Samarasinghe on 12 November 2018. Blood and urine samples were obtained and subject to further toxicological testing.

The inquest

7. A pre-inquest conference was held in Brisbane on 10 August 2021. Ms Zerner was appointed Counsel Assisting and leave to appear was granted to the Commissioner of the QPS, the police officers who were charged with guarding Mr Jessen and their supervisors, and West Moreton Health. The issues identified for exploration at the pre-inquest conference were refined following submissions from those granted leave to appear. I subsequently determined that the propriety of the use of force option used by Senior Constable Richardson on Mr Jessen would not be explored at the inquest.

8. The inquest was held over three days in Brisbane from 6 to 8 September 2021. Twelve witnesses gave evidence and over 190 exhibits were tendered. I am satisfied that all information relevant to and necessary for my findings was made available at the inquest.

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[1] Ex A4: 26 January 1990
[2] *Coroners Act 2003,* s10 'Death in Custody Defined'
[3] Ex A11 – Coronial Report

9. The witnesses who provided oral evidence at inquest were:

- Detective Sergeant Cunningham
- Senior Sergeant Burns-Hutchinson
- District Duty Officer, Acting Senior Sergeant McDonald
- Sergeant Heene (retired)
- Acting Sergeant Shilton
- Constable Whalin
- Senior Constable Kolera
- Constable Collihole
- Senior Constable Richardson
- Matthew Tallis, Chief Operating Officer, West Moreton Health
- Detective Senior Sergeant Thompson
- Acting Inspector Mowle.

10. The inquest considered the following issues:

1. The findings required by s45(2) of the Coroners Act 2003, namely the identity of the deceased, when, where and how he died and what caused his death;

2. The facilities and resources available to securely accommodate and supervise Mr Jessen while he was in police custody as an acute inpatient at the Ipswich Hospital; and what, if any additional steps were undertaken by the hospital and the QPS to manage the risk of accommodating Mr Jessen at the hospital;

3. Whether the actions of the police officers who were tasked to guard Mr Jessen at the Ipswich Hospital before he attacked Senior Constable Richardson were appropriate in the circumstances; and

4. Whether information which was known about Mr Jessen was appropriately relayed to the police officers guarding Mr Jessen after Mr Jessen was transferred to the Ipswich Hospital.

The evidence

11. A large amount of information was contained in the exhibits and oral evidence. These findings record only the evidence I believe is necessary to understand the findings I have made. I was provided with very comprehensive written submissions by Ms Zerner and Ms Devereaux which have greatly assisted the preparation of these findings.

Circumstances Leading up to the Death

Mr Jessen is arrested

12. On 31 August 2018, Mr Jessen and two co-offenders committed an armed robbery in Victoria.[4]

13. While attempting to locate Mr Jessen, Victorian Police were told by an associate of Mr Jessen that he was in possession of a handgun, and if police were to attempt to arrest him, he would produce his firearm to avoid arrest or provoke a confrontation.[5] The Special Operations Group in Victoria were tasked to arrest Mr Jessen when he was located because of the risk identified.[6]

14. As it was believed Mr Jessen was interstate, the Fugitive Taskforce were tasked to locate him.[7] On 6 November 2018, the Fugitive Taskforce put a 'Warrant Issued' post on the Victoria Police Facebook page seeking information regarding his whereabouts.[8]

15. On 8 November 2018, a Senior Constable from State Intelligence at Ipswich contacted Acting Detective Sergeant Price of Victoria Police to advise they had unverified intelligence that Mr Jessen had moved to Queensland and was residing in the Redbank area, attending the World Gym in Ipswich.[9]

16. It was suggested by Victoria Police that a Queensland special operations team arrest Mr Jessen as police had photographs of him in possession of firearms.[10] Acting Detective Sergeant Price liaised with Ipswich CIB officers Senior Constable Weatherby and Detective Sergeant Cunningham to coordinate Mr Jessen's arrest and extradition.[11] Acting Detective Sergeant Price stated:

> "*During phone calls it was reiterated by me that a SOG arrest had been authorized for JESSEN in Victoria on the basis of his demeanor, physical size, access to firearms and previously expressed intent of provoking a confrontation with police. It was suggested that an equivalent Queensland unit be utilized in any planned arrest and I was told that it was proposed to utilize the Special Emergency Response Team*".[12]

17. Victoria Police 'Operation Pre-Deployment' form included large colour photographs of Mr Jessen. Under 'Risk Summary' it stated:

> *"The overall risk summary for POI is HIGH. Current Intel has the POI in possession of a Glock Handgun which has been used in a sequence of offending. The POI has a history of violent offending, including a serious arson attack where a victim was set on fire".*

[4] Ex B7 para 8
[5] Ex B7, para 11
[6] Ex B7, para 12
[7] Ex B7, paras 13-15
[8] Ex B7, para16
[9] Ex B7, para 17
[10] Ex B7, para 19
[11] Ex B7 para 20
[12] Ex B7, para 20

Under the heading 'INVOLVEMENTS' it stated:

> *"41 prior charges re make threats to kill, assaults, numerous FV and persistent contravene IVO, reckless conduct endanger life, criminal damage by fire - arson*".[13]

18. On 9 November 2018, Senior Constable Weatherby tasked two officers from the Ipswich CIB to make enquiries with the World Gym regarding Mr Jessen. In an email to officers, Senior Constable Weatherby stated:

> *"If you locate JESSEN at the gym please be mindful of current flags suggesting he is in possession of a firearm and is known to be violent. Vic Police have suggested that SERT will be required to effect the arrest if we can identify where he is residing".*[14]

19. Staff at the gym recognised Mr Jessen from the photograph they were shown. They confirmed Mr Jessen was a member of the gym and usually attended every second day. The officers had requested CCTV footage of the last time Mr Jessen attended the gym.[15] The information was relayed to Victoria Police, who advised "*My suggestion would be that you have your special operations team to conduct the arrest. We have a photograph of him with a handgun down his pants at the gym*". [16]

20. As Mr Jessen had not been conclusively identified at the gym, Detective Sergeant Cunningham of the Ipswich CIB told Acting Detective Price of Victoria Police he had tasked officers to attend the gym and obtain CCTV footage.[17] It had been decided between Detective Sergeant Cunningham and Detective Senior Constable Weatherby that four officers should attend in case Mr Jessen was located at the gym.[18] Before the officers went to the gym, Detective Sergeant Cunningham emphasised in his briefing to them that Mr Jessen was a very large male, aggressive, violent and dangerous.[19]

21. While they were liaising with gym staff, the officers were told that Mr Jessen was in the gym. After police saw Mr Jessen leave the gym, they gave chase. During the chase, Mr Jessen gave the impression at times he was carrying a firearm. He was eventually stopped in the industrial site he had been running through.[20] A negotiation took place for approximately twenty minutes, during which time, other QPS units had attended. After some negotiation (which included the deployment of a police dog), Mr Jessen complied with police requests and laid down, face first, on the ground with his arms out to the front. He was taken into custody.[21]

[13] Ex C11
[14] Ex B9, para 7
[15] Ex B9, para 8
[16] Ex B9, para 11
[17] Ex B7, para 23
[18] Ex B9, para 19 and 20
[19] Ex B4, p1
[20] Ex A6, p3
[21] Ex A6, p3

22. Detective Senior Constable Weatherby attended the scene while police were trying to apprehend Mr Jessen. He observed Mr Jessen being taken into custody. He did not speak with Mr Jessen and after returning to the station, emailed his counterparts in Victoria that Mr Jessen was in custody. He had no further involvement in the matter.[22]

23. The Queensland Ambulance Service (QAS) had been on standby at the scene. After he was detained, Mr Jessen complained of chest pain and difficulty breathing. He was then transported by QAS to the Ipswich Hospital.[23]

24. Detective Sergeant Cunningham told the inquest that before Mr Jessen's arrest he had received a series of emails from Victoria Police attaching the Casey Crime Investigation Unit Circular-51[24] and Victoria Police Operation Pre-Deployment[25] which among other information, outlined Mr Jessen's 'Risk Summary' and 'Involvements'.

Mr Jessen is admitted to Ipswich Hospital

25. The handover provided by QAS to the Emergency Department nurse was that Mr Jessen:

> "*had experienced chest pain with shortness of breath, tachycardia with a heart rate of 200 bpm and vomiting following pursuit by the Queensland Police Service … Mr Jessen also had a medical history of recent steroid use for the purpose of body building*".[26]

26. Dr Cassidy, Emergency Department consultant, examined Mr Jessen. He recalled Mr Jessen was restrained in handcuffs in front of his body. He said he generally asks for the cuffs to be removed. Depending on the circumstances, the QPS may or may not agree to uncuff a patient. Dr Cassidy recalled one of the QPS officers responding to his question with words to the effect, "*this man will not be uncuffed*".[27] He ordered Mr Jessen undergo a number of investigations.[28]

27. Mr Jessen was eventually admitted to Ward 7D for telemetry monitoring (mobile cardiac monitoring) after a period of observation in the Emergency Department.

28. On Saturday, 10 November 2018, Dr Thomas Nathrow, Staff Specialist (Medical) reviewed Mr Jessen. He agreed with the initial diagnosis of Atrial Flutter and noted despite Mr Jessen commencing Metoprolol, his heartrate had remained elevated overnight.

[22] Ex B9, paras 21-27
[23] Ex A6, p4
[24] Ex ExC10
[25] Ex C11
[26] Ex B10, para 15
[27] Ex B11, paras 30 to 34
[28] Ex B11.1

29. Dr Nathrow increased the Metoprolol. He ordered an echocardiogram and for Mr Jessen to remain on telemetry monitoring.[29] The plan was to review Mr Jessen the following day with a view to discharging him then or on 12 November 2018 with follow up in the Outpatient Department.[30] Dr Nathrow recalled that when he reviewed Mr Jessen, he was in his hospital bed with each of his hands cuffed to a bed rail.[31]

Guarding Mr Jessen

30. Detective Sergeant Cunningham said after it became apparent Mr Jessen was going to stay in hospital, he sent an email at 8.23pm on 9 November 2019. He copied in:

- Al Badger, Watchhouse Manager;
- Sgt Steven Williamson, CIB (Sergeant across the weekend);
- Sgt David McDonald, afternoon Duty District Officer ('DDO');
- Set Sgt Wayne Griffith;
- Rebecca Nizeti-Panebianco;
- Garreth James, Night DDO; and
- Wayne Francis CIB (Acting Officer in Charge).[32]

31. He provided Mr Jessen's warnings and history, and recommended a minimum of two police were to remain with Mr Jessen at all times.[33] He did not create any Q-Prime entries/warnings but knew Intel was working on a profile for Mr Jessen.[34]

32. In the email Detective Sergeant Cunningham stated:

> *Please be aware that JESSEN has extensive warnings in Victoria for being violent, is being extradited for violent armed robbery offences and ran from officers this afternoon. Further JESSEN spends all of his spare time in the gym and is a rather imposing figure. It is recommended that at least two police guard him at all times while he is in the hospital. I have attached a picture below for your reference.*
>
> *JESSEN is currently on the watch house white board with a notation that he is receiving treatment at IGH. A copy of the Victorian warrant has also been provided to the watch house. It is expected (pending medical clearance) that an application will be made by Victorian Detectives to extradite JESSEN on Monday.*
>
> *D/Sgt Steve WILLIAMSON will liaise with the Victorian Detectives across the weekend and will be the point of contact if any issues arise with JESSEN.*
>
> *DDOs – As earlier discussed.*
>
> *Night wireless – FYI ONLY – It is likely that JESSEN will be transferred from the hospital to the watch house at some stage during your shift. All relevant paperwork has already been provided to the watch house*.[35]

[29] Ex B19, paras 13-14
[30] Ex B19, para 15
[31] Ex B19, para 18
[32] Ex E7 (10:49)
[33] Ex B27
[34] Ex B27
[35] Ex G7

33. Detective Sergeant Cunningham confirmed the reference to two police guarding Mr Jessen at all times was based on his risk assessment due to Mr Jessen's size and the warnings provided by Victoria Police. He told the inquest he did not create an entry in QPrime as he had given the information he had regarding Mr Jessen to Intelligence, and they uploaded relevant information to QPrime.[36]

34. During the inquest, screen shots of what officers could see if they accessed QPrime on a desktop computer were provided. A similar format would appear on an officer's Q-Lite device if they have accessed the material. On the summary page a number of entries were entered on 8 November 2018 (the day before the arrest). Those include:

> *Steroid User*
>
> *Intelligence JESSEN is in possessin* (sic) *of a firearm*
>
> *Recorded with interstate (VIC) history for violent offences*
>
> *Wanted on Warrants in Victoria for Armed Robbery*
>
> *Caution should be taken when dealing with JESSEN – known to be violent.*[37]

35. Under the flag 'Cautions', it stated: "*Caution should be taken when dealing with JESSEN – known to be violent*".[38]

36. Acting Senior Sergeant McDonald was the DDO on shift at the time Detective Sergeant Cunningham sent the email. There was a conversation between the two before the email was sent but he could not recall the content of the conversation due to the passage of time.[39]

37. DDO McDonald said that as he is on the road, he may not look at his email for up to six hours. He thought he saw the email from Detective Sergeant Cunningham at about 11.00pm, or around handover time to the oncoming DDO. He said the crews he spoke to who were assigned to guard Mr Jessen for the night before he read the email were already aware of his history and that two crew were to guard him.[40]

38. DDO McDonald confirmed at the inquest that except for seeing the colour photograph of Mr Jessen, he was already aware of the Victorian warnings and all of the information related to Mr Jessen provided by Detective Cunningham in his email. DDO McDonald felt he had enough information to brief Senior Constable Williamson (a Booval officer who was to relieve the crew at the hospital later in the shift) and Senior Constable Kolera, who was the shift supervisor at the Ipswich station. DDO McDonald did not recall the telephone conversation with Senior Constable Kolera but said it would have been in the same vein as the briefing he provided Senior Constable Williamson. It was his expectation Mr Jessen would be guarded by two officers and would remain in handcuffs.

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[36] Oral Evidence ('OE')
[37] Ex G31.1
[38] Ex G31.2
[39] OE
[40] Ex E21 (47:25)

39. Mr Jessen was under police guard until he could be medically discharged and transferred to a Watchhouse. Uniformed officers were assigned to guard Mr Jessen on Friday, 9 November 2018 through until his death on Saturday, 10 November 2018.[41]

Friday, 9 November 2018

40. Senior Constable Hermann and Constable Hill attended the scene where Mr Jessen was taken into custody. Senior Constable Hermann travelled with Mr Jessen in the ambulance. At the hospital a nurse asked for Mr Jessen to have his handcuffs removed. Detective Houghton-Hunter, who was at the hospital, advised Mr Jessen was to remain handcuffed at all times and police were to watch him when he was treated.[42]

41. Constable Hill told the relieving crew that Mr Jessen was to be handcuffed at all times. However, he was uncuffed at the time as he was having a cannula inserted. It was suggested he could be handcuffed to the bed.[43]

42. Senior Constable Kathryn Franklin was tasked with Constable Matthew Harding to guard Mr Jessen from 7.00pm. Senior Constable Franklin spoke with Senior Constable Kolera, who was the shift supervisor who tasked them to the job at around 6.00pm. He told them the DDO had requested they relieve the Booval crew and to give the DDO a call. She contacted DDO McDonald who gave a quick run-down of the arrest and Mr Jessen's outstanding warrants from Victoria. As well as being advised of the charges against Mr Jessen, she was told he had run from police, had a violent history and to 'Exercise all caution and take all measures'.[44]

43. By chance, Senior Constable Franklin also spoke to officers from the CIB who advised Mr Jessen was violent and likes to escape custody.[45] She also spoke with the dog squad officer who advised '*he is violent as fuck and likes to escape'*.[46] Her partner, Constable Harding, looked up Q-Lite and found out Mr Jessen was wanted for armed robbery and at least one of the robberies involved a handgun.[47]

44. On her arrival to the hospital, she noted Mr Jessen was handcuffed but not shackled. She was not happy with that due to her small stature. She directed her partner to handcuff Mr Jessen's right hand to the bed rail.[48] Constable Harding said if an offender comes from the watchhouse they would usually be shackled.[49]

45. The relieving crew of Senior Constable Williamson and Constable Piccinelli arrived at the hospital at 12.40am and brought a set of watchhouse handcuffs and shackles with them. The outgoing crew stayed while the shackles and the handcuffs were changed.[50] Constable Piccinelli said the handcuffs were replaced like for like, that is, the offender's right hand was handcuffed to the hospital bed.[51] Senior Constable

[41] Ex A6, p4
[42] Ex B31
[43] Ex B31
[44] Ex B28; Ex E19
[45] Ex B28
[46] Ex B28
[47] Ex B28
[48] Ex B28
[49] Ex E9 (19:55)
[50] Ex B28
[51] Ex E28

Franklin had briefed the oncoming staff by phone before their arrival to the hospital and then again at the hospital. She was aware the officers had also spoken to the DDO.[52]

46. Senior Constable Franklin recalled Mr Jessen being very friendly and happy to tell them all about his life, his gym and work. She said, 'it was weird' and thought he may have been trying to get them onside. She said to the relieving crew, words to the effect '*he had been very friendly and don't fall for it'*.[53]

47. Senior Constable Franklin said if the offender had wanted to go to the toilet, he would have remained in handcuffs. She said she never removes handcuffs when guarding an offender in the hospital, 'handcuffs don't come off'.[54] She had done over ten hospital guards over four years, the usual process being when the offender is transferred from the watchhouse they have leg shackles and handcuffs on, and the offender stays like that unless medical care is required. They are given a briefing and told about flags. A medical sheet that they are medically fit for custody is also sent to be completed by medical staff before the offender returns to the watchhouse.[55]

48. Constable Piccinelli said Senior Constable Williamson took a call from DDO McDonald advising to go to the hospital at 10.00pm but this was delayed to 12.00am due to other jobs. Senior Constable Williamson advised Constable Piccinelli the offender was a flight risk and that they 'had to be on top of it'. [56] While at the hospital the officers reviewed Mr Jessen's details on Senior Constable Williamson's Q-Lite. Constable Piccinelli recalled they had concluded 'he had done some bad stuff'.[57] They guarded Mr Jessen until around 6.00am. He was cuffed to the right side of the bed with shackles on his legs. The handcuffs were moved to the front of Mr Jessen on one occasion to go to the bathroom, and then removed on the second time Mr Jessen went to the bathroom.[58] This was because it was difficult for Mr Jessen to use the toilet. Mr Jessen was handcuffed back to the bed following each time he had used the toilet.[59]

49. The officers did not take a break between midnight and 6.00am. At one stage Constable Piccinelli went up the corridor to ask a nurse to fill her water bottle. She recalled Senior Constable Williamson was 'busting' to go to the toilet but would not leave her alone even when Mr Jessen was asleep.[60]

50. Constable Piccinelli and Senior Constable Williamson gave a handover to the oncoming crew. They advised they had tried to handcuff him to the front, but he was more comfortable being handcuffed to the bed. Senior Constable Williamson gave a briefing. Constable Piccinelli did not recall what was said but thought the oncoming crew were aware why Mr Jessen was there.[61]

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[52] Ex B28
[53] E19 (43:00)
[54] Ex E19(39:40)
[55] Ex E19 (41:20)
[56] Ex B34
[57] Ex E28
[58] Ex B34
[59] Ex E28
[60] Ex E28
[61] Ex E28

Saturday 10 November 2018

51. From about 6.00am, Senior Constable Kim Nguyen and Senior Constable Lisa Padden guarded Mr Jessen for about two hours. They had spoken to DDO McDonald about overtime as their shift finished at 6.00am.

52. Senior Sergeant Margetts was the night shift supervisor. Senior Constable Nguyen and Senior Constable Padden were part of his regular crew. He regularly reinforced to his crew that offenders being guarded at the hospital were to be shackled and handcuffed at all times. He did not provide specific instruction on that night but had on many occasions reinforced this instruction. He at times would relieve staff guarding offenders and on occasion would handcuff the offender to the bed, but said they are always handcuffed and shackled. If one of his crew needed a break, he would send a relieving crew up to the hospital. He was not sure what the arrangements were with crews which were not his. [62]

53. Senior Constable Nguyen said when an offender comes from the watchhouse they are usually leg shackled and handcuffed. If taken straight from custody, they will not have leg shackles and he may or may not handcuff the offender, depending on their demeanor and the circumstances.[63]

54. Senior Constable Nguyen said the general rule is two people are to guard an offender, but there are logistical problems if an officer needs to go to the toilet or have a meal. If the offender is compliant, you may decide that is okay.[64] According to Senior Constable Padden there is no requirement to make any notes while guarding an offender, and she has never seen this done. All that is required is to log on and off the job.[65]

55. Senior Sergeant Margetts never told his crew that they were not to leave an officer alone with the offender but thought that would be a given. He was not told by any person that the offender was to be guarded by two persons at all times and that his handcuffs were not to be removed.[66]

56. Senior Constable Nguyen and Senior Constable Padden were not provided the offender's name. They did not look up the offender on Q-Lite or the Job Card and were not aware of any specific warnings/flags before attending the hospital. However, Senior Constable Nguyen had assumed the offender was dangerous from what DDO McDonald had said. [67] Senior Constable Padden did not recall being told any details about the offender - just that they were to go up and take over from a crew guarding an offender. She did not recall receiving a briefing from the crew they were relieving but acknowledged she did go to the bathroom on her arrival to the hospital. She thought she had to be careful due to Mr Jessen's appearance.[68] He was guarded by both officers at all times.[69]

[62] Ex E20 (22:17)
[63] Ex E24 (35:00)
[64] Ex E24 (37:00)
[65] Ex E27
[66] Ex E20 (25:00)
[67] Ex B32
[68] Ex E27
[69] Ex E27

57. Sergeant Ron Heene was the shift supervisor at the Ipswich station. He had taken over from Sergeant Leon Margetts and was advised there was an offender at the hospital who required police guard. Sergeant Heene was erroneously told (or erroneously formed the impression) Mr Jessen had committed an armed hold up at the World Gym and produced a firearm. He believed there was a short siege, and Mr Jessen gave himself up peacefully.[70]

58. Sergeant Heene was advised the offender was handcuffed and foot shackled. He was told by Senior Sergeant Garreth James, District Duty Officer, the offender was dangerous and Senior Sergeant Andrews told him the offender was a 'shit bag' and had used steroids.

59. While Senior Sergeant Andrews had done a risk assessment and organised foot shackles, no instructions were provided as to how the offender was to be guarded.[71] Sergeant Heene did not look up Mr Jessen on Q-Prime.[72] He said he was not told anything in relation to leaving Mr Jessen alone or for him to remain handcuffed at all times.[73]

60. Sergeant Heene conceded before providing briefings to any officers, he was under the impression Mr Jessen was involved in an armed hold up at the World Gym, produced a gun, was involved in a siege, fought his arrest, was dangerous and violent, had used steroids for seven years, and had been involved in previous armed hold ups down south which he was wanted for.

61. Sergeant Heene tasked Senior Constable O'Brien and Constable McManus to take over guarding the offender from Senior Constable Nguyen and Senior Constable Padden. He provided details about the armed hold up but did not advise the crew of the offender's name. He provided the same briefing to Constable Whalin, Senior Constable Kolera and Constable Morrison. At 2.00pm, Senior Constable Lisa Shilton commenced her shift as shift supervisor and Sergeant Heene provided the same briefing to her.[74]

62. In his evidence, Mr Heene (now retired) thought in retrospect that at the time he knew Mr Jessen's name as he kept calling him David Jessen. He also said it was his usual practice to tell officers not to take the handcuffs off and to look up the offender themselves. He would also expect officers to call him if they needed to be relieved to go to the toilet or to have a break. He said he would go up to the hospital to relieve the staff. In oral evidence, he said it was difficult to give Acting Sergeant Shilton a briefing as it was busy, and her attention was constantly being drawn away. He said he told her as much as he could. However, his interview with the Ethical Standards Command did not record those matters.

63. Due to the passage of time, Mr Heene could not remember what he said in oral briefings to the officers he tasked to guard Mr Jessen or Acting Sergeant Shilton. However, he did wonder after the incident whether he had given a good enough briefing. He said Acting Sergeant Shilton could have looked up Mr Jessen on QPrime. He said if he was tasked to the job himself, he would have been asking more questions.

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[70] Ex B30
[71] Ex B30
[72] Ex B30
[73] Ex B30
[74] Ex B30

64. Senior Constable Whalin (as he now is) did not now recall the briefing he was provided by Mr Heene. He recalled he was not told to not remove the handcuffs from Mr Jessen.[75]

65. Mr Heene said if he had been provided Detective Sergeant Cunningham's email, he would have likely photocopied it and given it to the crews. Senior Constable Whalin said while documents and photographs can be uploaded as attachments in QPrime, it is not obvious, and an officer would have to know what they were looking for.[76]

66. Acting Sergeant Shilton could not recall if Senior Sergeant Heene had given her Mr Jessen's name or the extent of Mr Jessen's history. She recalled a discussion with Sergeant Heene and DDO Andrews about Mr Jessen being a big boy, a steroid user and that he had a heart condition. She said she was also aware from Senior Sergeant Heene that Mr Jessen had obstructed police when he was arrested and was wanted in Victoria on warrants. She does not recall undertaking her own verification of the information through QPrime.[77]

67. Constable Andrew O'Brien recalled being advised by Senior Sergeant Heene that Mr Jessen had been arrested the day prior, had a medical complication and was wanted for interstate extradition. Before going up to the hospital, Constable O'Brien and Constable McManus located the Job Card on LCAD and attached themselves to the job. When travelling to the hospital Constable O'Brien was able to get into the Q-Page function through his Q-Lite and saw that the offender was Mr Jessen and that he had a number of flags and alerts. From his memory, they included armed occurrence with a firearm, violence and an escape flag. He showed Constable McManus his iPad with the flags for Mr Jessen.[78]

68. Senior Constable Nguyen and Senior Constable Padden handed over to Senior Constable Andrew O'Brien and Constable Morgan McManus.[79] They advised Mr Jessen was asleep and was handcuffed to the bed. They also said they had not had any issues.[80]

69. At one stage Mr Jessen needed to use the bathroom. He was uncuffed for the short period with the bathroom door in his room left open and the officers standing nearby. This was because Mr Jessen had to carry a small device with leads (cardiac monitor) in one hand and would not have been able to use the toilet if he was cuffed.[81]

70. When the hospital staff arrived with Mr Jessen's breakfast, Constable O'Brien and Constable McManus noted he had metal cutlery on the tray. They asked the kitchen staff to replace it with plastic cutlery and to make a note for all future meals. This was attended to. The officers decided to uncuff Mr Jessen for the short time he needed to eat, as he was hampered from eating due to the monitoring and the cannula in his hand. Constable O'Brien estimates this was for 5-10 minutes. They both stood at the doorway while he ate his breakfast. He was re-cuffed to the bed

[75] OE
[76] OE
[77] OE
[78] Ex E25
[79] Ex B32
[80] Ex B32
[81] Ex E25

as soon as he finished eating. Constable O'Brien said they were never advised Mr Jessen was to be handcuffed at all times. [82]

71. Mr Jessen remained in handcuffs up until around 12.00pm,[83] when Constable Daniel Whalin and Constable Sam Morrison were tasked to guard him. Constable Morrison said they were told by shift supervisor Heene that the offender had been involved in an armed hold up at the World Gym the day prior.[84] Constable Whalin was aware of Mr Jessen's arrest the day before as he had heard it over the police radio.[85] They were assigned to Job 1989 to 'assist prison guard of Tyson Jessen 26/01/90'. They referred to a Q-Lite to obtain custody QP1802092215.[86]

72. Constable Whalin said he expected every officer would check out the details regarding an offender they were guarding on the Q-Lite.[87] He said, even if he was provided with 'paperwork' (Offender Medical Transfer, Treatment and Clearance Sheet[88]) on the offender, he would not use the paperwork (he would put it in his pocket) but would go through the digital information on the Q-Lite.[89]

73. The crew they were relieving provided a handover and said they had removed metal cutlery and a pencil during their shift. Mr Jessen had a pair of watchhouse handcuffs attached to his right wrist which were secured to the bed.[90]

74. Constable Whalin confirmed he and his partner were both larger in stature than Mr Jessen. He considered the job was high risk because it was in the hospital where nobody knows who is present, people are not in uniform, and members of the public are present.[91]

75. Constable Whalin checked his Q-Lite to understand who Mr Jessen was and why he was there. He could not understand why Mr Jessen was in custody and could not see any charge in Queensland linked to him. He did see there was an interstate warrant linked to Mr Jessen. He saw Mr Jessen had a previous violent history and as it was all in Victoria, he could not see it. The flags on Mr Jessen were from the previous day's events.[92]

76. Mr Jessen remained asleep for a period. At one stage Constable Morrison left to get a coffee.[93] This was from the nurse's station on the ward. Constable Whalin said he stood up and kept his eyes on Mr Jessen when this occurred.[94] He estimates Constable Morrison was away for about a minute and a half.[95]

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[82] Ex E25
[83] Ex A6, para 2.15
[84] Ex E22
[85] OE
[86] Ex B38
[87] OE
[88] Ex G17
[89] OE
[90] Ex B38
[91] OE
[92] Ex B38
[93] Ex E31
[94] OE
[95] OE

77. Mr Jessen asked for his handcuffs to be removed so he could eat his lunch. The officers agreed as he had been compliant. Constable Morrison stayed in the doorway with his OC spray in his hands. Constable Whalin said when nurses were attending Mr Jessen, he stood up and had OC spray in his hand which Mr Jessen was aware of. He warned Mr Jessen that he would not tolerate any fast actions or movements.[96]

78. After the meal, Constable Morrison was about to put the handcuffs on when Constable Whalin asked him to hold off while he read OPM 14.9.1. He understood the policy to mean that it is up to the custody officer to determine if handcuffs stay on someone or get reapplied. His assessment was that Mr Jessen posed no threat due to his medical condition (he had though not read the chart and confirmed Mr Jessen's medical condition with anyone). He wrote in his notebook, 'the use of restraints may hinder his medical recovery and only engage him longer at the hospital'. [97] He also indicated that of the 12 times he had previously guarded an offender, he estimated 20% of the time, when he received handover, the offender was not wearing handcuffs.[98]

79. The relevant OPM 14.9.1 provided guidance on the use of handcuffs and issues to consider in making such a decision.[99] The guide said an officer is 'not to handcuff a person in custody to a fixed object, e.g., signpost, except in extreme circumstances'. Constable Whalin said he undertook a risk assessment. The offender was in a single room with only one exit at which they were stationed. There was limited equipment in the room. The door swung towards them so they could close the door on the offender. There was no balcony or ledge. He thought the handcuff to the bed hindered nursing staff in their work. He did not think the situation was 'extreme circumstances' which warranted handcuffing Mr Jessen to the bed, which he saw as being a fixed object.[100]

80. Senior Constable Morrison had no objection to leaving the handcuffs off as he did not think Mr Jessen posed a threat as he had been compliant.[101] When the relieving crew arrived, they were advised the restraints had been removed but they could put them back on. Senior Constable Morrison recalled Senior Constable Kolera saying to Mr Jessen words to the effect, 'if you play up, we will put the cuffs back on you'.[102]

81. Senior Constable Kolera and Constable Gough guarded Mr Jessen from 3.30pm to 5.30pm. Constable Gough said they were not given any 'intel' on Mr Jessen and that they had been tasked by Acting Sergeant Lisa Shilton.[103] Constable Gough said no intelligence was provided, they were just told to go to the hospital to guard an offender.[104]

82. Senior Constable Kolera had been briefed earlier in the day by Sergeant Heene as it was proposed Senior Constable Kolera would do overtime from 4.00pm to 6.00pm to guard Mr Jessen. Senior Constable Kolera recalled being advised this was the offender from the World Gym who had interstate warrants for armed robbery and

[96] OE
[97] Ex B38
[98] OE
[99] Ex G15
[100] OE
[101] Ex E22
[102] Ex E22
[103] Ex B29
[104] Ex E8

that he would get a handover from the officers guarding the offender. He said he was not told much by Senior Sergeant Heene and did not recall the handover.[105] Senior Constable Kolera said he recalled hearing bits and pieces over the radio at the time Mr Jessen was being arrested.[106] Senior Constable Kolera could not recall if he was the shift supervisor on the day Mr Jessen was arrested and had no recollection of any conversation with DDO McDonald.[107] He did not do any QPrime checks before guarding Mr Jessen.[108]

83. Senior Constable Kolera said when guarding an offender, they would usually be provided a sheet with information on it from the watchhouse.[109] It would say if the offender was a flight risk, violent etc. The officers guarding the offender follow that sheet and sign in and out on that sheet.

84. He confirmed this sheet was the 'Offender Medical Transfer, Treatment and Clearance Sheet'.[110] He did not ask anyone about why there was not a sheet. This was because it was not the first time he did not have a sheet. He did not know at the time the offender had not been processed through the watchhouse. [111] He estimated he had guarded 5-10 offenders over 10 years before this incident. If the offender had not gone through the watchhouse there would be no 'sheet', but officers were reliant on an oral briefing. He said in his experience those offenders were always offenders he had arrested. In this case, as Mr Jessen had been in custody for some time, there was a longer separation from the arresting officer.[112]

85. Senior Constable Kolera's understanding was that the offender cannot be handcuffed to an object in case there is a fire, only handcuffed to themselves. Further, unless there is something specified on the sheet from the watchhouse, handcuffs are often left off while the offender is in the hospital.

86. When Constable Gough and Senior Constable Kolera took over, Mr Jessen was not handcuffed.[113] The offender was asleep but woke briefly at the time of the handover. Senior Constable Kolera did not feel uneasy about the offender not wearing handcuffs because he had been very polite and cooperative. He did think he might have been a flight risk at some stage, but the leg shackles would 'conquer that risk'. He did not feel threatened or that he was violent. He did think about handcuffing him after the offender woke up and had had his meal. This was primarily because Senior Constable Kolera needed to use the bathroom and would leave the offender with Constable Gough. As the offender remained asleep, Senior Constable Kolera did go to the toilet in the next room where he could still hear,[114] the toilet being in Mr Jessen's room. Senior Constable Kolera said he kept the toilet door open.[115]

[105] OE
[106] OE
[107] OE
[108] Ex G4, p7
[109] Ex E18 (20:54)
[110] OE
[111] Ex E18(28:15)
[112] OE
[113] Ex B29
[114] Ex E18 (36:45)
[115] OE

87. When Senior Constable Kolera undertook a risk assessment, he considered the handover from the outgoing crew about Mr Jessen's compliant behaviour, and that Mr Jessen was asleep at the time of the handover. He also considered the environment and that there was no way out for Mr Jessen except past them. In the context of Mr Jessen still having leg shackles on, they positioned themselves so they could stop him if he came out. When medical staff went into the room they would physically stand up and go in the room. They also constantly supervised Mr Jessen.

88. Acting Sergeant Lisa Shilton tasked Constable Isaac Collihole and Senior Constable Leesa Richardson to do the 'hospital guard' from about 6.00pm to 8.00pm or until a crew came to relieve them. Constable Collihole claimed he was not given any details about Mr Jessen or who they were taking over from.[116] He stated, "…*I just got told that we just had to, there was someone in custody and we had to watch him*".[117]

89. Acting Sergeant Shilton denied this was the only information she gave Constable Collihole and Senior Constable Richardson.[118] She said she gave them the same information that Sergeant Heene had given her. Constable Collihole did not have a recollection of what he was told but denied he was told Mr Jessen obstructed police when he was arrested. He confirmed he did not know how Mr Jessen came into custody and did not know Mr Jessen's name until the day after the incident.[119]

90. Constable Collihole asked Acting Sergeant Shilton who the person in custody was. He stated, "…*she said I don't know who he is I haven't been provided the details, she goes all I know is he's wanted for something in Victoria that Victorian police wanted him*".[120] Acting Sergeant Shilton said she was advised by Sergeant Heene what the plan was regarding staffing to guard the offender. She knew Mr Jessen was arrested for armed robbery offences and that he had obstructed police the day prior.[121]

91. Senior Constable Richardson also said she did not know who the offender was. The only thing she knew was that his first name was Tyson and did not know anything after that.[122] Senior Constable Richardson conceded it is possible Acting Sergeant Shilton told her Mr Jessen was wanted by Victorian Police for armed robbery and that he had obstructed police during arrest.[123]

92. On handover from the officers guarding Mr Jessen, Constable Collihole said they were advised Mr Jessen had been quiet and essentially there was nothing to worry about. He said he was not provided any history regarding Mr Jessen.[124] They advised he was not cuffed because he was eating.[125]

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[116] Ex B24, line 113-123
[117] Ex B24, line 123
[118] OE
[119] OE
[120] Ex B24 line 150
[121] Ex G5, lines 44-48
[122] Ex B25 line 557-570
[123] OE
[124] OE
[125] Ex B24, line174-177

93. Senior Constable Richardson said they were not introduced to the offender, she stated, "…*they were standing there, and the handcuffs and the key were under the seat on this side*".[126] She confirmed they were watchhouse issued handcuffs because they were yellow.[127] When asked during the investigation if she had formulated a plan to look after the offender, she said "*No, I've done this a million times…It just um is a normal process just watch the offender and that's about it*".[128] However, she acknowledged the offender would usually come from the watchhouse.[129]

94. Constable Collihole said he and Senior Constable Richardson 'got a bit shitty' because they could not find the Job Card or anything to book off on the job. The relevance of this is they could not 'book off' for the job so Comms would know they were taking over guard and could not be assigned jobs.[130] They also did not know the offender's name.[131] Because of this they did not have a name to run through the Q-Lite.[132] He asked Comms and they did not know.[133] He did not seek further information from Acting Sergeant Shilton and said this was probably due to complacency. He did ask hospital staff about Mr Jessen.[134]

95. Constable Collihole and Senior Constable Richardson did not know Mr Jessen's name until after the incident. They conceded because there was no Job Card and they did not know Mr Jessen's name they could not look him up, including looking at any relevant warnings or flags in QPrime.[135] Constable Collihole acknowledged he could have obtained more information and thinks he did not do this due to complacency on his behalf.[136] He said he was only new to Ipswich and was junior to Senior Constable Richardson.[137]

96. A Job Card (1989) had been established when Mr Jessen was first taken into custody, it continued to be used up until 4.01pm on 10 November 2019 when crew PM408 (the crew immediately before Senior Constable Richardson and Constable Collihole) had been tasked to the hospital but took another job. They changed the status from further inquiries at the station and this resulted in no crew being assigned to the job which sends the job to the file stage.[138] The Job was closed and sent for finalisation after crew PM408 were clear of the incident and to Comco to file. Sergeant O'Meara was the Comco who closed the job. This was done in error.[139]

[126] Ex B25, line 574
[127] Ex B25, line 617
[128] Ex B25, line 660-666
[129] Ex B25, line 674
[130] Ex B24, line 197 to 225
[131] Ex B24, line 265
[132] Ex B24 line 785-791
[133] OE
[134] OE
[135] OE
[136] OE
[137] OE
[138] Ex B33 and E26
[139] Ex E26

97. In explaining what occurs when an offender comes from the watchhouse compared to this job, Senior Constable Richardson stated:

> "*So, the watchhouse then give you paperwork that you sign each officer relieving signs then and takes over. And it gives you an outline of what the offender is arrested for um but there was nothing, there wasn't a job on the system or anything which I did say to my partner before shift I said there's not even excuse the expression, but there's not even a fucking job on Q-Lite*".[140]

98. Constable Collihole said in his past experience of guarding offenders when he had been stationed at Mt Isa, every offender had a form which provided relevant information about the offender which would be handed over to a relieving crew.[141]

99. Acting Senior Sergeant McDonald said it had been a long-standing problem with Comco with regard to allocating a Job Card for guarding an offender. They do not see it as a call for service and that the offender should be managed through custody. In this case as the offender had not been taken to the watchhouse he was managed through the original job from when he was first arrested.[142] Acting Sergeant Shilton said sometimes there was a CAD job for offenders, other times there would not be. If the offender was transferred from the watchhouse they would have accompanying 'paperwork' which would provide some background information.[143]

100. With regard to the handcuffs, Constable Collihole stated, "*to be honest I didn't even think about it to re-cuff him. Um and then, then dinner came, and I was like oh probably should have re-cuffed him in between that*".[144] Further, when asked if there is any reason they were not applied he stated, "*his demeanor and the way he was with us…like to be honest we just didn't even think about it because he was so nice and, and he was generally like any time he would move…he would ask us if he can move. Um yes I don't have any answer for that*".[145]

101. With regard to an offender being guarded at hospital, Senior Constable Richardson said all she knows was that they are not to be handcuffed all the time.[146] She recalled being told this at the station but does not remember reading it or having any training.[147] Senior Constable Richardson said she often would attend the hospital to guard an offender and they would not be handcuffed.[148]

102. Constable Collihole and Senior Constable Richardson spoke with Mr Jessen[149]. He told them he was wanted for armed robbery and disclosed he used steroids. Constable Collihole thought Mr Jessen's demeanor was 'quite nice'. Senior Constable Richardson said at no stage did she enter the room. She confirmed they had a conversation with Mr Jessen about his charges and steroid use.[150] She also thought his demeanour was nice. She stated:

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[140] Ex B25, line 678
[141] OE
[142] Ex E21 (51:00)
[143] Ex G5 lines 136-157
[144] Ex B24, line 1000
[145] Ex B24, line 1064-1076
[146] Ex B25, line 760
[147] Ex B25, line 763-790
[148] Ex B25, line 840-845
[149] Ex B24, 269 -374
[150] Ex B25, line 923-942

"he didn't seem, he wasn't aggressive towards police he was very um friendly um and yeah I know he had a lot of facial tattoos, but I don't judge people by that, so I just thought oh he seems like a, a young fellow that had just done the wrong thing".[151]

103. Constable Collihole and Senior Constable Richardson posted themselves outside Mr Jessen's room with the door open. Mr Jessen asked to go to the toilet. Constable Collihole escorted Mr Jessen who was in leg shackles to the toilet without incident.[152] Sometime after that, Senior Constable Richardson left the area to go to the toilet. There were no issues with Mr Jessen.[153]

104. Senior Constable Richardson said it was not usual practice to seek relief to go to the toilet and that you would just go and leave one officer with the offender. She estimated an officer would be away a couple of minutes at a time. She did not alter any control measures when Constable Collihole went to the toilet, she just watched Mr Jessen.[154] She conceded by this time Mr Jessen had advised her he was wanted for armed robbery by Victoria police. She acknowledged her decision not to re-cuff Mr Jessen at that time was a poor decision.[155] Constable Collihole also conceded they did not conduct a risk assessment when they arrived, when they went to the toilet or when he left the ward.[156]

105. Senior Constable Richardson received a call from Acting Sergeant Shilton to advise they were not going to be relieved. Shortly thereafter, at about 8.30pm, Senior Constable Richardson spoke to Acting Sergeant Shilton again and told her Constable Collihole wanted to get something to eat and that her food was at the station and asked her to bring it up.[157] Senior Constable Richardson said it is likely Mr Jessen could hear her part of the conversation she was having with Acting Sergeant Shilton.[158]

106. Senior Constable Richardson told Constable Collihole he was to go and buy himself some dinner, go back to the station to grab her dinner and then grab a couple of coffees and then come back.[159] Constable Collihole understood Acting Sergeant Shilton was to relieve him.[160] Because the lift closed off at 9.00pm, she encouraged Constable Collihole to go, on the understanding Acting Sergeant Shilton was on her way up.[161] Senior Constable Richardson did not reconsider the risk, including her small stature and being left alone with Mr Jessen. She reiterated this was due to complacency and was a poor decision on her part.[162] She explained on other occasions when guarding offenders, officers had left for a coffee or to have a smoke and that was basically normal practice and generally the offenders were not handcuffed.[163]

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[151] Ex B25, line 985
[152] Ex B24line 378 – 417
[153] Ex B24, line 417-420
[154] OE
[155] OE
[156] OE
[157] Ex B25, line 1168- 1174
[158] OE
[159] Ex B24 line 430 -443
[160] Ex B24 line 437
[161] OE
[162] OE
[163] OE

107. Senior Constable Richardson spoke again to Acting Sergeant Shilton after Acting Sergeant Shilton had arrived at the hospital. She told Acting Sergeant Shilton, 'hurry up because Isaac's just left'. Acting Sergeant Shilton said she was on her way.[164] Mr Jessen was able to overhear their conversation.[165] Acting Sergeant Shilton expected both officers would remain guarding Mr Jessen until she arrived and when she realised Senior Constable Richardson was on her own, she quickly made her way up to the ward.[166] Senior Constable Richardson confirmed she had her back to Mr Jessen when she was alone and speaking on her mobile phone to Acting Sergeant Shilton.[167]

108. Senior Constable Richardson agreed, had she had Mr Jessen's name and looked him up on Q-Lite, the information available to her (which was shown to her) would have changed her risk assessment as to how to guard Mr Jessen.[168]

109. As Constable Collihole was exiting the hospital, he ran into Acting Sergeant Shilton. He directed her to go through the Emergency Department due to the lifts closing off and walked down to the Emergency Department with her. As they were walking, they saw three security guards running and Sergeant Shilton advised she would follow them as they would be able to swipe her up to Ward 7D.[169]

110. Registered Nurse Gabrielle Kelly was on duty as Team Leader in Ward 7D on the night of Mr Jessen's death. She heard a person in distress and furniture flying and went to investigate. She saw Senior Constable Richardson on the floor in the doorway to Mr Jessen's room, trapped between the door and the bed. Mr Jessen was hunched over Senior Constable Richardson punching her in the face. She saw him hit her at least six times. RN Kelly stood between SC Richardson and Mr Jessen, trying to block his blows. He then pushed RN Kelly away and punched RN Kelly in the head, forcing her out of the room. Mr Jessen then said, "*I'm going to shoot her*".

111. While RN Kelly recalled that Mr Jessen dragged Senior Constable Richardson into the room and shut the door, Senior Constable Richardson said that he tried to close the door but failed. RN Kelly walked towards the nurse's station and heard three bangs from the room. She thought that Senior Constable Richardson had been shot and called code black indicating a major security incident. She then saw Senior Constable Richardson hunched in hallway and went to her aid, covering her with a blanket.[170] She later called code blue indicating a major medical incident. It was concluded that RN Kelly's bravery allowed Senior Constable Richardson time to remove her service weapon from the holster and defend herself from the attack.[171]

[164] Ex B25, line 1185-1190
[165] Ex B25, line 1834-1840
[166] Ex G5lines 171-182
[167] OE
[168] OE
[169] Ex B24, line 443 - 459
[170] Ex A6, 15.26
[171] Ex A6, 15.26

Conclusions on Factual Inconsistencies

112. The inquest was held close to three years after Mr Jessen's death. During the course of the inquest and throughout the material several factual inconsistencies emerged. I do not consider any witness intended to mislead or was untruthful in his or her evidence.

113. The evidence supports the conclusion that Senior Sergeant Heene (as he then was) did not brief the incoming officers, including Acting Sergeant Shilton, with Mr Jessen's name and that he was violent and dangerous. The effect of this was that this information was not provided by Acting Sergeant Shilton to Senior Constable Richardson and Constable Collihole.

114. However, there is no evidence that any officer was prevented from making the necessary further enquiries either within QPS or via QPrime to obtain this information before guarding Mr Jessen over protracted periods. Further, Mr Jessen's name could have been obtained from hospital staff on arrival at the hospital, enabling any officer to carry out a search on QPrime to locate Mr Jessen's history and to review any relevant flags or cautions.

115. I also accept the evidence of Constable Whalin over that of Senior Sergeant Heene regarding whether instructions were given about not removing handcuffs. Constable Whalin impressed me as a witness, and it would be illogical that he would have carefully considered the removal of the handcuffs including reviewing the relevant sections of OPM if he been directed that they were not to be removed.

116. Taking into account the evidence of DDO McDonald and Senior Constable Franklin, I accept that Senior Constable Kolera was the shift supervisor on the evening of Friday 9 November 2018. However, DDO McDonald acknowledged he did not recall the briefing he gave Senior Constable Kolera. Senior Constable Kolera's instructions to Senior Constable Franklin were that she was to guard Mr Jessen but to telephone DDO McDonald to find out further information. While Senior Constable Kolera may have known some information about Mr Jessen, he was reliant on the handover of Senior Sergeant Heene.

117. I am also unable to conclude that there was general complacency by many officers as suggested by Senior Constable Richardson with regard to leaving an uncuffed offender at the hospital to leave for a coffee or a cigarette. The evidence of the many other officers interviewed following Mr Jessen's death and the actions of those officers in managing the risk of an offender in custody does not support that proposition.

Autopsy results

118. An autopsy was carried out by experienced Forensic Pathologist, Dr Rohan Samarasinghe on 12 November 2018. The post-mortem examination showed Mr Jessen had sustained three gunshot wounds:

    a) One to the front of the neck and exit to the back of the right side of the neck. "*There was associated severe disruption to the larynx and right carotid artery*";
    b) One in the front of the chest without an exit wound. "*The bullet had traversed through the right chest cavity and lung and entered the right upper arm*";

c) One in the left lower chest. "*The bullet had passed through the chest wall, diaphragm, upper abdomen (spleen) and re-entered the chest cavity damaging the left lung, heart and blood vessels. The bullet was recovered from the upper mediastinum*".[172]

119. The toxicology report revealed the presence of Stanozolol (synthetic steroid) and Ondansetron (antiemetic) in antemortem blood. Stanozolol and Metoprolol (antihypertensive) were detected in Mr Jessen's post-mortem femoral blood.[173]

120. Dr Samarasinghe formed the view the cause of death was gunshot wounds of the neck, chest and abdomen. There was no obvious significant cardiac abnormality detected. Mr Jessen's previous tachyarrhythmia was likely provoked by physical stress.[174]

Investigation findings

121. Detective Senior Sergeant Ian Thompson of the QPS Internal Investigations Group, Ethical Standards Command was the Principal Investigator into Mr Jessen's death. DSS Thompson provided a detailed report addressing the circumstances surrounding the death.[175] DSS Thompson concluded:

> "*In the absence of a secure custodial facility and guiding policy and procedure* (QPS) *the detention of Tyson Jessen became the responsibility of individual officers who had to form their own risk and tactical assessments of the risks presented by Tyson Jessen's detention. The various officers who were tasked to guard Tyson Jessen were of a diverse mix of age, sex, education and experience and this affected how they undertook risk assessments*.[176]
>
> …
>
> *In the absence of policy officers had to rely on their own judgements. Tyson Jessen was a physically imposing individual who was covered in tattoos that made him look quite fierce. Against this perception was the evidence of officers that he was compliant and reasonable and was not exhibiting any behaviors that suggested he was an imminent risk. By the time SC Richardson took over the guard detail the information that had been originally relayed by Detectives to the first guarding officers had been lost and instead replaced by the individual assessments of uniform officers who were handing over custodial duties to the incoming officers.*[177]
>
> …
>
> *With the benefit of hindsight and investigation SC Richardson's assessment of the risk posed by Tyson Jessen was clearly erroneous. However, in the face of available information provided by other officers, guidance of policy, guidance by supervisors (Comco or DDO) and the demonstrated compliant and non—threatening actions of Tyson Jessen then her decisions are reasonable.*

[172] Ex A4, p17
[173] Ex A5
[174] Ex A4, p18
[175] Ex A6
[176] Ex A6, para 3 .18
[177] Ex A6, para 3.21

It would be easy to criticize SC Richardson for her perceived naive risk assessment of Tyson Jessen, however the QPS should and must put in place systems that draw back the insistence that risk assessment is the prerogative of individual officers and in situations such as this a formal risk assessment is undertaken, formalised and instructed to all officers with systems put in place to ensure compliance.[178] (emphasis added)

…

There is no evidence to support a criminal offence against any person other than Jessen. There is no evidence to support any breach of discipline or misconduct against any Police officer regarding Jessen's death. Having regard to the circumstances of this case do not recommend any disciplinary or restorative action regarding SC Richardson or any other Police officer.[179]

122. DSS Thompson's report noted there were no procedures within the QPS or interagency agreements on how offenders should be secured in medical facilities. If Mr Jessen had been 'processed' through a watchhouse he may have been transferred to Queensland Corrective Services (QCS) and then taken to the Princess Alexandra Hospital (PAH) Secure Unit. However, as he needed cardiac monitoring he may have ended up in an open ward at that hospital in any event. Regardless of who is guarding the offender the risk for offenders, officers, staff and the public in medical facilities remains.[180]

123. DSS Thompson reported that a number of steps have been taken in the Ipswich region, including an Ipswich Standing Instruction '*Guarding Persons in Custody in Hospital and related medical facilities'*.[181]

124. On 16 July 2019, DSS Thompson forwarded a request to the Operational Review Unit (ORU) to create an interagency working group between QPS, Q-Health and QCS to consider the issue of the lack of secure medical facilities statewide and the creation of facilities, policies and procedures to manage the risk.[182] DSS Thompson sought a recommendation for the creation of an interagency working group to consider and recommend outcomes to address the lack of secure medical facilities and policy and procedure in the guarding and custody of non-custodial offenders in medical facilities.[183]

125. DSS Thompson also highlighted the need to review a number of internal QPS policies and processes:

Recommendation 1: *Review the OPM in relation to guarding of persons in custody at medical facilities, for the purpose of standardising a whole-of—service approach to this type of activity and; use the Ipswich District Instruction as an exemplar to inform this review.*

Recommendation 2: *Review OPM 14.19.1 'Use of handcuffs' and remove ambiguity, particularly regarding ss (iii) not handcuff a person in custody to a fixed object; and review OPM 16.151 'Medical transfer of an offender' with a view to removing ambiguity and clearly articulate the use of the QP0856 'Offender Medical Transfer, Treatment and Clearance Sheet' during all*

[178] Ex A6, paras 4.15 and 4.16
[179] Ex A6, para 4.19
[180] Ex A6, para 4.22 to 4.24
[181] Ex A6, para 4.26
[182] Ex A6, para 4.31
[183] Ex A6, para 4.33

instances where an offender is in custody and receiving treatment at a medical facility.

Recommendation 3: *Consider incorporating officer safety principles such as the ten fatal errors (including complacency) into the officer safety training curriculum. This concept is common within other Australian jurisdictions and overseas (refer also recommendation 6)*

Recommendation 4: *People Capability Command review the adequacy of recruit and in-service training curriculums regarding incident action planning with a view to promoting this as a standard approach for all police tasks. This includes the development of a basic aide memoir, based on the SMEAC model, for use by officers as a planning tool when formulating and communicating a response to allocated tasks.*

Recommendation 5: *A review of leg shackles and body belt equipment be conducted by the Operational Equipment section, in consultation with the State Watchhouse coordinator, to address gaps in training, policy and procedure and to research alternative methods of restraint which may be more fit for purpose.*

Recommendation 6: *Consider incorporating officer safety principles such as the ten fatal errors (including inattention/sleepy or asleep) into the officer safety training curriculum. This concept is common within other Australian jurisdictions and overseas (refer also recommendation 3).*

Recommendation 7: *ESC review targeted drug and alcohol testing requirements and, where appropriate, consider an alternative process.*

Recommendation 8: *That ESC review their post—incident procedures and, where appropriate, ensure that early contact and/or a briefing is provided to the Queensland Police Union of Employees (QPUE) and other interested entities.*[184]

126. On 16 April 2021, Acting Inspector Tim Mowle of the Ethical Standards Command provided a Memorandum '*Status update – Review recommendations regarding the death of Tyson Jessen*' which was provided to the inquest. In the memorandum, Acting Inspector Mowle confirmed QPS Recommendations 1-6 have been implemented.

127. Recommendation 7 was implemented by the passage of the *Police Legislation (Efficiencies and Effectiveness) Amendment Act 2022* in March 2022. Recommendation 8 was noted but it was considered no further action was required.[185]

[184] Ex A6, para 4.30
[185] Ex A7

Conclusions on Issues

Coronial Issue 1: Findings required by s. 45

Identity of the deceased – Tyson Lee Jessen

How he died – On 9 November 2018, Tyson Jessen was taken into custody by the Queensland Police Service in relation to an arrest warrant issued by Victoria Police. During his arrest Mr Jessen developed cardiac symptoms and was admitted to the Ipswich Hospital for investigation and monitoring. While being guarded by a sole female police officer on 10 November 2018 in the Coronary Care Unit, Mr Jessen attacked the police officer, and in self-defence she shot him three times.

Place of death – Ipswich Hospital Chelmsford Avenue, Ipswich, Queensland

Date of death– 10 November 2018

Cause of death – Gunshot wounds of the neck, chest and abdomen.

Coronial Issue 2:

The facilities and resources available to securely accommodate and supervise Mr Jessen while he was in police custody as an acute inpatient at the Ipswich Hospital; and what, if any additional steps were undertaken by the hospital and the QPS to manage the risk of accommodating Mr Jessen at the hospital.

128. The treating clinicians determined Mr Jessen required cardiac telemetry monitoring due to the nature of his symptoms. Patients requiring cardiac monitoring were admitted to the Coronary Care Unit (CCU) of Ward 7D at the Ipswich Hospital.[186] The decision was based on the clinical needs of the patient. Mr Jessen was admitted to a single room (Room 1) of Ward 7D. He was located as far away from other patients as possible, as he was in police custody. At the time of his admission there was no formal policy or processes concerning the hospitalisation of an offender who required police guarding at the Ipswich Hospital.[187]

129. Mr Tallis confirmed the accommodation of an offender in hospital depends on their clinical needs and that it is for the Queensland Police Service to keep the offender secure. The same scenario could occur in other hospitals across the State where an offender requires, for example, cardiac monitoring.

130. The hospital has since implemented a policy, 'Management of Patients in Queensland Police Service or Queensland Corrective Services Custody within the

[186] Ex G22, p1
[187] Ex G22, p2

Ipswich Hospital Clinical Areas'.[188] While the policy requires better communication from the Queensland Police Service and understanding by the clinical staff of the risks associated with an offender, the resourcing for guarding and decision making about restraints such as handcuffs falls to the Queensland Police Service.

131. Following the inquest hearing, West Moreton Health advised there were no secure units in Queensland, New South Wales, Victoria or Western Australia to house offenders requiring acute clinical care while in police custody. Each State has a dedicated secure unit to treat incarcerated prisoners who are in correctional custody. However, as indicated by Mr Tallis, even correctional prisoners with certain clinical conditions (such as Mr Jessen) cannot be treated in a secure unit such as that within the PAH, but would need to be accommodated in open acute specialist clinical units.

132. I agree with the submission from West Moreton Health that it is clear from the evidence that Mr Jessen presented to the Ipswich Hospital with symptoms which warranted immediate assessment, treatment and ongoing management and monitoring. Having regard to his clinical needs, I conclude that Mr Jessen was appropriately accommodated by the Ipswich Hospital in Room 1 of the Cardiac Care Unit.

133. The task of guarding Mr Jessen in an acute care hospital ward was described by a number of police officers as 'high risk'. This was because the hospital is not a secure facility, has members of the public and patients in close proximity and persons are not easily identifiable. While it was argued a secure facility should be available for offenders in police custody, this would not be feasible in all clinical scenarios and in all geographical settings. As a consequence, the Queensland Police Service needs to be able to manage the risks associated with guarding offenders in an acute hospital setting.

134. OPM 16.15.1 'Medical transfer of an offender' included a section for when an offender was taken to a hospital or other medical facility to receive medical treatment following arrest and before acceptance at a watchhouse.[189] There are a number of requirements of the arresting officer. One of those being "*whenever possible completes Parts 'A' and 'B' of the QP 0856: 'Offender Medical Transfer, Treatment and Clearance Sheet' to the best of their ability and information available*".

135. Acting Inspector Mowle confirmed the grey shaded box requiring a risk assessment on the current QP 0856 was inserted into the form following Mr Jessen's death.[190] There is no reference to the completion of a risk assessment by the arresting officer or any other officer in the OPM. There is also no reference to an officer identifying any specific guarding requirements of the offender in the OPM.

136. There was an 'Establishment Instruction' for the Ipswich District Watchhouse 3.5/2018 in place at the time. This applied to an offender who was being guarded at the hospital and who had been processed through the watchhouse. It required the designated OIC, shift supervisor or DDO to make an assessment and negotiate the supply of officers to guard the offender. It also stipulated:

[188] Ex G22.4
[189] Ex G16, p2
[190] OE

a) *No officer should perform more than 4 hours continuous guard duty.*
b) *The officer will maintain log of duties and record the offender's visitors.*
c) *The officer shall book out a portable radio and provide half hourly sit-reps on the status of the offender, and if any problems are being encountered, to the DDO. If radio communications is not acceptable to hospital staff, the officer is to make arrangements to use the ward telephone to contact the DDO, and to provide the DDO with the contact number.*
d) *Where possible officers performing guard duty should make arrangements to have a laptop computer or QLite with them so they can attend to outstanding correspondence but be diligent in guarding of the offender.*
e) *The DDO or shift supervisor is to maintain regular contact with the guarding officers should they not receive the half hourly sit-rep to ascertain if the officer and offender are safe and well.*
f) *The DDO or Watchhouse Manager will provide a briefing to the officer guarding the offender. This briefing is to include but not limited to, familiarization of the ward area, offender background including security risk and relief arrangements.*
g) *The guarding officer is to ensure that at all times visual contact is maintained with the offender where possible. If the offender is utilising the bathroom facilities and an officer of the same sex is available, the officer is to accompany the offender and maintain discrete observation.*
h) *The general duties shift supervisor are to encourage patrol crews to call into the hospital and physically check on the wellbeing of the guard. This may also be used as a toilet break by the guarding officer provided the offender is kept under observation by a police officer.*[191]

137. The evidence was that this 'Instruction' only applied to the Ipswich Watchhouse and general duties officers would not have been aware of it unless they had also worked at the watchhouse. It is difficult to understand why this did not apply to all offenders and why general duties officers were not aware of the instruction when they were often tasked to guard watchhouse offenders at the hospital. In any event, there was no confirmation the instruction was being followed at the time, in particular in relation to the half hourly sit reps and follow up by the DDO.

138. The evidence suggested officers would usually expect to be provided with an Offender Medical Transfer, Treatment and Clearance Sheet where they were tasked to guard an offender at the hospital but that this did not always occur. If this was the repository of information in such scenarios, it is difficult to understand why an 'oral briefing' alone was accepted as the norm when the 'paperwork' was not available.

[191] ExG30, p43

139. Senior Sergeant Hayden provided a statement as part of the investigation. Senior Sergeant Hayden was previously the Officer in Charge of the Operational Skills Section at the Queensland Police Academy. He stated,

> "*good policing practice is to perform a continual threat assessment as to the level of risk both real and potential. During any interaction, officers are to conduct a continual threat assessment…Threat assessment requires continuous re-evaluation being mindful that threat levels rise and fall during use of force incidents; Police Officers must therefore continuously reassess the situation and take appropriate safeguards. The product of the continuous threat assessment process is the creation of situational awareness".*

140. Senior Sergeant Burns-Hutchinson is the Officer in Charge of the Ipswich Station. It was her expectation that the shift supervisors would brief those staff tasked to guard an offender with the offender's name, why the offender was in custody, and any flags or warnings. She also expected an officer tasked to such a duty to confirm this information before guarding an offender in order to be situationally aware. She agreed an officer could not have situational awareness in guarding an offender if they did not have the offender's name and history.[192]

141. As borne out by the evidence, there were a wide variety of approaches taken to assessing the risks involved in the guarding of Mr Jessen. In his report, DSS Thompson stated:

> "*The various officers who were tasked to guard Tyson Jessen were of a diverse mix of age, sex, education experience and this affected how they undertook risk assessments*".[193]

142. DSS Thompson was not able to explain the divergence in approach and accepted the evidence did not support that officer experience necessarily played a part in the assessment of risk. While the degree of variability was concerning, I agree with Counsel Assisting's submission that the critical requirement is that officers arm themselves with the relevant information through QPrime (in addition to any briefing they receive) in order to undertake an appropriate risk assessment of the offender they are tasked to guard, and to adjust that risk assessment when circumstances change through the period of guarding.

143. QPrime contained a caution warning officers that '*Caution should be taken when dealing with Jessen - known to be violent'*. This should have been examined in circumstances where there was no Offender Medical Transfer, Treatment and Clearance Sheet which would have provided some information regarding the offender.

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[192] OE

[193] ExA6, p71

144. I also agree with the submission that it was the responsibility of the individual officers to undertake a risk assessment to mitigate the risk. For example, Constable Whalin obtained as much information as he could about Mr Jessen from QPrime but still made the decision to leave the handcuffs off. I accept that in the absence of prescriptive guidelines or protocols, his interpretation of the OPM cannot be criticised. He managed the risk of the removal of the handcuffs by adopting other control measures which included standing up with OC spray in his hand and watching Mr Jessen when his partner went to get a coffee at the nurse's station, or when nursing staff entered the room. He also took into account that he was a much larger person than Mr Jessen.

145. A number of officers changed their control response when for example, Mr Jessen's handcuffs were removed, or when clinical staff entered the room. This included not taking eyes off Mr Jessen, standing up and watching him directly, going inside the room, and holding capsicum spray. Up until Senior Constable Richardson and Constable Collihole were guarding Mr Jessen, Mr Jessen was kept under close direct supervision by at least one officer. The periods when another officer was not present were short periods with that officer remaining within the clinical unit.

146. The system in place at the time of this death meant that Senior Constable Richardson and Constable Collihole relied on oral handovers which did not provide the necessary information concerning Mr Jessen. The result was they were not aware of the QPrime caution for Mr Jessen. They were likely lulled into a sense of false security due to Mr Jessen's demeanour and apparently compliant behaviour.

147. I agree that it is hard to comprehend that an officer would guard an offender without knowing the offender's name, history, offences and checking for any flags or cautions which had been identified regarding the offender. However, there were other officers who did not arm themselves with the information available on QPrime. By her own admission, had Senior Constable Richardson been aware of the caution she would have managed the risks associated with guarding Mr Jessen differently.

148. I conclude that the policies and processes of the Queensland Police Service concerning managing the risk of guarding an offender, such as Mr Jessen, who had not been processed through the watchhouse were inadequate.

Coronial Issue 3:

Whether the actions of the police officers who were tasked to guard Mr Jessen at the Ipswich Hospital before he attacked Senior Constable Richardson were appropriate in the circumstances.

149. The OIC at Ipswich, Senior Sergeant Burns-Hutchinson, expected that the shift supervisors would adequately brief officers being tasked to guard Mr Jessen with his name, history, offences and any warning or flags. DDO McDonald said it was for the shift supervisors to discuss Mr Jessen with the crews who were being tasked to guard the offender.[194]

[194] Ex G29, para 196

150. Counsel Assisting submitted there was a failure by shift supervisors Sergeant Heene and Acting Sergeant Shilton to provide the officers they tasked to guard Mr Jessen with adequate information, and that if they were not aware of the pertinent details it was incumbent upon them to access that information. Counsel Assisting also submitted if they were not satisfied with the information available to them, they could have contacted the relevant District Duty Officer.

151. It was also expected that the officers tasked with guarding Mr Jessen were to undertake their own independent verification of the information available about the offender on QPrime.

152. However, it was clear that there was a handover meeting with DDO Andrews and Officers Heene and Shilton at the start of Acting Sergeant Shilton's 2:00pm shift where she was given limited information. DDO Andrews was aware that there had been a request for SERT/PSRT assistance to arrest Mr Jessen because of his history of firearms use and he was wanted for armed holdup. He did not share that information with Acting Sergeant Shilton but asked her to make enquiries about whether Mr Jessen could be assessed by a cardiologist and returned to the watchhouse that day.

153. I agree with the submission on behalf of Acting Sergeant Shilton that on 10 November 2018 there was a wider failure by officers in leadership positions in the Ipswich District to share pertinent information relevant to the risk posed by Mr Jessen which would have informed the officers tasked to guard Mr Jessen at the Ipswich Hospital.

154. A number of officers required a toilet break or to obtain coffee or water while they were guarding Mr Jessen. In doing so, before Senior Constable Richardson and Constable Collihole, no officer left the ward, and all remained in relatively close proximity to Mr Jessen's room. The OPM did not address how this would be managed by officers. While it was expected they would obtain relief from another officer, many said it was impractical.

155. Following the decision by Constable Whalin and Constable Morrison to leave the handcuffs off Mr Jessen, it was necessary to consider the control measures should one of the officers decide or need to leave, even for a short period. The simplest option would have been to replace the handcuffs. There was no reason why this could not have occurred.

156. However, as the officers who took over guarding duties from Constable Whalin and Constable Morrison were not informed, and did not inform themselves of the cautions applying to Mr Jessen, this did not occur to them. In addition, it seems there was some complacency and a false sense of security adopted by the officers due to Mr Jessen's demeanor and behaviour, which was reinforced at the handovers that day. It is apparent that this was regarded as a routine or mundane task with little appreciation of the specific risks attaching to Mr Jessen.

157. I also accept the submissions from Counsel Assisting that Senior Constable Richardson and Constable Collihole made some poor decisions including:

- Senior Constable Richardson discussing meal relief arrangements by telephone with Acting Sergeant Shilton and Constable Collihole in front of Mr Jessen. Control measures were available to Senior Constable Richardson and Constable Collihole which included re-handcuffing Mr Jessen to the bed and leaving Constable Collihole directly to observe Mr Jessen while she worked through the arrangements.

- Permitting Constable Collihole to leave the ward before Acting Sergeant Shilton's arrival to the ward without completing a risk assessment and implementing further control measures which would have included reapplying the handcuffs and maintaining constant supervision of Mr Jessen.

- After Constable Collihole left the ward, Senior Constable Richardson speaking with Acting Sergeant Shilton by mobile telephone with her back turned to Mr Jessen in circumstances where there was nobody watching Mr Jessen and Mr Jessen was not handcuffed.

158. It is apparent that this sequence of decisions enabled Mr Jessen to take advantage of the situation in order to attack Senior Constable Richardson. I conclude Senior Constable Richardson and Constable Collihole did not appropriately manage the risks associated with guarding Mr Jessen and did not adhere to good policing practice in maintaining situational awareness.

159. It is important to note that I have assessed these issues having regard to the facts and circumstances which presented themselves to the police officers on the night of Mr Jessen's death.

160. In assessing the actions of the officers, I am also mindful of hindsight bias - the tendency of those with knowledge of an outcome to overestimate the predictability of what occurred relative to alternative outcomes that may have seemed likely at the time of the event. In most critical incidents there are a wide variety of issues at play, and a combination of systemic and individual factors. Poor communication, inadequate documentation and a lack of systems can result in poor decisions being made.

161. Notwithstanding, Senior Constable Richardson acted bravely in the face of the violent assault upon her by Mr Jessen. He clearly expressed an intent to harm her and likely would have caused serious harm to other persons in the hospital had he managed to seize her service revolver. I consider that the courage both she and RN Kelly displayed should be formally recognised and I understand that process has commenced.

Coronial Issue 4:

Whether the information which was known about Mr Jessen was appropriately relayed to the police officers guarding Mr Jessen after Mr Jessen was transferred to the Ipswich Hospital.

162. The information provided by Victoria Police was comprehensive, in particular the 'Operative Pre-Deployment'. It is not clear from the evidence why this information was not attached to QPrime or more information had been entered into QPrime by Intelligence officers.

163. A number of witnesses were shown the email distributed by Detective Sergeant Cunningham. They agreed it would have been helpful had they been provided a copy of that email before guarding Mr Jessen. As Detective Sergeant Cunningham advised, the email was multi-purpose and not specifically directed to the officers guarding Mr Jessen. He thought he had informed the right people about Mr Jessen and that this information would be distributed on an as needs basis. Email communication potentially can become lost or not passed on to the appropriate parties. The evidence suggests the most reliable repository of relevant information regarding an offender is QPrime which can be readily accessed via officers' portable Q-Lite devices.

164. Mr Jessen was clearly a flight risk and a violent offender. More information should have been included in QPrime about his history. However, individual officers also needed to be disciplined in checking QPrime in order to appropriately complete a risk assessment. This information may have made a difference to how Senior Constable Richardson and Constable Collihole approached the guarding of Mr Jessen if they had conducted a risk assessment.

165. One witness describing the verbal briefing process as leading to the original message becoming distorted as it was passed along by a number of people. The incident confirms the need for contemporaneous reliable documentation in QPrime which can be accessed by all officers to inform their decisions as to how they approach the guarding of an offender. It also confirms the need for officers to check this information before guarding a prisoner.

166. I accept the submission from Counsel Assisting that there was a failing by the QPS in not having systems in place which avoided the need for officers to rely on verbal briefings in the absence of 'watchhouse paperwork', and in not having a direction in place that each officer was to independently verify an offender's history, warnings, flags and cautions on QPrime before being tasked to guard that offender. As noted below, this can be remedied with appropriate amendments to the OPM.

Comments and recommendations

167. Section 46 of the *Coroners Act 2003* provides that a Coroner may comment on anything connected with a death that relates to:
    a) Public health and safety,
    b) The administration of justice, or
    c) Ways to prevent deaths from happening in similar circumstances in the future.

168. West Moreton Health has made a number of improvements following Mr Jessen's death. The primary change directly relevant to Mr Jessen's death, was the implementation of the policy '*Management of Patients in Queensland Police Service or Queensland Corrective Services Custody within the Ipswich Hospital Clinical Areas'*.

169. Mr Tallis confirmed West Moreton Health are able to audit the policy through their daily briefing with the police guarding an offender which is documented in the patient's clinical record. The Hospital also encourage staff to speak to a Team Leader if they have any concern about security measures adopted by police officers in a particular case.

170. In addition, West Moreton Health has:

- Strengthened governance processes in relation to occupational violence assessment, prevention and management;
- Identified a more appropriate area of the Ipswich Hospital for the treatment of persons in QPS/QCS custody (and which has the capacity to provide bedside cardiac monitoring);
- Ensured access issues for QPS to enter the Ipswich Hospital after hours have been resolved;
- Undertaken a comprehensive security review of all facilities including the Ipswich hospital. A majority of the recommendations flowing from that review have been implemented;
- Implemented an emergency lockdown procedure in the event of an identified internal or external threat;
- Enhanced code black response capability;
- Implemented an active armed offender procedure;
- Improved communication and hand over policies and procedure relevant to persons in QPS custody and/or who may pose a violence risk; and
- Hired additional security personnel.

171. It was identified during the that inquest there was a slight inconsistency in the hospital policy and the procedure implemented by the Ipswich District following Mr Jessen's death. This related to the Queensland Police Service reference to the use of security officers in circumstances when an officer is left alone when an officer for example takes a comfort break. The Hospital Policy states hospital staff including security officers are not to be used to supervise a patient in custody at any time. This anomaly has been resolved between the agencies.

172. I am satisfied West Moreton Health has implemented appropriate measures following Mr Jessen's death to attempt to avert this type of incident from occurring again.

173. Mr Tallis confirmed it is his understanding Queensland Health more broadly has not adopted any policy, procedure or guidelines concerning the accommodation of offenders who require police guarding in an acute hospital setting since the death of Mr Jessen. As was borne out by the evidence, this type of incident could occur at any hospital throughout the State. It is incumbent on Hospital and Health Services to liaise with local police regarding the management of offenders in an acute care setting.

174. Mr Tallis advised West Moreton Health was in discussions with Queensland Corrective Services about how they might improve efficiencies and use technology, including virtual health to support prisoners remotely and avoid the need to transfer prisoners to hospital. He welcomed the opportunity to speak with QPS regarding any similar initiatives that could be utilised at watchhouses.

175. Counsel Assisting submitted that I should make a recommendation for this issue to be considered by other Hospital and Health Services in consultation with their local police service and/or correctional centres regarding the guarding of prisoners in the acute care clinical setting.

176. As West Moreton Health has made considerable progress in this regard, it may be that the circumstances leading to Mr Jessen's death could be used as a case example by Queensland Health in discussions with representatives from other Hospital and Health Services, who in turn could liaise with their local QPS and QCS representatives.

Recommendation 1.

I recommend that the Queensland Police Service consults with Queensland Health to:

- *ensure there is a consistent approach in relation to the deployment of security staff within Hospital and Health Services to assist in the management of patients in police custody;*
- *explore the use of technology to reduce the need for medical transfers of persons in police detention to watchhouses; and*
- *consider whether other measures adopted by West Moreton Health could be applied in other Hospital and Health Districts.*

177. DSS Thompson made a number of recommendations in his report, which have generally been adopted.

178. The revised version of OPM 14.19 'Handcuffs', includes a section headed 'Handcuffed prisoners or persons under arrest in medical facilities'.[195] It requires the officer to conduct a continuous risk assessment based on 'person, object, place' and to 'maintain continuous, direct and constant supervision'.

179. The OPM requires that the offender be handcuffed at all times and if transferred to a hospital bed or gurney they are to be handcuffed to the bed frame or rail. It states: "*In all situations when medical staff request the removal of handcuffs, officers should seek the assistance of another officer or hospital security to maintain increased vigilance*". Apart from the anomaly regarding the use of hospital security staff, I am satisfied the ambiguity on the use of handcuffs when guarding a prisoner who is not being attended to by a clinician has been addressed.

[195] Ex G15.2

180. In considering the revised version of OPM 16.15.1[196] there still seems to be some uncertainty on a number of aspects, particularly when considering the Ipswich 'District Instruction'[197]. The District Instruction states:

> "*DDO will cause brief summary of risk assessment and resourcing in the form of a 'caution' to be entered into QPrime against the person in relevant occurrence as a simple dot point advice to guard crew (e.g. 'will assault police; will attempt escape; minimum two crew guard and handcuffed all times"* and "*Shift supervisors or DDO must advise crews to review caution before commencing guard duty*".

181. The revised OPM only refers, if the arrest is to continue, to the obligations of the 'arresting officer'. It does not seem to cover a scenario where an offender may be guarded for a protracted period of time or to have a senior officer undertake the necessary risk assessment. Acting Inspector Mowle explained the OPM is the overarching document, and it is for the Districts to implement their own Instruction. This because a number of regions do not have a DDO and it is up to the arresting officer, who may be a junior officer to manage the prison guard.[198]

182. Accepting this, there still is no requirement in the revised OPM for any person to enter a 'caution' in QPrime as suggested in the 'District Instruction' which includes advice to the guard crew, or to direct future guarding officers to review the caution before guarding the offender. This seems pertinent when the evidence suggests the prudent course is for the tasked officer to check details on QPrime regarding an offender before commencing guard duties and that some officers will discard 'paper', and instead rely on the 'digital' material.

183. It is this caution along with briefings and the QP 0856 form which will equip the officer with the information required to undertake an appropriate risk assessment. There is also no reference to the need for ongoing situational awareness and what occurs when an officer requires a comfort break. This relates to the need to re-assess the risk and implement any necessary further control measures. It seems impractical to rely on a relieving officer, particularly in small rural or remote settings to come up to a hospital to relieve an officer.

184. The Commissioner's submissions indicated that the QPS was open to a review of the OPM to provide further instruction to arresting officers and crews guarding offenders, where they require medical treatment prior to being processed by the watchhouse.

Recommendation 2.

I recommend the OPM be reviewed to consider whether section 16.15.1 of the OPM should include an order that the risk assessment be completed, and relevant information recorded both on the QP0856 and in an offender's QPrime cautions.

[196] Ex G16.2
[197] Ex G30, p40
[198] OE

185. I extend my condolences to the family and friends of Mr Jessen and close the inquest.

Terry Ryan
State Coroner
BRISBANE